Association for Palliative Medicine
Of Great Britian and Ireland

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Twenty-Two Key Questions for MSPs on the Assisted Dying for Terminally Ill Adults (Scotland) Bill 2024 (Updated Feb 26)

1. Patient Safety: Gaps in Safeguards

1. **Prognostic uncertainty**
    - The bill requires a terminal illness diagnosis with a "reasonably foreseeable" death, but Scottish GPs report only 55% accuracy in 6-month mortality predictions for non-cancer conditions[1]. How will the bill prevent inappropriate deaths, of people who may have more living to do, given this uncertainty?
2. **Coercion thresholds**
    - The presence or absence of possible coercion is based solely on the opinion of the assessing medical practitioner. The bill gives no clarification on how such coercion is to be assessed for or ruled out. Police Scotland recorded only 476 coercive control prosecutions in 2022–23 (5.3% of 9,000 reports)[2]. How will the bill prevent deaths due to underlying and unseen coercion? Why not require proof "beyond reasonable doubt"?
3. **"Unbearable suffering" subjectivity**
    - What a person describes as "unbearable" is subjective and changes. Many who present to the hospice or palliative care specialists outlining 'unbearable symptoms' settle remarkably quickly. How will the bill prevent approvals for assisted dying based on treatable distress?
4. **Exclusion of psychiatric assessments**
    - Scotland's suicide rate (753 deaths in 2022) is 45% higher than England's[3], and 90% of suicides involve mental illness[4]. Why omit mandatory psychiatric evaluation before assisted dying?
5. **Lethal medication risks**
    - Oregon reports 4.3% of assisted deaths involve complications like vomiting or prolonged dying[5]. Why doesn't the bill require risk disclosure comparable to Scotland's Treatment Regulations 2009?
6. **Family notification**

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- 92% of Scots believe families should be informed about end-of-life decisions[6], and exclusion increases PTSD risk in bereavement by 300%[7]. Why allow next-of-kin and family exclusion?

7. **NHS delays as a factor**
   - 28% of Scottish patients with chronic pain wait over 6 months for review by a chronic pain specialist.[8] If their chronic pain contributes to "unbearable suffering," how will the bill distinguish system failures from true consent?

2. Palliative Care and Equity

8. **Postcode lotteries**
   - 22% of Scottish health boards lack 24/7 community palliative care, rising to 89% in island communities[9]. How will assisted dying not become the default option for people where other services are absent?
9. **Hospice opt-outs**
   - Only 40% of Scottish hospice funding is NHS commissioned with the rest charitably funded[10]. Can you justify having a charitably funded palliative care services yet 100% tax funded and commissioned assisted dying service?
10. **Doctor shopping**
    - 75% of Scottish Palliative care doctors would not be willing to participate in any part of the assisted dying process and 95% of Scottish palliative care doctors would not prescribe lethal medications.[11] Who is going to provide this service?
11. **Workforce impacts**
    - Scotland has 1.02 palliative consultants per 100,000 people vs England's 1.95[12]. There are less Scottish Palliative Care consultants than MSP's in Scotland. Has modelling accounted for staff diverted from providing palliative care to assisted dying?
12. **Palliative care access**
    - Glasgow's most deprived areas see 45% of patients die without specialist care vs 15% in affluent areas[13]. Shouldn't equitable access precede assisted dying?

3. Professional Conscience and Transparency

Since removal of schedules H1 and G2 in Dec 25 there are no conscience clauses currently in the Bill. Question 13-16 are not in the Bill as it currently stands. See Here

13. **Conscience protections**
    - The bill protects only prescribing doctors, unlike Scotland's Abortion Act which covers all staff?[14] Why exclude nurses (the majority of the palliative care workforce)?

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14. **Data collection gaps**
    - Canada's MAID system found 3 times the uptake in the poorest areas after implementing its tracking data[15]. Why omit similar requirements for data collection?
15. **"Treatment" classification**
    - The bill bypasses Scotland's Adults with Incapacity Act requirements for second opinions[16]. Why this exception?
16. **No pause mechanism**
    - 12% of Canadian MAID approvals were paused in 2022 due to improved prognosis[15]. Why is there no equivalent safeguard in this Bill?

4. Vulnerable Groups and Mission Creep

17. **Mental health exclusions**
    - Canada reports 7.4% of MAID cases have a diagnosed mental illness as a contributing factor[15] and in 2021 2.2% of MAID mental illness was the sole reason of assisted dying. There is a plan to legislate for sole mental illness in 2027[17]. What prevents similar expansion in Scotland?
18. **Socioeconomic disparities**
    - In Glasgow Calton (SIMD1), patients in need of palliative care wait 11 weeks vs 2 weeks in East Renfrewshire (SIMD10)[18]. What prevents assisted dying becoming the only realistic and timely option for people? [*SIMD - Scottish Index of Multiple Deprivation*]
19. **Ethnic minority access**
    - South Asian Scots access palliative care 20% less than white Scots[19]. How will MSPs address this disparity?
20. **Doctor-initiated discussions**
    - Doctors in Scotland are now required to inform patients of all 'reasonable' treatment choices. This bill would make suicide a healthcare treatment for any terminal illness. The power imbalance in every doctor-patient interaction is well evidenced and yet is disregarded in this Bill. What stops this influencing vulnerable patients? This has also been removed from the bill as it stands (See Here)
21. **Expansion risks**
    - Belgium's euthanasia law expanded from terminal to chronic conditions in 3 years[21] and Canada in 4 years. What "terminal illness" definition prevents this?

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