

# Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide

## Who this guidance is for and when it should be used

- 1 This guidance is for the Investigation Committee and case examiners when they are considering allegations about a doctor's involvement in encouraging or assisting suicide which is unlawful in the United Kingdom.

## Legal context

- 2 In the United Kingdom, it is a criminal offence to encourage or assist a person to commit or attempt suicide.\* Suicide itself is not a crime.
- 3 *The Suicide Act* and the *Criminal Justice Act (Northern Ireland)* require the consent of the relevant Director of Public Prosecutions (DPP) before a prosecution can be brought. In determining whether to bring a prosecution it has long been recognised that the DPP has discretion. Even if there is sufficient evidence to justify a prosecution, one will be brought only if required in the *public interest*. In February 2010, as required by the House of Lords judgment in *R (Purdy) v DPP*, the DPP for England & Wales issued a policy setting out the factors to be considered (for and against prosecution) when exercising that discretion. A similar policy was issued by the DPP for Northern Ireland.
- 4 In Scotland, the Lord Advocate has decided not to issue guidance, but has said that a person encouraging or assisting a suicide could be guilty of culpable homicide.

\* In England and Wales, the full offence is set out in section 2 (1) of the *Suicide Act 1961* and in *Criminal Justice Act (Northern Ireland) 1966*. Both Acts are amended by the *Coroners and Justice Act 2009*. In Scotland, although there is no specific statute relating to assisting suicide, it is likely that encouraging or assisting suicide would constitute culpable homicide (see paragraph 4).

## Relationship between the law and our guidance

- 5** Our fitness to practise procedures serve a different purpose from criminal proceedings, as they are designed to protect the public and the wider public interest. They are not intended to be punitive although we recognise that they can have a punitive effect. This guidance aims to promote consistency and transparency in the decision making process to determine whether or not a case should be referred to a medical practitioners tribunal. Decision-makers apply different tests and considerations at the various stages of the process which do not always correlate with the criminal law; they are not deciding whether a criminal offence has been committed.

## Ethical guidance and principles

- 6** A central part of our role is to give advice to doctors on standards of professional conduct, performance and medical ethics. We do this to protect, promote and maintain the health and safety of the public.\* The main way we do so is through our guidance, *Good medical practice*, and its supporting booklets.
- 7** Our guidance is developed through extensive consultation with the profession and the public. It reflects ethical and legal principles, including the rights set out in the European Convention on Human Rights.
- 8** In our guidance we make clear that doctors must:
  - a** show respect for human life
  - b** make the care of their patient their first concern
  - c** follow the laws, our guidance and other regulations relevant to their work
  - d** ensure that their conduct at all times justifies their patients' trust in them and the public's trust in the profession
  - e** listen to patients and respect their views about their health
  - f** provide patients with the information they want or need so they can make decisions about their health or healthcare, and answer patients' questions honestly and, as far as is practical, as fully as patients wish
  - g** treat patients as individuals and respect their dignity and privacy

\* Section 1(1A) *Medical Act 1983*.

- h** respect competent patients' right to make decisions about their care, including their right to refuse treatment, even if this will lead to their death\*
  - i** provide good clinical care, including treatment to address patients' pain and other distressing symptoms.
- 9** We provide more detailed guidance about doctors' responsibilities in our booklets *Consent: patients and doctors making decisions together* and in *Treatment and care towards the end of life: good practice in decision making*. These include the obligation to discuss with patients their treatment options (including the option of no treatment) and plans for future treatment, including the kinds of treatment or care patients would want – or would not want – when they can no longer make or express their own decisions. We encourage doctors to create opportunities for patients to raise concerns and fears about the progression of their disease and about their death and to express their wishes. Listening to patients, providing them with information, and respecting their decisions to accept or refuse treatment offered to them, are integral parts of good practice.
- 10** Where patients raise the issue of assisting suicide, or ask for information that might encourage or assist them in ending their lives, doctors should be prepared to listen and to discuss the reasons for the patient's request but they must not actively encourage or assist the patient as this would be a contravention of the law. Any advice or information they give in response should be limited to an explanation that it is a criminal offence for them to encourage or assist a person to commit or attempt suicide. For the avoidance of doubt, this does not preclude doctors from providing objective advice about the lawful clinical options (such as sedation and other palliative care) which would be available if a patient were to reach a settled decision to kill himself, or agreeing in advance to palliate the pain and discomfort involved should the need for it arise. Doctors should continue to care for their patients and must be respectful and compassionate. We recognise that doctors will face challenges in ensuring that patients do not feel abandoned while ensuring that the advice or information that they provide does not encourage or assist suicide. Doctors are not required to provide treatments that they consider will not be of overall benefit to the patient, or which will harm the patient. Respect for a patient's autonomy cannot justify illegal action.

\* A patient who dies as a result of the natural progression of their disease, following the refusal of life-prolonging treatment, does not commit suicide. *Airedale NHS Trust v Bland* [1993] 1 All ER 821, *Re JT (Adult: Refusal of medical treatment)* [1998] 1 FLR 48 and *Re AK (Medical treatment: Consent)* [2001] 1 FLR 129

- 11** Nothing in this guidance prevents doctors from prescribing medicines or treatment to alleviate pain or other distressing symptoms. Our guidance in *Good medical practice* and in *Treatment and care towards the end of life* place a duty on doctors to provide such care, and provide further advice, including references to clinical guidance on pain management.\*

## Status of this guidance

- 12** Nothing in this guidance changes the law on assisting suicide; neither should it be taken to imply that the GMC supports or opposes a change in that law.
- 13** This guidance does not replace any other GMC guidance. It should be read alongside all existing guidance for the Investigation Committee and case examiners, operational guidance and guidance on standards of professional conduct and medical ethics. This includes but is not limited to:
- *Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and Case Examiners*
  - *Guidance on convictions, cautions and determinations*
  - *The realistic prospect test*
  - *The meaning of fitness to practise*
  - *Good medical practice*
  - *Treatment and care towards the end of life: good practice in decision making*
  - *Good practice in prescribing*
  - *Consent: patients and doctors making decisions together.*

\* See references in *Treatment and care towards the end of life: good practice in decision making*.  
[www.gmc-uk.org/guidance/ethical\\_guidance/end\\_of\\_life\\_sound\\_clinical\\_judgements.asp](http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_sound_clinical_judgements.asp) and [www.nice.org.uk/guidance/CG140](http://www.nice.org.uk/guidance/CG140)

## The test to be applied

- 14** When considering any allegation of encouraging or assisting suicide, the Investigation Committee or case examiner must decide whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on their registration.\* In making this decision they must have in mind the GMC's duty to act in the public interest. The public interest comprises:
- a** protecting patients
  - b** maintaining public confidence in the profession, and
  - c** declaring and upholding proper standards of conduct and behaviour.

In applying this test decision-makers must consider the intensity of the encouragement or assistance: whether it was persistent, active and instrumental, or minor and peripheral. They should also consider the whole context and the nature of the support or information sought, before deciding whether a referral to a medical practitioners tribunal is required. It is difficult to lay down hard and fast rules and this guidance is not intended to fetter the discretion of the Investigation Committee or case examiners. Each case will depend on its own specific facts.

## Cases involving convictions, cautions or determinations<sup>†</sup>

- 15** Any case in which a doctor has been convicted of encouraging or assisting suicide should be referred directly to a medical practitioners tribunal.<sup>‡</sup> Usually a direct referral should be made where a doctor has accepted a caution and/or has been the subject of an adverse determination by another regulatory body for encouraging or assisting suicide.

\* *Making decisions on cases at the end of the investigation stage: guidance for Investigation Committee and case examiners and The Realistic Prospect Test*

<sup>†</sup> Convictions, cautions and determinations are defined in Section 35C *Medical Act 1983*

<sup>‡</sup> Rule 5 of the *Fitness to Practise Rules* directs the registrar to refer convictions to a medical practitioners tribunal in some circumstances, without first being considered by any case examiner. See also the GMC's Guidance on convictions, cautions and determinations [http://www.gmc-uk.org/DC4594\\_CE\\_Decision\\_Guidance\\_Annex\\_D\\_Convictions\\_Guidance.pdf](http://www.gmc-uk.org/DC4594_CE_Decision_Guidance_Annex_D_Convictions_Guidance.pdf) 58067974.pdf

## Other cases

### Presumption of impaired fitness to practise

- 16** There are certain categories of case (such as violence and sexual assault, or improper relationships with patients) where the allegations, if proved, would amount to such a serious failure to meet the standards required of doctors, that there is a presumption of impaired fitness to practise. Such cases should normally be referred to a medical practitioners tribunal. Exceptions will arise, for example, if, following the investigation of the case, the case examiners decide that the case does not meet the investigation stage test because there is no realistic prospect of establishing the case evidentially.
- 17** Allegations of encouraging or assisting suicide should normally be referred to a medical practitioners tribunal where:
- a** the doctor's encouragement or assistance depended upon the use of privileges conferred by a licence to practise medicine (such as prescribing) or took place in the context of a doctor-patient relationship (as distinct from providing advice or support for family members, see paragraph 21b) and
  - b** the doctor knew, or should reasonably have known, that their actions would encourage or assist suicide or
  - c** the doctor acted with intent to encourage or assist suicide.
- 18** Examples of where such encouragement or assistance might arise include, although are not limited to, where a doctor has prescribed medication that was not clinically indicated:
- a** after a patient had expressed or implied a wish or intention to commit suicide, or their intention was clear from the circumstances
  - b** and the medicine would cause death if taken at the prescribed dose or according to the doctor's instructions.

### Other serious or persistent failures to comply with the principles set out in *Good medical practice* or other GMC guidance

- 19** Doctors' conduct may also raise a question of impaired fitness to practise by (this list is not exhaustive):
- a** encouraging a person to commit suicide, for example by suggesting it (whether prompted or unprompted) as a 'treatment' option in dealing with the person's disease or condition

- b** providing practical assistance, for example by helping a person who wishes to commit suicide to travel to the place where they will be assisted to do so
- c** writing reports knowing, or having reasonable suspicion, that the reports will be used to enable the person to obtain encouragement or assistance in committing suicide
- d** providing information or advice about other sources of information about assisted suicide
- e** providing information or advice about methods of committing suicide, and what each method involves from a medical perspective.

### **Application of the realistic prospect test**

**20** In each case, the prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration must be considered and must proceed on the basis of the individual circumstances of the case and in the light of the GMC's duty to act in the public interest (see paragraph 14). Each act undertaken by the doctor may be considered either separately or together with other allied acts (though see paragraph 22b for exceptions relating to the disclosure of records) but always within the overall context.

**21** A number of factors may be helpful in applying the realistic prospect test (see paragraph 14). The factors below are listed in no particular order of priority and this list is not exhaustive.

- a** Whether the allegation relates to an isolated action or is part of a wider pattern of behaviour.

A 'one-off' action may suggest that the doctor does not pose a risk to patient safety in the future. However, isolated actions may in themselves still undermine public confidence in the profession or contravene the proper standards of conduct expected of a doctor.

- b** Whether the doctor was acting in a professional or personal capacity.

Actions to assist suicide undertaken in a professional capacity will raise questions about the protection of patients, trust in the profession and proper standards of professional conduct.

If the doctor's actions concern a close relative or partner, for example, it is less likely that they would repeat their actions or pose a danger to patient safety. However, such actions may still undermine public confidence in the profession or contravene the proper standards of conduct expected of a doctor.

- c** Whether the doctor intended to encourage or assist the person seeking to commit suicide or whether the doctor knew (or should have known) that their actions could or would have the effect of encouraging or assisting a person in committing suicide.

A doctor may provide information or advice which a patient uses to commit suicide, but the doctor could not reasonably have foreseen this outcome.

- d** Whether the doctor has acted honestly and openly; for example, whether they have kept an accurate record of their prescribing and/or the advice or information provided.

Dishonesty is in itself a serious matter. However, in cases involving encouraging or assisting suicide, records may also indicate whether a doctor knew or should have known the patient's intentions when providing treatment or advice.

- e** Whether the person who has been encouraged or offered assistance was under 18 years of age.
- f** Whether the person who has been encouraged or offered assistance had mental capacity\* to decide to take their own life.
- g** Whether the doctor benefits, financially or otherwise, from the death or from the encouragement or assistance itself (and the extent to which gain was part of the motive).
- h** Whether the person has reached and communicated a clear, voluntary, settled and informed decision to commit suicide or whether there was evidence of threats or pressure to commit suicide, which the doctor knew about, or should reasonably have known about.
- i** Whether the encouragement or assistance was intended (or known to be likely) to have a significant impact on the person's decision or ability to commit suicide.

\* As defined in the *Mental Capacity Act 2005* or the *Adults with Incapacity (Scotland) Act 2000*. There is no primary legislation defining how capacity should be assessed in Northern Ireland.

## Allegations that will not normally give rise to a question of impaired fitness to practise

**22** Some actions related to a person's decision to, or ability to, commit suicide are lawful, or will be too distant from the encouragement or assistance to raise a question about a doctor's fitness to practise. These include but are not limited to:

- a** providing advice or information limited to the doctor's understanding of the law relating to encouraging or assisting suicide
- b** providing access to a patient's records where a subject access request has been made in accordance with the terms of Article 15 of the General Data Protection Regulation (GDPR)
- c** providing information or evidence in the context of legal proceedings relating to encouraging or assisting suicide.

