Scottish Partnership for Palliative Care

20th November 2024

Clare Haughey MSP
Convener Health, Social Care and Sport Committee

cc Clerk to the Committee

Dear Clare

Evidence Session Follow-Up

Thank you for the opportunity to present oral evidence about palliative care during the Committee's ongoing consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill yesterday.

The session covered a lot of ground but there were two important points which it was not possible to raise during the allotted time and which are relevant to the Committee's lines of questioning. I would be grateful if this letter could be shared with members of the Committee.

Coercion – the definition in the Bill is less rigorous than that contained in current GMC guidance

In Section 6 (2) (c) and elsewhere the Bill states that medical practitioners' assessments must ascertain whether in their opinion the person wishing to access AD made the necessary declarations *"…*voluntarily and has not been **coerced or pressured by any other person** into making it."

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The Policy Memorandum published alongside the Bill points to existing GMC guidance on Decision Making and Consent in the context of identifying coercion. This GMC guidance highlights issues for practitioners to be aware of in terms of the exercise of free will (the term coercion is not used), and factors which may increase a person's vulnerability to coercion, for example if they are:

"a. experiencing domestic or other forms of abuse

b. resident in a care home

c. cared for or supported by others because of a disability

d. detained by the police or immigration services, or in prison

e. subject to compulsory treatment or assessment orders, or at risk of becoming so"

The GMC Guidance also highlights that:

*"*Pressure can come from others – partners, relatives or carers, employers or insurers – *or from patients' beliefs about themselves and society's expectations."*

SPPC notes therefore that the conception of coercion in the Bill is significantly narrower than that in the current GMC guidance. The Bill's conception of coercion is that it is pressure exerted **by one person on another**. The GMC's conception of coercion quoted above expands this to include the influence of a person's internalised beliefs and society's expectations.

SPPC's position is that the GMC's conception of coercion is more appropriate and safer in the context of AD, and that this should be on the face of the Bill. It is not appropriate that the Bill should include a definition of coercion which is significantly narrower and less rigorous than that already expected in current medical practice across the UK.

The Bill is an international outlier in its "neglect" of suffering

SPPC notes that the original proposal for legislation stated:

"under this Bill proposal, 2 doctors would be required to independently assess the person making a request, including enquiring about their reasoning and motivations. This is an opportunity to make sure all options have been explored and to refer the person for psychiatric assessment if necessary".

However, in the Bill as eventually published there is no requirement within the stipulated assisted dying process for the assessing doctors to explore/understand the applicant's reasoning and motivation, nor to identify/assess any causes of suffering which may have

led to their request to end their life, even though this suffering may be preventable/reversible in some instances.

In the process set out in the Bill assisted dying is therefore not positioned as the final stage of a sequence which is only reached after other efforts to address suffering. Instead, assisted dying is available without any legal requirement for exploration of the applicant's suffering and the potential to relieve it.

In many countries the experience of suffering is one of the eligibility criteria for AD. This is true for jurisdictions such as New Zealand and Australian states where eligibility is primarily linked to a terminal diagnosis (the person must be expected to die within a specific limited time frame), as well as for countries like Belgium, Canada and Holland where there is broader eligibility and intolerable suffering is generally sufficient grounds even without a terminal diagnosis. In Oregon suffering is not part of the eligibility criteria. However, there is a requirement in Oregon to report on the aspects of suffering which may have led the individual to access assisted dying and so these issues must be addressed. The Assisted Dying for Terminally Ill Adults (Scotland) Bill seems to be an international outlier (and perhaps unique) in requiring no inquiry as to the suffering which may have led the person request AD. This topic is not part of the assessment processes specified by the Bill and the recording forms appended to the Bill require no data to be recorded on this topic.

On matter of accuracy I incorrectly stated in my oral evidence that most people in care homes for older people are in the last 15 **years** of life. I should have said **months** rather than **years** and I hope this error can be noted in the official report.

Best wishes

Yours sincerely

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