Liam McArthur MSP
Scottish Parliament
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Cc Members of the Health, Social Care and Sport Committee
Bob Doris MSP

7th November 2025

Dear Liam,

Assisted dying and the definition of coercion – response to your request for clarification - for consideration before Committee votes on amendment 139 (Bob Doris)

Scottish Partnership for Palliative Care (SPPC) is concerned that the Assisted Dying Bill currently applies a narrower, weaker definition of coercion to the life and death decisions associated with assisted dying than applies routinely through GMC Guidance to other clinical decision making. I explain this in detail below. SPPC can't see any justification for such an approach.

In discussion at the Health Social Care and Sport Committee meeting on 4th November meeting you said:

> *"….there is nothing wrong with that [GMC] guidance. It is consistent with the approach that is taken in the bill. The discussions that my team and I have had with the Scottish Partnership for Palliative Care on that have yet to determine where that difference is. I will continue those discussions with the SPPC and, indeed, with Bob Doris to establish whether more can be done. However, as yet, I have not seen the evidence that shows the disconnect between the definition in the bill and the GMC guidance."*

I am writing to reiterate SPPC's position on this issue. I hope this will provide you with the clarification you seek. Obviously the definition of coercion is a central and critically important feature of the safeguards in the Bill. This is not a minor matter of semantics.

The Bill currently doesn't define coercion. However, in the Bill "coerced" is always used to mean something ***done by a person***. For example P3 Section 6 line 12

> *"…..made the declaration voluntarily and has not been coerced or pressured by any other person into making it."*

So the concept of coercion in the Bill is one in which coercion is exclusively **something done by a person**.

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The General Medical Council publishes Professional Standards on Decision making and Consent. A section of this Guidance (p18) addresses the scenario **"If you're concerned a patient can't make a decision freely"** It states:

> "Para 70: Patients may feel pressure to have particular treatment or care. Pressure can come from others – partners, relatives or carers, employers or insurers – ***or from patients' beliefs about themselves and society's expectations***." [my italics]
>
> Para 71. You should be aware of this possibility and of other situations in which patients may be particularly vulnerable or susceptible to pressure [and goes on to give examples]"

Thus the GMC Guidance is very explicit that coercion is broader than pressure from others – it is **not only** "something done by a person". It is therefore very clear that the usage of coercion in the Bill is inconsistent with the GMC Guidance.

Amendment 139 (Bob Doris) inserts a definition of coercion into the Bill which is consistent with GMC Guidance. GMC Guidance is consistent with existing Scots law on consent.

SPPC believes that this definition should be on the face of the Bill and not left to guidance. The definition should be as clear and prominent as possible for legislators, the public and for practitioners, otherwise there is risk of confusion (as the discussion at the Committee illustrates).

SPPC is not claiming that identifying and assessing coercion using the GMC's definition is easy. It requires nuance, judgement and engagement with the messy complexities of individuals and their circumstances. You will have heard evidence from SPPC and others during the development of the Bill that clinicians can find it difficult to identify and assess coercion and that the outcomes may be imperfect. However, as the Policy Memorandum to your Bill states, this is something which *"healthcare professionals already have guidance on [footnote link to GMC Guidance] and experience in assessing"* and are expected to do.

MSP's need to decide whether they are happy to apply a narrower, weaker definition of coercion to the life and death decisions associated with assisted dying than applies routinely to other clinical decision making. To reiterate, SPPC can't see any justification for such an approach.

I hope that this letter of clarification has been helpful and that you and other MSPs on the Committee will support amendment 139 (and consequentials).

Best wishes

Mark Hazelwood
Chief Executive

Scottish Partnership for Palliative Care