Royal College of Physicians and Surgeons of Glasgow: Members' views on Assisted Dying Legislation

Report by The Diffley Partnership
7 November 2025

Diffley Partnership

From many voices to smart choices

Contents

1. Background and methodology

This chapter sets out the background and methodology of this research, exploring the views of members of the Royal College of Physicians and Surgeons of Glasgow on the subject of assisted dying legislation in different parts of the UK.

Background

There are currently two legislative bills related to assisted dying being considered in parliaments in the UK: the Terminally Ill Adults (End of Life) Bill (Leadbeater Bill) in Westminster, applicable to England and Wales, and Assisted Dying for Terminally Ill Adults Bill (McArthur Bill) in Scotland.

The Royal College of Physicians and Surgeons of Glasgow (The College), which has a neutral stance on assisted dying, is interested in understanding their members' views on the assisted dying legislation in the UK. In September 2025, The College commissioned the Diffley Partnership to survey their members about views on the legislation relevant to their jurisdiction.

Methodology

Diffley Partnership and The College collaboratively designed the survey questionnaire. The final questionnaire is in Appendix A. Diffley Partnership scripted, tested and administered the survey on the SurveyMonkey platform.

Diffley Partnership researchers sent email invitations to The College's members during the fieldwork period of 26th September to 20th October 2025. The College promoted the survey on their social media and communications channels and Diffley Partnership sent frequent reminders to members who had yet to respond. The survey received a total of 635 responses from members across jurisdictions and professions.

Diffley Partnership undertook quantitative analysis of closed questions and qualitative thematic analysis of open questions. Researchers created a topline analysis of the survey responses (Appendix B) and used 'R' software to create a tabular dataset, including response breakdowns by variables of interest. They also tested for statistically significant differences between subgroups.

Report structure

The remainder of this report outlines the full results of the survey.

2. Survey findings

This chapter of the report outlines results from the survey.

2.1 About the respondents

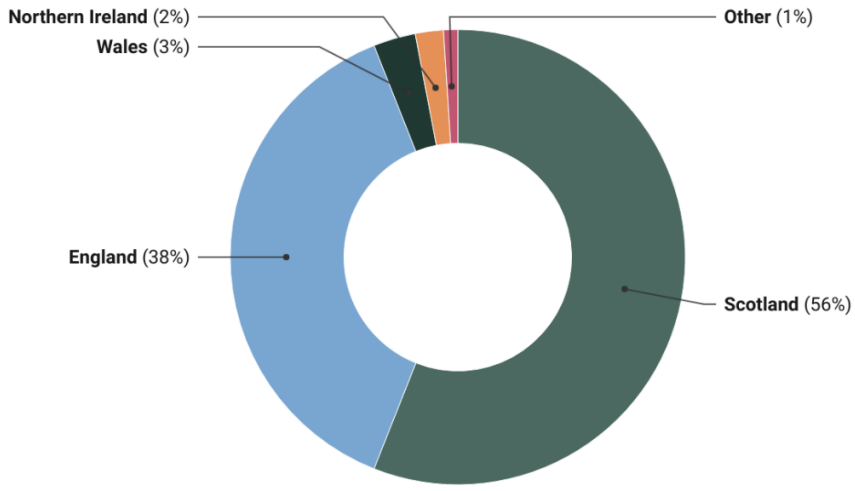
This section contains the results from the survey questions which asked for information about the respondents, including their profession and jurisdiction.

Jurisdiction

We asked members which jurisdiction in the UK is or was their primary place of employment. The majority (56%) of respondents worked in Scotland, and an additional two-fifths (38%) worked in England (Figure 2.1). Only 3% worked primarily in Wales and 2% in Northern Ireland. A further 1% of respondents' primary jurisdictions were outwith the UK.

Respondents based in Scotland were routed to questions related to the McArthur Bill, while those from England and Wales were routed to questions related to the Leadbeater Bill. Respondents whose primary jurisdiction was in Northern Ireland or 'other' were given the option to opt out of the rest of the survey or respond to the questions for the Leadbeater Bill. Of the 20 respondents from Northern Ireland or 'other', 19 chose to respond to the questions for the Leadbeater Bill and one opted out.

Figure 2.1a. Respondents' primary jurisdictions

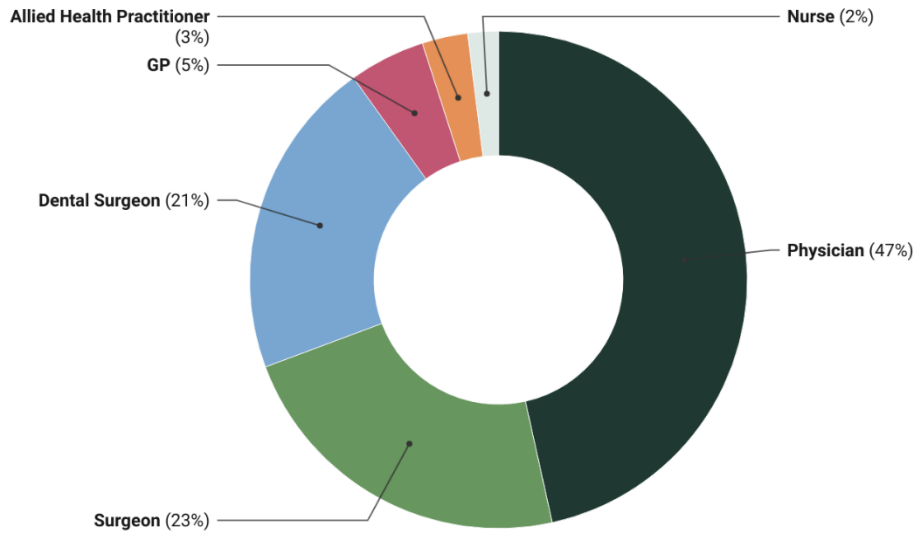


Which jurisdiction is/was your primary place of employment? Base 635

Profession

We also asked which category of medical professional most closely aligned with their role. Almost half (47%) of respondents were physicians and around one quarter (23%) were surgeons (Figure 2.1b). About a fifth (21%) were dental surgeons, while the remaining respondents were GPs (5%), allied health practitioners (3%) or nurses (2%).

Figure 2.1b Respondents' professions



Which category most closely aligns to your profession? Base 635

Career Stage

Members also shared their current career stage. Of respondents who were physicians, almost half (43%) were consultants NS around one third (35%) were retired. Meanwhile, 10% were in speciality training and 4% were SAS doctors. Just 3% were in internal medicine training, 2% were locally employed doctors or selected 'other', respectively, and 1% were foundation year doctors.

Looking at respondents who were surgeons, again almost half (48%) were consultants. Just under a third (30%) were retired, while 9% were SAS surgeons. Just 5% were either in core surgical training or speciality training, respectively. Smaller numbers were locally employed surgeons (2%) or 'other' (1%). None were in their foundation years.

Looking to dentists, half (50%) said they were 'another' type of dentist to the options provided. They provided their titles, including academic dentists, associate dentists and general dental practitioners. Around a fifth (21%) were at consultant level and 18% were retired. Smaller numbers were in specialty training (8%) or dental core training (2%).

Of the GPs in the sample, the same number (21%) were either GP partners or retired. Less than a fifth (17%) were locum GPs and 14% were salaried GPs. The same number (10%) were GPs with a specialised interest or 'another' type. Only 7% were GPs in training.

In terms of nurses and allied health practitioners, a relatively large proportion (29%) were in private practice. The same number (145) were either working at Band 7 or retired, and 11% were either Band 6, Band 8A or an 'other' type, including one Band 9 professional. Meanwhile, 7% were Band 5 and 4% were Band 8b.

2.2 Eligibility criteria

Next, members were asked about eligibility criteria in the legislation, including their familiarity with the criteria in the Bill and any support which would be helpful for assessing eligibility.

Familiarity

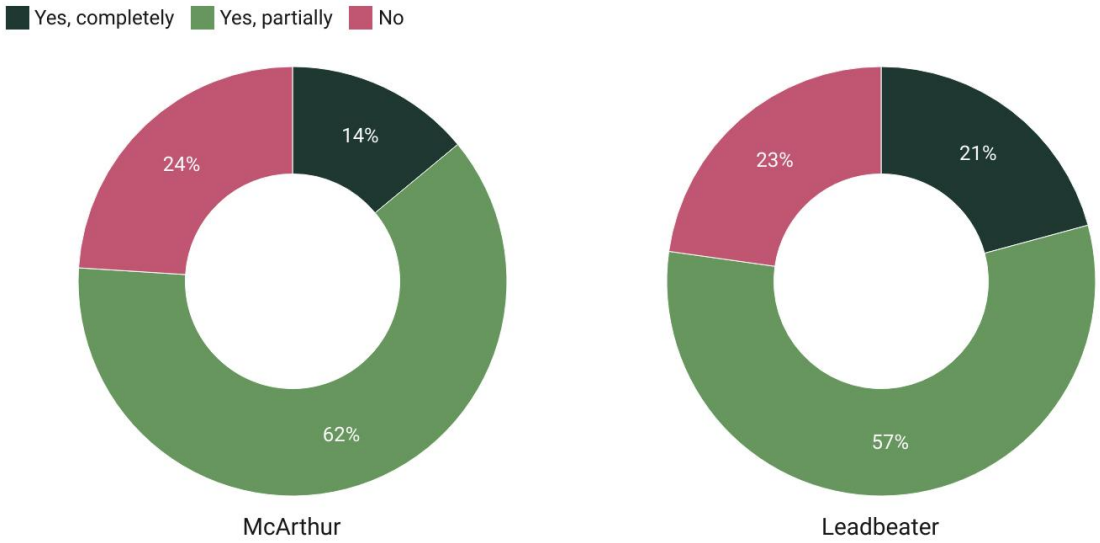
Respondents based in Scotland were asked how familiar they were with the eligibility criteria associated with assisted dying in the McArthur Bill.

Three-quarters (76%) of respondents based in Scotland were at least partially familiar with the eligibility criteria in the McArthur Bill, while the remaining quarter (24%) were not (Figure 2.2a). However, about one in seven (14%) were 'completely' familiar with it.

We asked respondents whose primary jurisdiction was outwith Scotland the same question with regards to the Leadbeater Bill.

Similar to responses for the McArthur Bill, about one in four (23%) said they were not familiar with the eligibility criteria associated with the Leadbeater Bill (Figure 2.2a). About one in five (21%) respondents selected that they were 'completely' familiar with the eligibility criteria, while a bit under three in five (57%) were 'partially' familiar.

Figure 2.2a. Familiarity with the eligibility criteria in the McArthur and Leadbeater Bills



Are you familiar with the eligibility criteria associated with assisted dying outlined in the [Leadbeater or McArthur] Bill? Base 346; 276

Challenges assessing eligibility

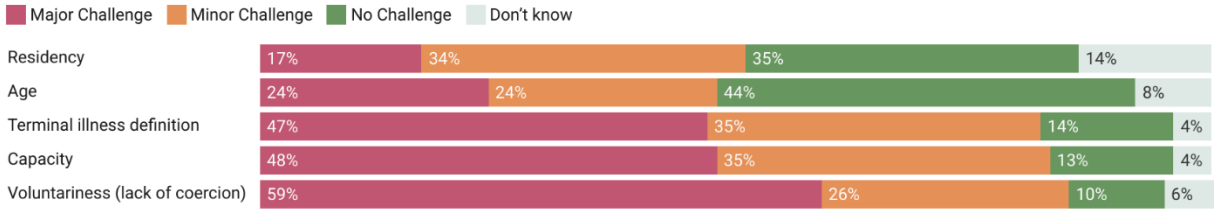
All respondents were asked to what extent they anticipated there being challenges in assessing eligibility based on 'terminal illness' as defined in the relevant piece of legislation, a patient's residency status, age or capacity, as well as their voluntariness, or ensuring they were not being coerced into a decision.

In looking at this range of potential challenges, it is clear that assessing voluntariness is seen as the most significant by members. Three in five (59%) respondents felt assessing voluntariness would pose a 'major' challenge, one in four (26%) said this would be a 'minor' challenge and one in ten (10%) do not foresee this being a challenge (Figure 2.2c). Almost one in two (48%) respondents said assessing capacity would pose a 'major' challenge, while about one in three (35%) felt this would be a 'minor' challenge and one in eight (13%) said this would not be a challenge. Assessing eligibility based on the definition of terminal illness received similar results to capacity; 47% said this would be a 'major challenge', 35% said this would be a 'minor' challenge and 14% said this would not be a challenge.

Significantly fewer respondents thought assessing eligibility based on age or residency would be a 'major' challenge and likewise, were more likely to say they would pose 'no challenge', compared to the other criteria surveyed. One in four (24%) said assessing eligibility based on a patient's age

would be a 'major' challenge, and the same proportion (24%) said this would be a 'minor' challenge. On the other hand, over two in five (44%) said this would be 'no challenge'. Residency was the criteria which the fewest respondents thought would be a 'major' challenge; one in six (17%) said this would be a 'major' challenge, while one in three (34%) said this would be a 'minor' challenge and a similar proportion (35%) said this would not be a challenge.

Figure 2.2b. Challenges assessing eligibility criteria



To what extent, if at all, do you think that you will have challenges in competently assessing eligibility based on the following: Base 547

Interestingly, while about one in four respondents said they were not familiar with the eligibility criteria in the bills (Figure 2.2a), 'don't know' responses to this question were markedly lower, between 4% and 14%.

There were no significant differences in perceptions of challenges based on level of familiarity with the eligibility criteria in the bills or based on jurisdiction.

Support for assessing eligibility

Respondents were also given space to share any support they think would be helpful in assessing eligibility for assisted dying.

The most common suggestion for support was clear guidelines and best practice standards for assessing eligibility according to each of the criteria would be helpful and some suggested this includes case studies or examples of complex situations.

In line with responses to the previous question about challenges assessing these criteria, voluntariness, or lack of coercion, was the criterion which respondents most frequently expressed concerns about assessing. Many respondents stated they imagine this to be very complex and difficult and wondered what "validated and reliable methods" there are to identify the presence of coercion in a patient's decision.

Some suggested that significant guidance and training is needed to learn how to assess coercion, while others believed that guidelines or training would not be sufficient to eliminate risk of undetected coercion. Specific suggestions for support or guidance in assessing coercion included private interviews without family members present, input from professionals with psychiatric expertise and examining factors such as the individual's financial, familial and social circumstances as part of the assessment.

2.3 Definition of 'Terminal illness'

We then asked members two questions about their perspectives on the relevant bill's definition of 'terminal illness'.

In the McArthur Bill, a person is considered terminally ill if:

a) they have an advanced and progressive disease, illness or condition from which they are unable to recover and
b) that can reasonably be expected to cause their premature death.

And for the purposes of the Leadbeater Bill, a person is terminally ill if:

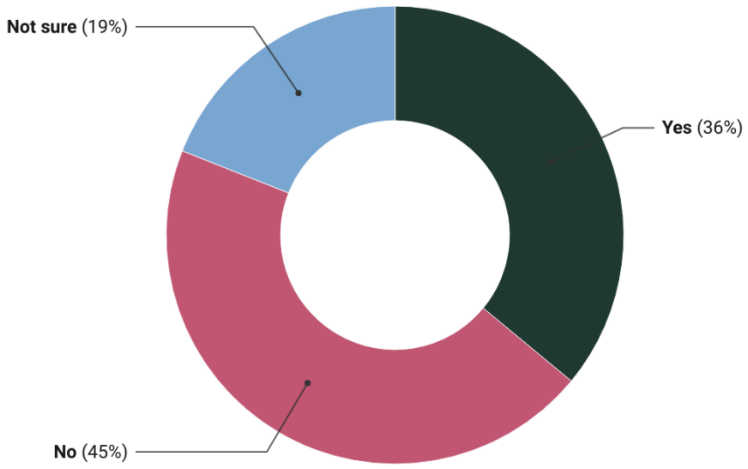
a) the person has an inevitably progressive illness or disease which cannot be reversed by treatment, and
b) the person's death in consequence of that illness or disease can reasonably be expected within six months.

Clarity (McArthur)

Respondents whose primary jurisdiction was in Scotland were asked if they thought the definition provided in the Bill is sufficiently clear for clinical application.

One in three (36%) respondents agreed that the definition provided in the McArthur Bill is clear for clinical application, while nearly half (45%) disagreed (Figure 2.3a). The remaining one in five (19%) responded that they were not sure.

Figure 2.3a. Clarity of the definition of 'terminal illness' in the McArthur Bill



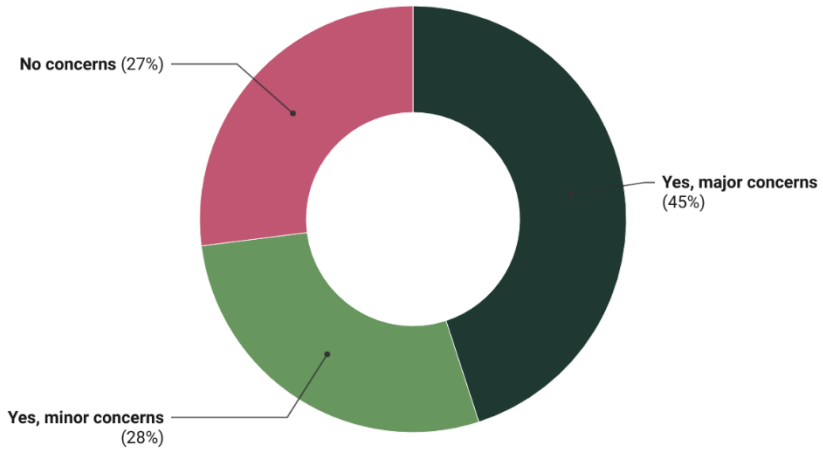
Do you think the definition provided in the Bill is sufficiently clear for clinical application? Base 304

Concerns (McArthur)

Next, respondents were asked if they had any concerns regarding the Bill's definition of terminal illness and were given space to elaborate on their concerns.

Nearly half (45%), the same proportion of respondents who said the definition was not clear, said they had 'major concerns' regarding the Bill's definition of 'terminal illness' (Figure 2.3b). About one-quarter (28%) of respondents said they had 'minor concerns' and a similar proportion (27%) said they had 'no concerns' regarding the definition of 'terminal illness' in the Bill.

Figure 2.3b. Concerns regarding the definition of 'terminal illness' (McArthur)



Do you have any concerns regarding the bill's definition of terminal illness? Base 299

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Respondents were also given space to elaborate on any concerns they may have about the definition of terminal illness in the McArthur Bill.

The most frequently cited concern was that this definition is 'too vague' and too 'open to interpretation'. Some of the wording which respondents found problematic were 'advanced and progressive', 'reasonably expected' and 'premature death'. For example, many explained that this definition describes too many long-term health conditions, such as diabetes, or mental health conditions such as depression or neurodegenerative diseases such as dementia. For instance, one respondent wrote:

> "[The definition] is extremely broad. I think you could interpret most chronic diseases as terminal illness. I look after patients with diabetes which is a progressive disease, from which patients are unable to recover and that can reasonably be expected to cause their premature death. Many mental health conditions, not only dementia, also fit this definition".

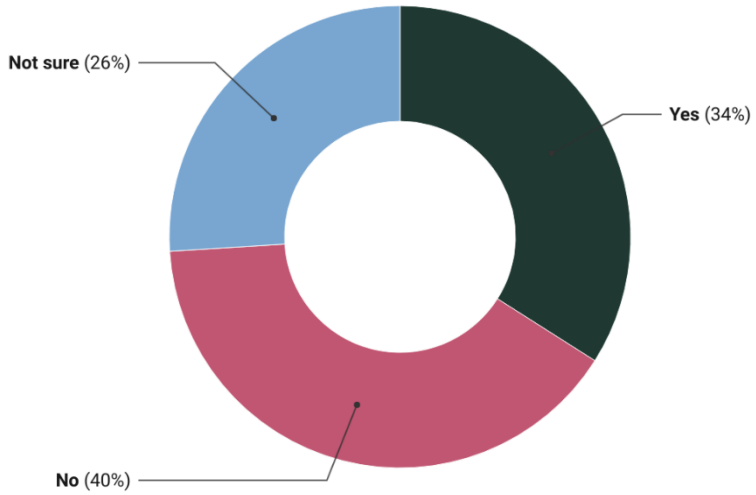
Some respondents also noted the absence of a clear timescale regarding expected prognosis and suggested adding one would be beneficial in clarifying who meets the criteria for assisted dying. On the other hand, some pointed out the difficulty in accurately predicting life expectancy, and suggested that rather than a specific timescale for expected death, the presence of intolerable symptoms or a significant reduction in quality of life should be considered in this definition.

Clarity (Leadbeater)

Respondents answering the questions for the Leadbeater Bill were also asked about if they thought the definition of 'terminal illness' was sufficiently clear for clinical application.

Results were similar to those for the McArthur Bill. One in three (34%) said 'yes', the definition in the Leadbeater Bill is sufficiently clear for clinical application, while two in five (40%) said 'no' it is not sufficiently clear (Figure 2.3c). The remaining one in four (26%) said they were not sure.

Figure 2.3c. Clarity of the definition of 'terminal illness' in the Leadbeater Bill



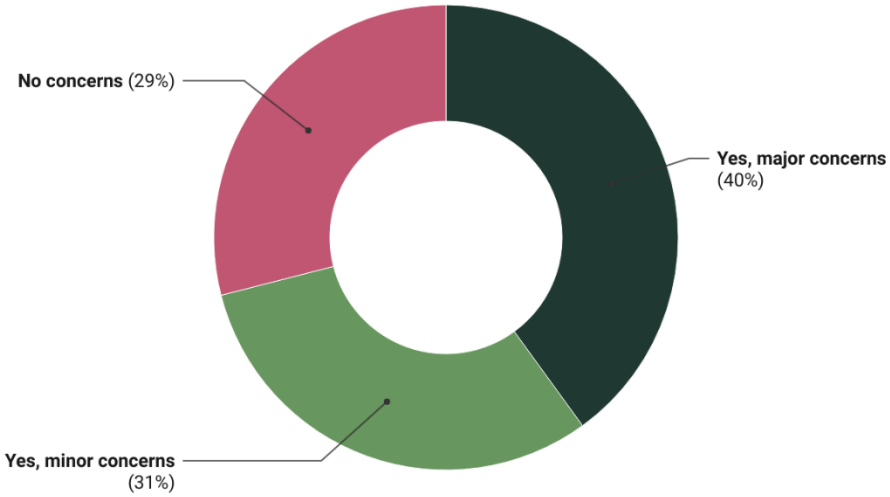
Do you think the definition provided in the Bill is sufficiently clear for clinical application? Base 224

Concerns (Leadbeater)

Respondents whose primary jurisdictions were areas outwith Scotland were also asked if they had any concerns regarding the Bill's definition of 'terminal illness'.

Again, two in five (40%), the same proportion of respondents who said the Bill's definition was not sufficiently clear said they had 'major concerns' regarding the definition of 'terminal illness (Figure 2.3d). The remaining three in five were about evenly split between having 'minor concerns' or 'no concerns'; three in ten (31%) said their concerns regarding the Bill's definition of 'terminal illness' were 'minor' and three in ten (29%) said they had 'no concerns'.

Figure 2.3d. Concerns regarding the definition of 'terminal illness' (Leadbeater)



Do you have any concerns regarding the bill's definition of terminal illness? Base 225

Again, respondents were given the opportunity to share any concerns they have with the definition of terminal illness in the Leadbeater Bill.

The primary concern shared by respondents was related to the six-month timeframe for death prognosis due to the difficulty of predicting this and the large margin of error involved. Many felt this was too restrictive and too difficult to determine to be included in the definition. Similar to responses to concerns about the definition in the McArthur Bill, respondents suggested that the Leadbeater Bill's definition includes something about quality of life. One wrote,

> "I am not sure the 6 months criteria is fair. Surely there are patients with a terminal diagnosis who may be expected to live for longer than this but could be suffering terribly and wish to end their suffering sooner?"

Some respondents also expressed concern about some of the specific language being too subjective such as 'reasonably expected', and a few had concerns about the clause that the patient's illness or disease 'cannot be reversed by treatment' due to the difficulty of accurately predicting this in some cases without actually providing the treatment.

2.4 Capacity assessments

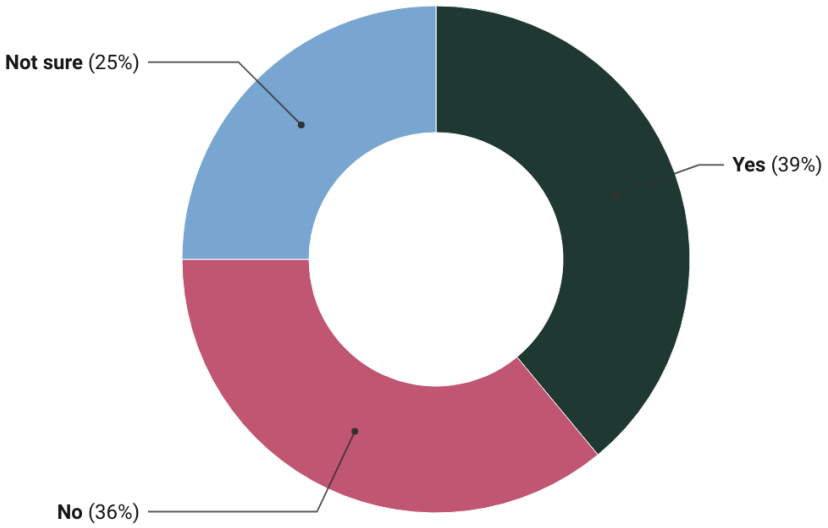
Members were asked for their views on whether or not current clinical tools and frameworks are sufficient to assess capacity in this context, and were asked to share any additional training or resources they believe are needed to support capacity assessments.

Sufficiency of current clinical tools and frameworks (McArthur)

Respondents whose primary jurisdiction was Scotland were asked if they thought current clinical tools and frameworks were sufficient to assess capacity in the context of assisted dying.

About two in five (39%) said 'yes', that they believed current clinical tools and frameworks were sufficient to assess capacity in this context, while about one in three (36%) said 'no', that they did not think they were sufficient (Figure 2.4a). One in four (25%) said they were 'not sure' if they thought current clinical tools and frameworks were sufficient to assess capacity in this context.

Figure 2.4a. Sufficiency of clinical tools and frameworks to assess capacity (McArthur)



Do you think current clinical tools and frameworks are sufficient to assess capacity in this context? Base 299

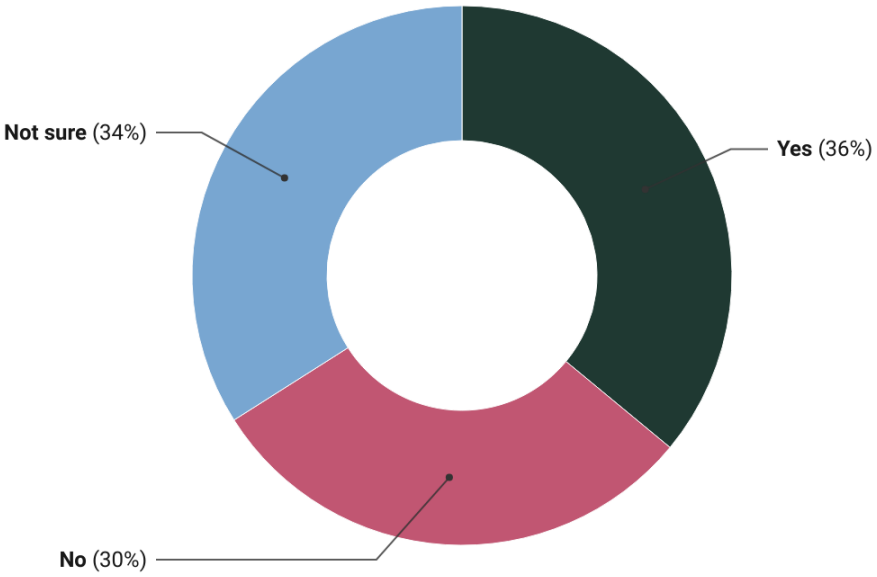
Sufficiency of current clinical tools and frameworks (Leadbeater)

Respondents whose jurisdictions were outwith Scotland were asked the same question about the sufficiency of current clinical tools and frameworks to assess capacity.

While responses for both bills were similar, a slightly higher proportion of members thinking about the Leadbeater Bill responded that they were unsure. About one in three (34%) respondents outwith Scotland said they were not sure about this (Figure 2.4b), compared to one in four (25%) of those who said the same and primarily worked in Scotland (Figure 2.4a).

Moreover, about one in three (36%) respondents to this question said 'yes', while three in ten (30%) said 'no', clinical tools and frameworks are not currently sufficient to assess capacity in this context.

Figure 2.4b. Sufficiency of clinical tools and frameworks to assess capacity (Leadbeater)



Do you think current clinical tools and frameworks are sufficient to assess capacity in this context? Base 224

Additional training or resources

Respondents were then given space to elaborate on any additional training or resources they thought were needed to support capacity assessments. Generally, themes in these responses did not vary depending on members' jurisdictions. Desire for greater support from psychiatric experts emerged more prominently amongst those in Scotland, but members from across jurisdictions shared this view.

A number of respondents said the training which is currently available is already sufficient, but many respondents said they thought additional training for this would be beneficial or should be required for clinicians who would be involved in capacity assessments for assisted dying. Some suggested formats to deliver this training including "regular in person training", "refresher courses", "mentoring and some form of CPD [continuing professional development]", "seminars at hospital grand rounds" and "an online learning module". Some thought that this training should be made available for all clinicians who may be involved while others thought it should be reserved for designated specialists.

Respondents expressed concerns about "fluctuating capacity", where an individual's capacity to make decisions varies at different points in time, influenced by multiple factors including their illness, symptoms and medication; many suggested that multiple capacity assessments over time may be beneficial to address this issue.

Members articulated a desire to have clear, standardised frameworks and guidelines for assessing capacity for assisted dying, although there were mixed views on the adequacy of current tools; a few respondents suggested current tools for assessing capacity could be applied in these circumstances while others believed existing tools are unreliable for this purpose and unique assessment tools should be developed for assisted dying. Some cited that the Royal College of Psychiatrists has stated that current tools are not sufficient to be applied in capacity assessments for assisted dying as evidence that new frameworks are necessary.

Respondents also frequently recommended that multiple opinions or assessors are involved in these decisions, and emphasised the value in multi-disciplinary input, particularly from those with psychiatric expertise or training. Many, particularly those whose work was primarily based in Scotland, suggested that a psychiatric professional should be involved in capacity assessments for assisted dying, particularly where a patient may have mental health conditions such as depression or anxiety which may be influencing their decision-making. Ensuring an "independent" assessment by a professional who has not been involved in the patient's care was also considered an important element of capacity assessments to avoid bias.

Members acknowledged that underlying their support and training needs is a systemic lack of time and resources, and some had concerns that the healthcare system does not presently have scope to provide this training or resources. One respondent summarised:

"There would not be resource in the system - clinic time, and access to specialty psychiatry review if required - to address this currently."

2.5 Practicalities

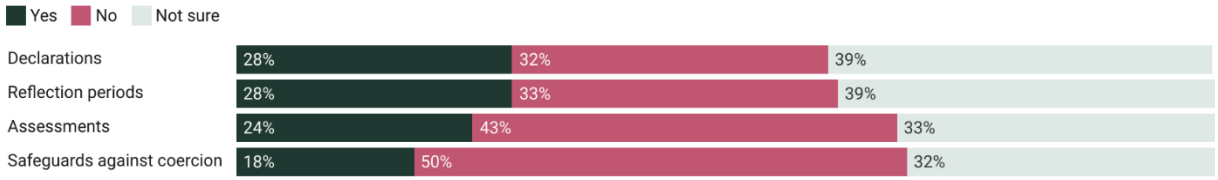
Survey respondents from all jurisdictions were also asked questions about some of the pragmatic aspects of the legislation. This includes how practical the legislation is within the current service structures, protocols and professional standards, if the method of assisted death should be addressed in the legislation and confidence in legal protection for professionals.

Service structures and protocols

Members were asked about their views on whether or not procedures involved in assisted dying including declarations, assessments, reflection periods and safeguards against coercion are practical within current service structures and protocols.

For each of the surveyed procedures, the proportion of respondents who said 'no' as well as the proportion who said, 'not sure' were greater than the proportion of respondents who said 'yes', they thought the procedures were practical. About three in ten (28%) respondents said 'yes', the procedures for declarations are practical, while one in three (32%) said 'no' they are not and two in five (39%) said they were 'not sure' (Figure 2.5a). Views on the procedures for reflection periods were about the same; 28% responded 'yes', 33% responded 'no' and 39% responded 'don't know'. With regards to the procedures for assessments, one in four (24%) respondents said 'yes', they thought these were practical, while over two in five (43%) said 'no' and one in three (33%) said they were 'not sure'. Respondents were least likely to think safeguards against coercion were practical within current service structures and protocols; fewer than one in five (18%) said 'yes', these were practical, while half (50%), said 'no', they were not. The remaining one in three (32%) said they were 'not sure'. Responses did not significantly vary by profession or jurisdiction.

Figure 2.5a. Practicality of procedures within current service structures and protocols



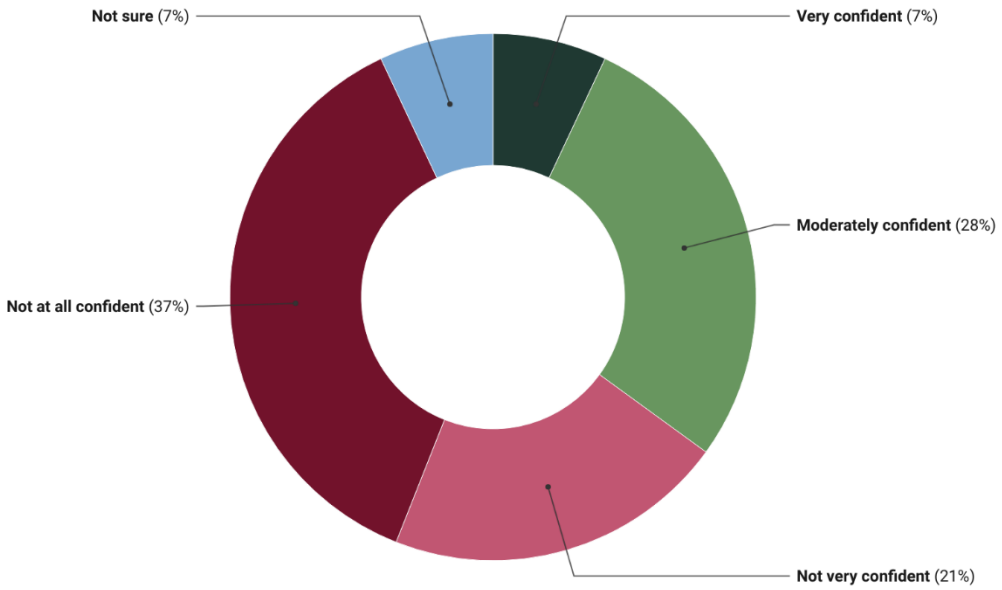
Do you think the following proposed procedures are practical within current service structures and protocols? Base 494

Professional standards and oversight

Respondents were then asked how confident they were that current professional standards and oversight will ensure safe implementation of the bill.

Overall, confidence in professional standards was low; only about one in three (35%) respondents were 'very' or 'moderately' confident, while three in five (58%) were 'not very' or 'not at all' confident (Figure 2.5b). More specifically, fewer than one in ten (7%) were 'very' confident, while about three in ten (28%) were 'moderately' confident; about two in five (21%) were 'not very' confident and almost two in five (37%) were 'not at all' confident. The remaining 7% were 'not sure' how confident they were that current professional standards and oversight would ensure safe implementation of the bill.

Figure 2.5b. Confidence in professional standards and oversight for safe implementation of the bill



How confident are you that current professional standards and oversight will ensure safe implementation of the bill? Base 495

Confidence was consistent across jurisdiction, whether respondents were answering for the Leadbeater or the McArthur Bill - about one in three (34%) of those primarily based in England, Wales, Northern Ireland or 'other' felt confident, and a similar proportion (35%) of those based in Scotland said the same.

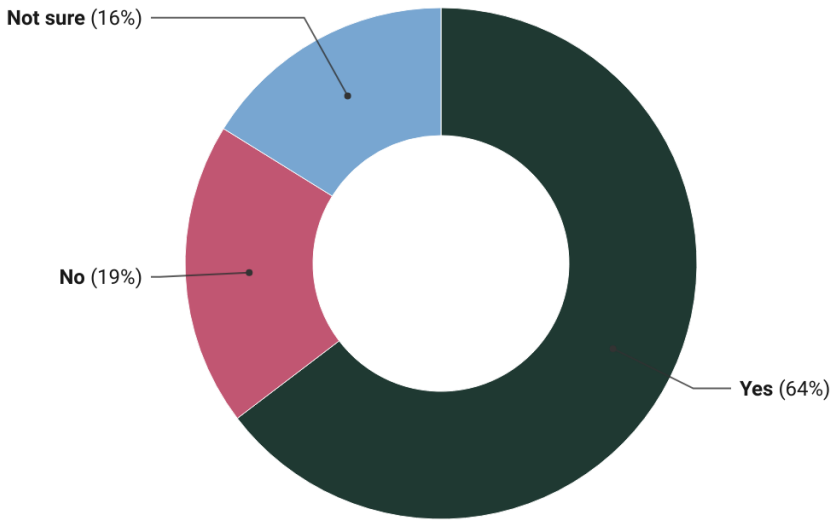
However, when looking at responses from those considering the Leadbeater Bill, those who said they were 'completely familiar' with the eligibility criteria were more likely than those who said 'no' they were not familiar with the eligibility criteria in the Bill to feel confident that current professional standards and oversight will ensure safe implementation of the Bill (39% and 20%, respectively). There were not significant differences in confidence based on familiarity with the eligibility criteria in the McArthur Bill.

Method of assisted death addressed in the legislation

Respondents were then asked if they thought the method of assisted death should be addressed in the legislation.

Almost two in three (64%) of respondents said 'yes', they thought the method of assisted death should be addressed in the legislation, while about one in five (19%) said 'no' (Figure 2.5c). The remaining one in six (16%) were 'not sure' if they thought the method of assisted death should be addressed in the legislation. Responses to this question were consistent regardless of jurisdiction, profession and familiarity with eligibility criteria in the bills.

Figure 2.5c. Views on if the method of assisted death be addressed in the legislation

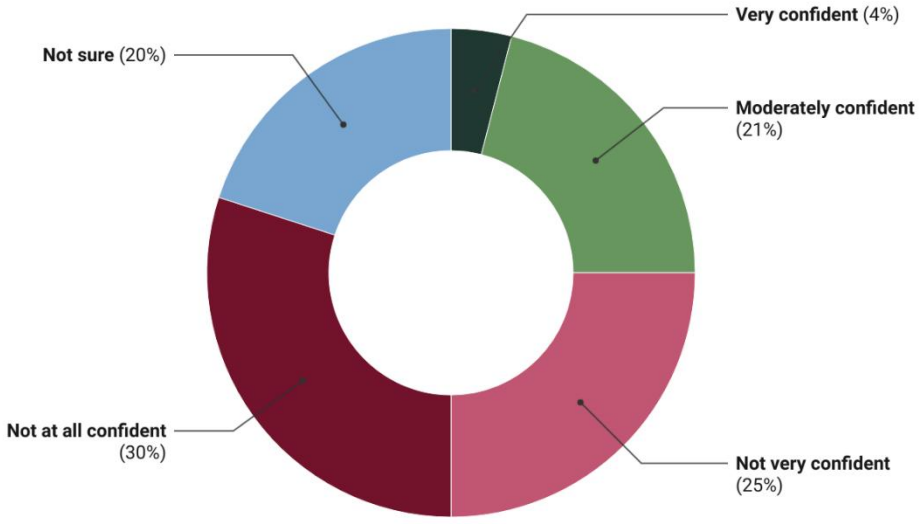


Do you think the method of assisted death should be addressed in the legislation? Base 495

Confidence in legal protection for professionals

About one in four (25%) were 'very' or 'moderately' confident in legal protection for professionals, while over half (55%) were 'not very' or 'not at all' confident that the Bill provides sufficient legal protection for professionals involved in assisted dying (Figure 2.5d). Fewer than one in twenty (4%) said they were 'very' confident while one in five (21%) said they were 'moderately' confident; one in four (25%) were 'not very' confident and around one in three (30%) were 'not at all' confident about the relevant legislation's legal protection for professionals involved in assisted dying. The remaining 20% were 'not sure'. There were no significant differences in confidence in legal protection for professionals between respondents considering the Leadbeater Bill or the McArthur Bill.

2.5d. Confidence in legal protection for professionals



How confident are you that the bill provides sufficient legal protection for professionals involved in assisted dying? Base 495

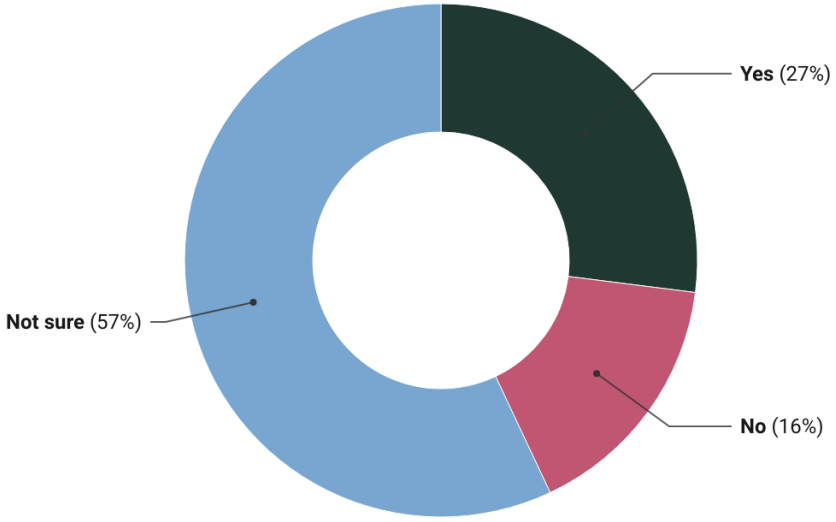
2.6 Clarifications

Next, members were asked about additional protections or clarifications they would recommend for the legislation.

Additional protections or clarifications

The majority (57%) of respondents said they were 'not sure' if they had any additional protections or clarifications they would recommend, while one in four (27%) said 'yes' and one in six (16%) said no (Figure 2.6a).

Figure 2.6a. Additional protections or clarifications to the bills



Are there additional protections or clarifications that you would recommend? Base 477

Considering differences between the pieces of legislation, respondents considering the Leadbeater Bill were slightly more likely than those answering with regards to the McArthur Bill to say 'yes', there were additional protections and clarifications they would recommend (32% and 24%, respectively). However, respondents considering the McArthur Bill were not more likely to say 'no' there were not any additional protections or clarifications they would recommend than those responding about the Leadbeater Bill, but they were more likely to say they were 'not sure' (61% and 51%, respectively).

Suggested additional protections or clarifications

Those who answered 'yes' then set out their recommendations for additional protections or clarifications.

Many emphasised the need for legal support and protections – this was often tied to the need for a clear understanding of what physicians would or would not be liable for should they choose to

participate in assisted dying. A few respondents recommended there be an explicit declaration that families cannot take legal action against physicians involved, with one calling for a clear statement that no fault can be attributable to the assessing physician. It was also felt that legal/ethical committees should be involved in more complex cases, to reduce the risk of potential legal repercussions.
Others called for specific protections of those who choose to be involved in assisted dying from malpractice claims from individuals or groups who disagree with it, including protest groups. One respondent felt practitioners should have access to anonymity from press if needed.

Several respondents asked that there be full, state-backed indemnity and protection from future litigations from patients and families. Indeed, one felt that the legislation and its potential impacts be clarified by medical insurance companies.

Several respondents mentioned the need for protections from the influence of family dynamics. Some felt it could be difficult to determine whether patients wish to end their life to reduce the impact of their suffering on family or are experiencing coercion from family members. They therefore called for safeguards and guidance for clinicians to look out for such pressures:

> "Safeguards for coercion or undue influence – clinicians should assess for subtle pressure from family, carers, or healthcare systems".

An audit trail of clinical decisions was seen as a key layer of protection. Respondents recommended clear guidelines on the required documentation, to ensure evidence of clinical decision-making, the patient's capacity and the 'journey' until the point of assisted death:

> "There should be evidence of a decision process - not a one-off point in time - this is an issue that should be revisited on multiple occasions in the discussion between patient and practitioner, with family support and/or advocacy as appropriate".

Others felt that the legislation should set out mental health protections for staff involved in assisted dying, including counselling and psychological support.

Several respondents were keen for clarifications that clinicians can choose whether or not they participate in the assisted dying process, and assurances that those who opt out of the practice will not be discriminated against:

> "[There is a need for clarity on the] Implications for clinicians who have ethical/religious objections to being involved – will they be able to opt out? Will this have implications for their career choices?".

Some respondents saw specific training pathways for assisted dying practices as important, while others called for those opting to take part to undergo revalidation. They also felt it would be useful for the legislation to require a register of trained approved practitioners. Relatedly, a few respondents believed there should be a standalone service and dedicated teams performing this role, similar to palliative care teams:

> "I believe it would be to the benefit of all involved, for this to be a standalone service delivered and lead by those experienced and trained to do so".

Other recommendations included the incorporation of advanced care directives and escalation paths.

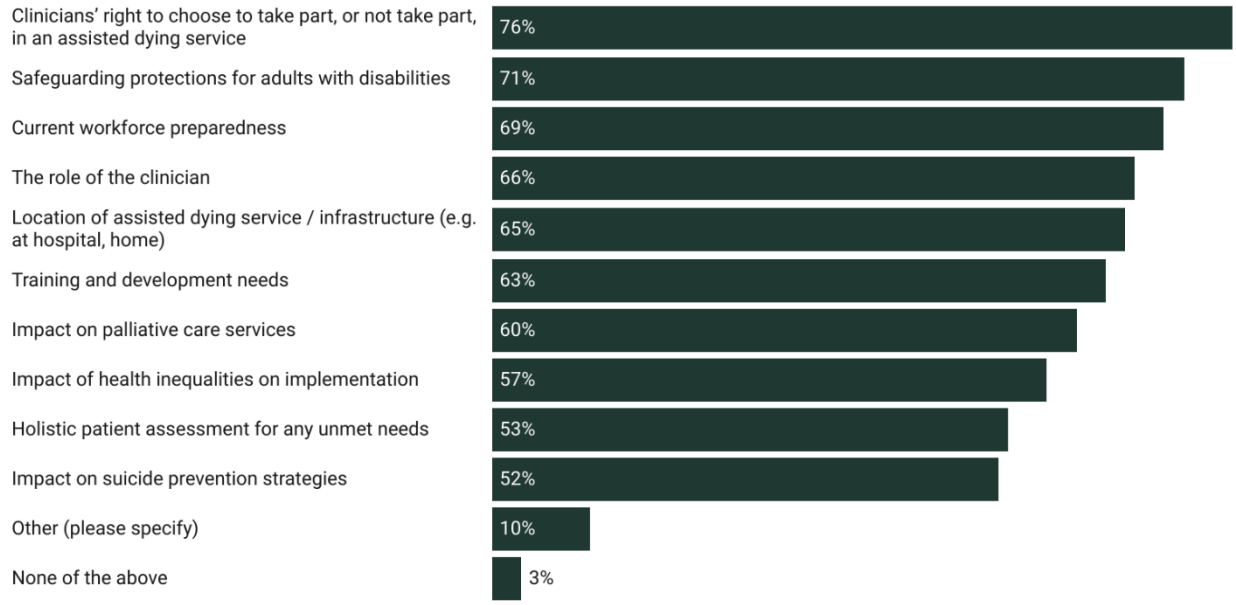
Areas that require further clarification

The most frequently selected area requiring clarification was 'clinicians' right to choose, take part, or not take part in an assisted dying service', which three in four (76%) respondents said required clarification (Figure 2.6b). About seven in ten (71%) said 'safeguarding protections for adults with disabilities' required clarification and a similar proportion (69%) said 'current workforce preparedness' needed clarification.

Around two in three (66%) said 'the role of the clinician' required clarification, about the same proportion (65%) said the 'location of assisted dying service(s)' needed clarification in the Bill and slightly fewer (63%) said 'training and development needs' required clarification. About six in ten (60%) said 'impact on palliative care services' needed clarification and a similar proportion (57%) of respondents said the same about the 'impact of health inequalities on implementation". A bit more than half (53%) of respondents said 'holistic patient assessment for any unmet needs' and a similar proportion (52%) said the 'impact on suicide prevention strategies' needed clarification in the legislation.

Fewer than one in twenty (3%) said there were no areas which required clarification within the Bill and around one in ten (10%) said there was another area not listed which they thought required clarification.

Figure 2.6b. Areas requiring clarification within the legislation



Please select any areas you feel may require further clarification within the bill: Base 474

Considering differences between different medical professions, physicians were more likely than surgeons to want clarification about the location of assisted dying service/infrastructure required further clarification (69% and 60%, respectively), as well as the impact of health inequalities on implementation (60% and 50%, respectively).

Looking at differences between jurisdiction, there were a few slight differences in terms of priorities for clarification (Table 2.6.), however the only significant difference was with regards to the proportion of those who thought clarification was required on training and development needs (marked with **). Those based in jurisdictions outwith Scotland were more likely than those based in Scotland to say this required clarification (68% and 58%, respectively).

Table 2.6. Areas requiring clarification within the Leadbeater and McArthur Bills

	Leadbeater (Base: 197)	McArthur (Base: 273)
	%	%
Clinicians' right to choose to take part, or not take part, in an assisted dying service	77	76
Current workforce preparedness	71	69
Safeguarding protections for adults with disabilities	69	74
Training and development needs**	68	59
Location of assisted dying service / infrastructure (e.g. at hospital, home)	65	66
The role of the clinician	65	67
Impact of health inequalities on implementation	59	55
Impact on palliative care services	57	62
Impact on suicide prevention strategies	54	51
Holistic patient assessment for any unmet needs	51	53
Other (please specify)	10	11
None of the above	2	3

'Other' clarifications

Many respondents used the 'other' option to express their concerns about the ethical or moral basis of assisted dying. Some of the remaining responses elaborated on some of the areas listed above such as questions about the role of palliative care and "exploring ways to support terminally ill individuals in living their final days with dignity". Some respondents also wondered how to handle assisted dying for patients with incapacity or disabilities. For example, members would like clarification on "safeguarding but also enabling adults with disability."

Respondents said they would like the legislation to clarify how the risk of coercion will be managed and several wondered how participating clinicians will be protected from potential legal action from patients' families. Some respondents also expressed concern about how these services will be funded and resourced in a system which is already strained.

2.7 Willingness to participate

Members were then asked a few questions about their willingness to participate in a patient's decision to pursue assisted dying if the Bill were to be implemented. They were also given space to expand on their views as to why or why not they would participate in the process of assisted dying as governed by the proposed legislation. They were asked about their willingness to participate to varying degrees: discussing assisted dying with patients, prescribing drugs to patients to self-administer to assist their own death and directly helping a patient self-administer drugs to assist their own death.

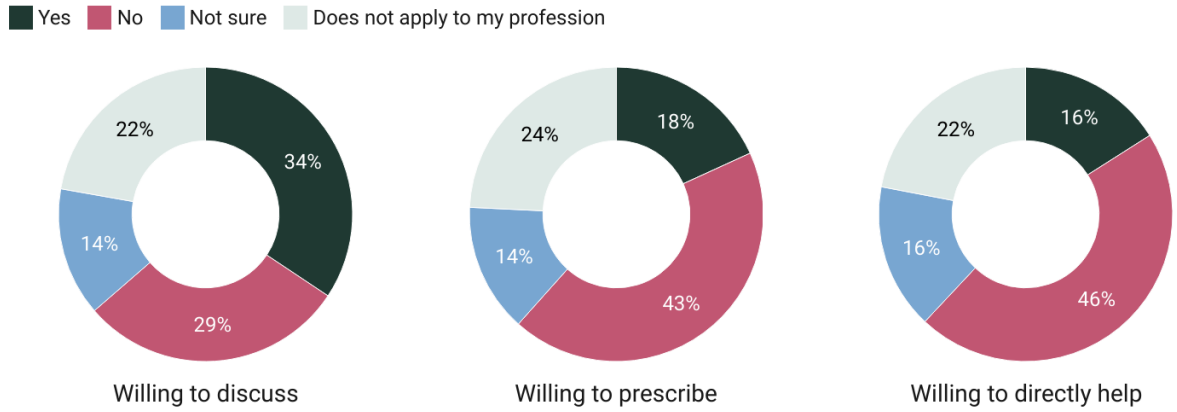
About one in three (34%) said that 'yes' they would be willing to discuss assisted dying with eligible patients, while slightly fewer (29%) said 'no', they would not be willing to do this and one in seven (14%) said they were 'not sure' (Figure 2.7).

About one in five (22%) said this 'does not apply to [their] profession'. Expectedly, this was similar to the proportions who said this did not apply to their profession with regards to their willingness to prescribe drugs for assisted dying (24%) or willingness to directly help patients administer drugs to assist their own death (22%).

Considering their willingness to prescribe drugs to patients to self-administer to assist their own death, one in five (18%) said 'yes', they were willing to do this, significantly fewer than the one in three (34%) who said they were willing to discuss assisted dying. Meanwhile, over two in five (43%) said 'no' they would not be willing to prescribe drugs for this purpose and one in seven (14%) said they were 'not sure'.

Similarly, about one in six (16%) said 'yes', they would be willing to directly help an eligible patient self-administer drugs to assist their own death, while nearly half (46%) said 'no', they would not be willing to directly help patients in this way and one in six (16%) said they were 'not sure'.

Figure 2.7. Willingness to discuss, prescribe drugs for or directly help an eligible patient's assisted death



If the bill became law... would you be willing to directly help an eligible patient self-administer drugs to assist their own death? Base 483
...would you be willing to participate in prescribing drugs for eligible patients to self-administer to assist their own death? Base 484
...would you be willing to directly help an eligible patient self-administer drugs to assist their own death? Base 483

There were slight but not significant differences in willingness to discuss, prescribe or directly help an eligible patient's assisted death between physicians and surgeons. There were also no significant differences between jurisdictions with regards to willingness to prescribe or directly help. There was however a difference between willingness to discuss assisted dying with a patient between; those whose work was primarily based in Scotland were more likely than those based outwith Scotland to be willing to discuss assisted dying (37% and 30%, respectively).

Respondents were then given the opportunity to expand on their views on whether they would or would not be prepared to actively participate in the process of assisted dying. Many of these responses reiterated previous points made regarding ethics, appropriate safeguards and concern for palliative care.

The primary rationale provided behind members' willingness to participate or not was their ethical beliefs. Fundamentally, this came down to beliefs about the role of physicians and medicine and different ways of looking at assisted dying. Those who were not willing to discuss, prescribe or directly help in the process cited their moral conscience and often framed assisted dying as 'killing' patients. There were many responses similar to the following:

> "Ethically I am not willing to go against my conscience not to facilitate the killing or suicide of patients."

Some also said their opposition towards this is related to their religious beliefs:

> "Assisting people to kill themselves (regardless of their circumstance) is immoral and against my religious beliefs and ethos."

On the other hand, those who said they would be willing to prescribe or to directly help a patient said they felt this was the most ethical decision, to avoid the most suffering for their patients, improving "the dignity of death". Members who were willing to participate also spoke about the ethics in giving patients the right to choose, agency in one's life and bodily autonomy:

> "I think that, whilst it may not be suitable for all, the choice should be available to any patients that are eligible. I feel that for medical professionals to ensure that a patient does not have a choice is unethical."

A few expressed conflicted feelings about participating for the ethical reasons stated above, seeing the rationale behind both perspectives. One said they felt, "really concerned about the process", as while they "wish to help alleviate suffering" they do not want to "cause death".

Perspectives also related to members' views of the role and responsibilities of clinicians towards their patients. Those who were opposed to participating said they feel participating in assisted dying breaks the Hippocratic oath of 'do no harm' and worried this would harm the relationship and trust they have with their patients. Respondents who were willing to participate argued that assisted dying is inherently part of healthcare in "enabling access to a safe and dignified death" and that the ethical basis of medicine is patient welfare, making patients' choices most important.

> "If a patient of sound mind decides to end his or her life due to terminality of disease and [the] patient [is] suffering from it, we should be dutiful in helping."

Some said that while they believed in the principle of assisted dying, it's essential that proper measures and safeguards are in place for it to be implemented properly.

> "The whole focus of healthcare, for many years, has been to work in partnership with patients to allow them to make appropriate healthcare decisions and give them agency over their health and their treatments. The logical conclusion of this is that they should also

> have agency over their death…however appropriate safeguards need to be put in place first."

Additionally, many respondents explained they would be willing to have the discussion about assisted dying with patients but would not be willing to prescribe or directly help, as they believe in the right to autonomy, but see this as being outwith a doctor's duties.

> "I am happy to discuss this issue with my patients, as I would be happy to discuss any decisions about their health. However, I believe that prescribing or administering medication to end someone's life is diametrically opposed to the role of a doctor and should be independent from 'usual' services."

Some explained they would be willing to discuss this with patients in a "non-judgemental capacity", "spending time with them to explore their concerns, explain the available options, and answer questions", and would "make an appropriate referral" to a clinician who provides this service, but could not participate themselves as this would compromise their ethical boundaries.

Many also explained their willingness to participate is related to how they view palliative care. Some expressed concern that assisted dying will "undermine funding" for palliative care and some felt this was a "distraction" from the issue of the lack of high-quality palliative and hospice care. Many of the respondents who felt this way thought that improving palliative care would avoid the need for assisted dying procedures. Others, however, who would be willing to participate, felt that assisted dying could be considered part of palliative care and is a "natural progression from other aspects of palliative care" in its intention to "provide comfort, dignity and autonomy".

Again, as was brought up as an issue throughout the responses to other survey questions, many said their reluctance or unwillingness to participate was related to concerns about coercion. A few were worried about protecting clinicians from feeling coerced to assist in these procedures, and many were not convinced that they would be able to confidently assess whether or not patients had been coerced into decisions by their families or loved ones. Some also expressed concerns about systemic coercion, if patients are made to feel like a burden to the state.

Some of those who said they were 'not sure' about their willingness to discuss, prescribe or directly help patients in this role said this was contingent upon the appropriate legal safeguards being put in place to protect professionals from being sued by family members, as well as adequate training and support:

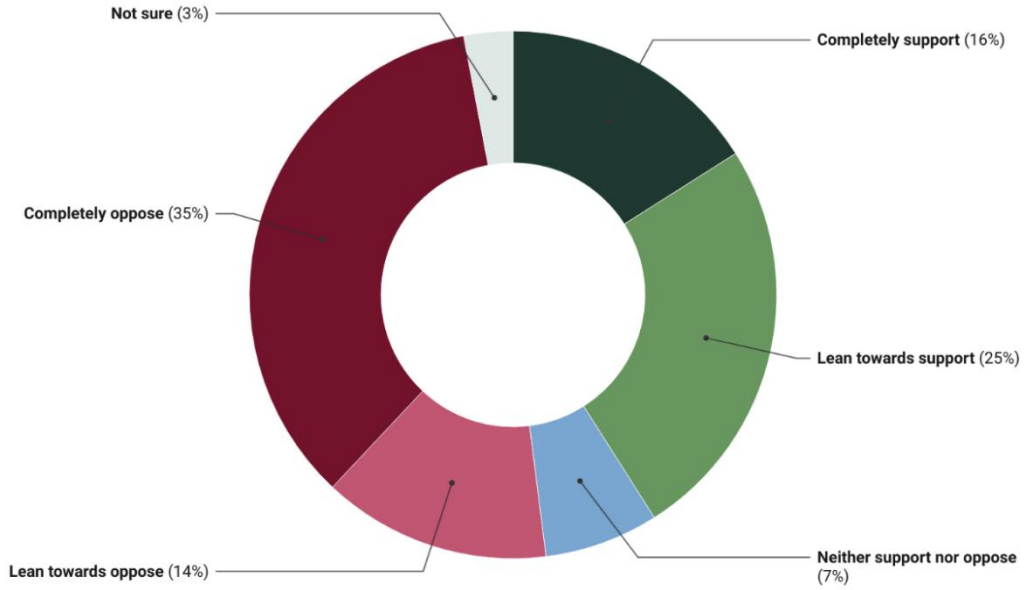
"My preparedness to participate would depend on how well the NHS supports me in doing it, with training and ongoing support experts in palliative care, legal and ethics."

2.8 Support

Finally, respondents were asked to what extent they support or oppose the relevant legislation's implementation, based on its current form.

About two in five (41%) said either 'completely' supported or were 'lean[ing] towards' supporting the bill, while about half (49%) said they were either 'lean[ing] towards' opposing or 'completely' opposed the Bill in its current form (Figure 2.8). The remaining respondents were split between being neutral on the bill's implementation (7%) or said they were not sure (3%).

Figure 2.8. Support for the bills' implementation



Based on the bill in its current form, to what extent do you support or oppose its implementation? Base 483

Interestingly, there were slight, but no statistically significant differences between support for the bills between those who were responding with regards to the Leadbeater Bill or the McArthur Bill (Table 2.8).

Table 2.8. Support for the Leadbeater and McArthur Bills

	Leadbeater Bill (Base 206)	McArthur Bill (Base 277)
	%	%
Completely support	18	15
Lean towards support	25	24
NET: Support	44	39
Neither support nor oppose	5	8
Lean towards oppose	12	16
Completely oppose	36	35
NET: Oppose	48	51
Not sure	3	3

Appendix A: Survey: Practical Implications of Assisted Dying Legislation (Scotland and UK)

This survey seeks to gather insights from Fellows and Members on the practical, legal, and professional implications of the assisted dying legislation currently under consideration. It does not ask for views on the principle of assisted dying. It also does not require extensive familiarity with the legislation.

The survey should take no more than 10 minutes to complete. There are some free text boxes – it is not necessary to complete these if you prefer not to, though we would appreciate your views.

Your responses will be fully anonymous and confidential. Diffley Partnership will not share any information which could identify you with the Royal College of Physicians and Surgeons of Glasgow.

Section 1: About you

Question 1*

Which category most closely aligns to your profession?

ASK ALL

SINGLE CODE

RANDOMISE

- Physician
- Surgeon
- Dental Surgeon
- GP
- Nurse
- Pharmacist
- Allied Health Practitioner

Question 2*

In which jurisdiction is/was your primary place of employment?

ASK ALL

SINGLE CODE

RANDOMISE

- England
- Scotland
- Wales
- Northern Ireland
- Other, please specify [TEXT BOX]

Question 3*

Which of the following options best describes your current career stage?

ASK IF Q1 = PHYSICIAN

SINGLE CODE

- Student
- Foundation years
- Internal medical training
- Specialty training
- Locally Employed Doctor
- SAS Doctor
- Consultant
- Retired
- Other, please specify [TEXT BOX]

Question 4*

Which of the following options best describes your current career stage?

ASK IF Q1 = SURGEON

SINGLE CODE

- Student
- Foundation years
- Core surgical training
- Specialty training
- Locally employed surgeon
- SAS surgeon
- Consultant

- Retired
- Other, please specify [TEXT BOX]

Question 5*

Which of the following options best describes your current career stage?

ASK IF Q1 = DENTAL SURGEON

SINGLE CODE

- Student
- Vocational training
- Dental Core training
- Specialty training
- Consultant
- Retired
- Other, please specify [TEXT BOX]

Question 6*

Which of the following options best describes your current career stage?

ASK IF Q1 = GP

SINGLE CODE

- GP in Training
- Salaried GP
- GP Partner
- GP with a Specialist interest
- Locum
- Other, please specify [TEXT BOX]

Question 7*

Which of the following options best describes your current career stage?

ASK IF Q1 = NURSE, PHARMACIST, OR ALLIED HEALTH PRACTITIONER

SINGLE CODE

- Student
- Band 5
- Band 6
- Band 7
- Band 8A
- Band 8B

- Private practice
- Retired
- Other, please specify [TEXT BOX]

Question 8*

The Terminally Ill Adults (End of Life) Bill – also known as the Leadbeater Bill – would make it legal for over-18s who are terminally ill to be given assistance to end their own life. Among other requirements, they must be resident of England and Wales and be registered with a GP for at least 12 months.

Although this does not apply to your jurisdiction, we are still keen to understand your views if you'd like to share them. The remainder of the survey will pertain to your opinion on this piece of legislation. Would you like to proceed?

ASK IF Q2 = NI OR OTHER

SINGLE CODE

- Yes
- No [ROUTE TO END OF SURVEY]

Section 2: Eligibility Criteria

Question 9

The Assisted Dying for Terminally Ill Adults (Scotland) Bill – also known as the McArthur Bill – will allow terminally ill adults in Scotland, who are eligible, to lawfully request, and be provided with, assistance by health professionals to end their own life.

Are you familiar with the eligibility criteria associated with assisted dying outlined in the (Scottish) McArthur Bill?

ASK IF Q2 = SCOTLAND

SINGLE CODE

- Yes, completely
- Yes, partially
- No

Question 10

The Terminally Ill Adults (End of Life) Bill – also known as the Leadbeater Bill – would make it legal for over-18s who are terminally ill to be given assistance to end their own life. Among other requirements, they must be resident of England and Wales and be registered with a GP for at least 12 months.

Are you familiar with the eligibility criteria associated with assisted dying outlined in the (UK) Leadbeater Bill?

ASK IF Q2 = ENGLAND OR WALES OR Q9 = YES

SINGLE CODE

- Yes, completely
- Yes, partially
- No

Question 11

To what extent, if at all, do you think that you will have challenges in competently assessing eligibility based on the following:

ASK ALL

MATRIX

- Age
- Residency
- Terminal illness definition
- Capacity
- Voluntariness (lack of coercion)

SCALE: Major challenge, minor challenge, no challenge, don't know

Question 12

What support and/or guidance would be helpful in assessing eligibility?

ASK ALL

[OPEN TEXT]

Section 3: Definition of Terminal Illness

Question 13

The McArthur Bill states "a person is terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death."

Do you think the definition provided in the Bill is sufficiently clear for clinical application?

ASK IF Q2 = SCOTLAND

SINGLE CODE

- Yes
- No
- Not sure

Question 14

Do you have any concerns regarding the bill's definition of terminal illness?

ASK IF Q2 = SCOTLAND

SINGLE CODE

- Yes, major concerns
- Yes, minor concerns
- No concerns

Please explain any concerns [TEXT BOX]

Question 15

The Leadbeater Bill defines a terminal illness as:

> **"(a) the person has an inevitably progressive illness or disease which cannot be reversed by treatment, and**
> **(b) the person's death in consequence of that illness or disease can reasonably be expected within six months."**

There are additional restrictions in place for the definition of terminal illness in the context of the bill. For example, a person would not be considered terminally ill if they are considered to have a mental illness or disability only, or if a person had voluntarily stopped eating or drinking.

Do you think the definition provided in the Bill is sufficiently clear for clinical application?

ASK IF Q2 = ENGLAND OR WALES OR

SINGLE CODE

- Yes
- No
- Not sure

Question 16

Do you have any concerns regarding the bill's definition of terminal illness?

ASK IF Q2 = ENGLAND OR WALES OR Q9 = YES

SINGLE CODE

- Yes, major concerns
- Yes, minor concerns
- No concerns

Please explain any concerns [TEXT BOX]

Section 4: Capacity Assessment

Question 17

The McArthur Bill states a person must have sufficient capacity to request assistance. This is defined as a person who is:

> **"(a) not suffering from any mental disorder which might affect the making of the request, and**
> **(b) capable of -**
> > **(i) understanding information and advice about making the request,**
> > **(ii) making a decision to make the request,**
> > **(iii) communicating the decision,**
> > **(iv) understanding the decision, and**
> > **(v) retaining the memory of the decision."**

A person cannot be deemed to not have capacity due to restrictions of communication which could be aided through human or technological means.
Assessment of mental disorder defers to the Mental Health (Care and Treatment) (Scotland) Act 2003.

Do you think current clinical tools and frameworks are sufficient to assess capacity in this context?
ASK IF Q2 = SCOTLAND
SINGLE CODE

- Yes
- No
- Not sure

Question 18

The Leadbeater Bill states "references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005."
Do you think current clinical tools and frameworks sufficient to assess capacity in this context?
ASK IF Q2 = ENGLAND OR WALES OR Q9 = YES
SINGLE CODE

- Yes
- No
- Not sure

Question 19

ASK ALL

What additional training or resources are needed to support capacity assessments?

[OPEN TEXT]

Section 5: Procedures and Safeguarding

Question 20

Do you think the following proposed procedures are practical within current service structures and protocols?

ASK ALL

MATRIX

- Declarations
- Assessments
- Reflection periods
- Safeguards against coercion

Scale: Yes, No, Not sure

Question 21

How confident are you that current professional standards and oversight will ensure safe implementation of the bill?

ASK ALL

SINGLE CODE

- Very confident
- Moderately confident
- Not very confident
- Not at all confident
- Not sure

Question 22

Do you think the method of assisted death should be addressed in the legislation?

ASK ALL

SINGLE CODE

- Yes
- No
- Not sure

Section 6: Protection for Medical Professionals

Question 23

How confident are you that the bill provides sufficient legal protection for professionals involved in assisted dying?

ASK ALL

SINGLE CODE

- Very confident
- Moderately confident
- Not very confident
- Not at all confident
- Not sure

Question 24

Are there additional protections or clarifications that you would recommend?

ASK ALL

SINGLE CODE

- Yes, please explain below
- No
- Not sure

[text box]

Section 7: Broader System Implications

Question 25

Please select any areas you feel may require further clarification within the bill:

ASK ALL

MULTICODE

RANDOMISE

- Current workforce preparedness
- Training and development needs
- Location of assisted dying service / infrastructure (e.g. at hospital, home)
- Impact on palliative care services
- Impact on suicide prevention strategies
- Safeguarding protections for adults with disabilities
- Impact of health inequalities on implementation
- Holistic patient assessment for any unmet needs

- The role of the clinician
- Clinicians' right to choose to take part, or not take part, in an assisted dying service
- Other (please specify)

Section 8: Participation

Question 26

If the bill became law, would you be willing to discuss assisted dying with eligible patients?

ASK ALL

SINGLE CODE

- Yes
- No
- Not sure
- Does not apply to my profession

Question 27

If the bill became law, would you be willing to participate in prescribing drugs for eligible patients to self-administer to assist their own death?

ASK ALL

SINGLE CODE

- Yes
- No
- Not sure
- Does not apply to my profession

Question 28

If the bill became law, would you be willing to directly help an eligible patient self-administer drugs to assist their own death?

ASK ALL

SINGLE CODE

- Yes
- No
- Not sure
- Does not apply to my profession

Question 29

Please use the space below to expand on your views on whether you would, or would not, be prepared to actively participate in the process of assisted dying governed by the proposed legislation. Please support your answer with a rationale.

ASK ALL

[TEXT BOX]

Section 9: Final Comments

Question 30

ASK ALL

SINGLE CODE

Based on the bill in its current form, to what extent do you support or oppose its implementation?

- Completely support
- Lean towards support
- Neither support nor oppose
- Lean towards oppose
- Completely oppose
- Not sure

Appendix B: Topline results

Question 1

Which category most closely aligns to your profession?

Base: All (635)	%
Physician	47
Surgeon	23
Dental Surgeon	21
GP	5
Nurse	2
Pharmacist	-
Allied Health Practitioner	3

Question 2

Which jurisdiction is/was your primary place of employment?

Base: All (635)	%
England	38
Scotland	56
Wales	3
Northern Ireland	2
Other (please specify)	1

Question 3

Which of the following options best describes your current career stage?

Base: Physicians (300)	%
Student	-
Foundation years	1
Internal medical training	3
Specialty training	10
Locally Employed Doctor	2
SAS Doctor	4
Consultant	43
Retired	35
Other (please specify)	2

Question 4

Which of the following options best describes your current career stage?

Base: Surgeons (142)	%
Student	-
Foundation years	-
Core surgical training	5
Specialty training	5
Locally employed surgeon	2
SAS surgeon	9
Consultant	48
Retired	30
Other (please specify)	1

Question 5

Which of the following options best describes your current career stage?

Base: Dental surgeons (131)	%
Student	-
Vocational training	-
Dental Core training	2
Specialty training	8
Consultant	21
Retired	18
Other (please specify)	50

Question 6

Which of the following options best describes your current career stage?

Base: GPs (29)	n
GP in training	2
Salaried GP	4
GP Partner	6
GP with a Specialist interest	3
Locum	5
Retired	6
Other (please specify)	3

Question 7

Which of the following options best describes your current career stage?

Base: Nurses and Allied Health Practitioners (28)	n
Student	-
Band 5	2
Band 6	3
Band 7	4
Band 8A	3
Band 8B	1
Private practice	8
Retired	4
Other (please specify)	3

Question 8

Although this does not apply to your jurisdiction, the Royal College of Physicians and Surgeons of Glasgow are still keen to understand your views if you'd like to share them. The remainder of the survey will pertain to your opinion on this piece of legislation. Would you like to proceed?

Base: Based in Northern Ireland or Other (20)	n
Yes	19
No	1

Question 9

Are you familiar with the eligibility criteria associated with assisted dying outlined in the (Scottish) McArthur Bill?

Base: Based in Scotland (346)	%
Yes, completely	14
Yes, partially	62
No	24

Question 10

Are you familiar with the eligibility criteria associated with assisted dying outlined in the (UK) Leadbeater Bill?

Base: Based outwith Scotland (276)	%
Yes, completely	21
Yes, partially	57
No	23

Question 11

To what extent, if at all, do you think that you will have challenges in competently assessing eligibility based on the following:

Base: All (547)	Major Challenge	Minor Challenge	No Challenge	Don't know
	%	%	%	%
Age	24	24	44	8
Residency	17	34	35	14
Terminal illness definition	47	35	14	4
Capacity	48	35	13	4
Voluntariness (lack of coercion)	59	26	10	6

Question 12

What support and/or guidance would be helpful in assessing eligibility?
*Qualitative analysis to follow

Question 13

Do you think the definition provided in the Bill is sufficiently clear for clinical application?

Base: Based in Scotland (304)	%
Yes	36
No	45
Not sure	19

Question 14

Do you have any concerns regarding the bill's definition of terminal illness?

Base: Based in Scotland (299)	%
Yes, major concerns	45
Yes, minor concerns	28
No concerns	27

Please share your concerns:
*Qualitative analysis to follow

Question 15

Do you think the definition provided in the Bill is sufficiently clear for clinical application?

Base: Based outwith Scotland (224)	%
Yes	34
No	40
Not sure	26

Question 16

Do you have any concerns regarding the bill's definition of terminal illness?

Base: Based outwith Scotland (225)	%
Yes, major concerns	40
Yes, minor concerns	31
No concerns	29

Please share your concerns:
*Qualitative analysis to follow

Question 17

Do you think current clinical tools and frameworks are sufficient to assess capacity in this context?

Base: Based in Scotland (299)	%
Yes	39
No	36
Not sure	25

Question 18

Do you think current clinical tools and frameworks are sufficient to assess capacity in this context?

Base: Based outwith Scotland (224)	%
Yes	36
No	30
Not sure	34

Question 19

*Qualitative analysis to follow

Question 20

Do you think the following proposed procedures are practical within current service structures and protocols?

Base: All (494)	Yes	No	Not sure
	%	%	%
Declarations	28	32	39
Assessments	24	43	33
Reflection periods	28	33	39
Safeguards against coercion	18	50	32

Question 21

How confident are you that current professional standards and oversight will ensure safe implementation of the bill?

Base: All (495)	%
Very confident	7
Moderately confident	28
NET: Very or moderately confident	35
Not very confident	21
Not at all confident	37
NET: Not very or not at all confident	58
Not sure	7

Question 22

Do you think the method of assisted death should be addressed in the legislation?

Base: All (495)	%
Yes	64
No	19
Not sure	16

Question 23

How confident are you that the bill provides sufficient legal protection for professionals involved in assisted dying?

Base: All (492)	%
Very confident	4
Moderately confident	21
NET: Very or moderately confident	25
Not very confident	25
Not at all confident	30
NET: Not very or not at all confident	55
Not sure	20

Question 24

Are there additional protections or clarifications that you would recommend?

Base: All (477)	%
Yes	27
No	16
Not sure	57

What additional protections or clarifications?

*Qualitative analysis to follow

Question 25

Please select any areas you feel may require further clarification within the bill:

Base: All (474)	%
Clinicians' right to choose to take part, or not take part, in an assisted dying service	76
Safeguarding protections for adults with disabilities	71
Current workforce preparedness	69
The role of the clinician	66
Location of assisted dying service / infrastructure (e.g. at hospital, home)	65
Training and development needs	63
Impact on palliative care services	60
Impact of health inequalities on implementation	57
Holistic patient assessment for any unmet needs	53
Impact on suicide prevention strategies	52
Other (please specify)	10
None of the above	3

Question 26

If the bill became law, would you be willing to discuss assisted dying with eligible patients?

Base: All (483)	%
Yes	34
No	29
Not sure	14
Does not apply to my profession	22

Question 27

If the bill became law, would you be willing to participate in prescribing drugs for eligible patients to self-administer to assist their own death?

Base: All (484)	%
Yes	18
No	43
Not sure	14
Does not apply to my profession	24

Question 28

If the bill became law, would you be willing to directly help an eligible patient self-administer drugs to assist their own death?

Base: All (483)	%
Yes	16
No	46
Not sure	16
Does not apply to my profession	22

Question 29

Please use the space below to expand on your views on whether you would, or would not, be prepared to actively participate in the process of assisted dying governed by the proposed legislation. Please support your answer with a rationale.
*Qualitative analysis to follow

Question 30

Based on the bill in its current form, to what extent do you support or oppose its implementation?

Base: All (483)	%
Completely support	16
Lean towards support	25
NET: Support	41
Neither support nor oppose	7
Lean towards oppose	14
Completely oppose	35
NET: Oppose	49
Not sure	3

Technical details:

- The survey was designed by Diffley Partnership and the Royal College of Physicians and Surgeons of Glasgow,
- Results are based on a survey of 635 respondents,
- The survey was in field from 26th September to 20th October 2025,
- The survey was distributed to Royal College of Physicians and Surgeons of Glasgow members by Diffley Partnership,
- An asterisk (*) denotes a response of less than 1% and a dash (-) denotes a response of zero,
- Where there were fewer than 30 responses, the number of responses (n) was depicted rather than percentages.

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From many voices to smart choices