

Assisted Dying for Terminally Ill Adults (Scotland) Bill

Policy Memorandum

Introduction

1. As required under Rule 9.3.3A of the Parliament's Standing Orders, this Policy Memorandum is published to accompany the Assisted Dying for Terminally Ill Adults (Scotland) Bill introduced in the Scottish Parliament on 27 March 2024. It has been prepared by the Parliament's Non-Government Bills Unit on behalf of Liam McArthur MSP, the Member who introduced the Bill. It does not form part of the Bill and has not been endorsed by the Parliament.

2. The following other accompanying documents are published separately:

- Explanatory Notes (SP Bill 46–EN);
- a Financial Memorandum (SP Bill 46–FM);
- a Delegated Powers Memorandum (SP Bill 46–DPM);
- statements on legislative competence by the Presiding Officer and Liam McArthur MSP (SP Bill 46–LC).

Policy objectives of the Bill

3. The aim of the Assisted Dying for Terminally Ill Adults (Scotland) Bill is to allow mentally competent terminally ill eligible adults in Scotland to voluntarily choose to be provided with assistance by health professionals to end their lives. The Bill establishes a lawful process for an eligible person to access assisted dying, which is safe, controlled and transparent, and which the Member believes will enable people to avoid the existential pain, suffering and symptoms associated with terminal illness, which will in turn afford the person autonomy, dignity and control over their end of life.

4. The Member believes that an individual's personal autonomy to decide on their medical care, and how their life should end in situations of terminal illness, should be protected in law and that people in Scotland should have access to safe and compassionate assisted dying if they choose, rather than face the potential of a prolonged, painful and traumatic death. He believes that the current de facto prohibition

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on such assistance has been proven to be unjust, unsafe, and unacceptable, causing needless suffering for many dying people and their families.

5. The Member believes that the current legal position is unacceptably unclear as there is currently no specific legislation in Scotland which makes assisted dying a criminal offence, yet it is also possible to be prosecuted for offences such as murder or culpable homicide for assisting the death of another person. The Bill improves legal clarity by making it lawful for a person to voluntarily access assisted dying if they meet the various criteria set out in the Bill and for health professionals to assist in that process, while continuing to ensure that assisting death outwith the provisions of the Bill remains unlawful.

6. The Member believes that the respect for personal autonomy should equally apply to registered medical practitioners (doctors) and other health professionals (as is the case with abortion and some other medical procedures) and therefore that they should not have to participate in the provision of assistance if they conscientiously object¹ to doing so. The Bill therefore provides that no-one should be compelled to directly participate in assisted dying if they have a conscientious objection to doing so.

Operation and limited effect of the Bill

7. The Bill sets out the assisted dying process, including the provision of assistance to end life. Section 15 sets out the end-of-life process, and how a terminally ill adult, once assessed as eligible, can be provided with assistance to end their life. It enables the Scottish Ministers, by way of regulations, to approve substances which can then be provided to, and used by, a terminally ill adult to enable them to legally and voluntarily end their life. Section 22 of the Bill (“Limitations on effect of Act”) puts it beyond doubt that the Scottish Ministers can approve such substances by way of regulations only if they are not regulated by or under the Misuse of Drugs Act 1971 or the Medicines Act 1968 or, if they are so regulated, their use for the purposes of assisted death has been approved under those Acts. These are subject matters which are reserved to the UK Parliament under the Scotland Act 1998.

8. The Member acknowledges that, in order to achieve a truly comprehensive assisted dying scheme, something else would likely need to happen. This could be if for example the use of certain regulated medicines or controlled drugs were to be brought within the executive competence of the Scottish Ministers, or by way of a transfer of legislative power through amendment of Schedule 5 (or Schedule 4) of the Scotland Act 1998. The Member understands there are various possible routes to ensure that, including the agreement of a Section 30 Order under the Scotland Act 1998. A Section 30 Order is a type of subordinate or secondary legislation which can be used to increase or restrict, temporarily or permanently, the Scottish Parliament’s legislative competence. It does this by altering the list of reserved powers set out in Schedule 5,

¹ Conscientious objection is understood as a person’s refusal to participate in medically indicated, legal, and professionally accepted medical practices that conflict with their deeply held personal convictions (whether they be of a religious, belief, moral or philosophical basis).

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and/or the protections against modification set out in Schedule 4 of the Scotland Act. Section 30 Orders can be initiated either by the Scottish or UK Governments but require approval by the House of Commons, House of Lords and the Scottish Parliament before becoming law.

9. The Member has had informal discussions with relevant parties in the Scottish and UK Governments about a Section 30 Order being made and approved to allow the Bill to operate comprehensively and will continue to have those discussions during the Bill's passage through the Scottish Parliament. Other options the Member is aware of include an order under Section 63 of the Scotland Act, whereby the UK Government would transfer the function of making the necessary regulations to the Scottish Ministers (while the reservations would remain as they are – this requires approval by both the UK and Scottish parliaments), or an order under Section 104 of the Scotland Act, which would allow for consequential modifications to be made to reserved law in consequence of an Act of the Scottish Parliament (all Section 104 Orders are laid before the UK Parliament, those which amend primary legislation are debated in both houses). The UK Government could also use existing powers under the Misuse of Drugs or the Medicines Acts to permit the use of controlled drugs in Scotland for the purpose of the Bill.

10. The Member believes that, should the Scottish Parliament support the general principles of the Bill at Stage 1 (that eligible terminally ill mentally competent adults in Scotland should have access to a legal, safe and humane assisted death) that, given it would be Parliament's will for the Bill to proceed, the Scottish Government should work with the UK Government to ensure that powers are made available to the Scottish Parliament, or to the Scottish Ministers, as soon as possible.

Background

Legal position

11. In Scotland, there is no specific statutory offence of assisting someone's death. This is different from other parts of the United Kingdom. In England and Wales, under the Suicide Act 1961,² and in Northern Ireland, under the Criminal Justice Act 1966,³ it is not a crime to take your own life, but it is a crime to encourage or assist suicide.

12. However, while assisted dying is not a specific criminal offence in Scotland, a person assisting the death of another person could potentially be prosecuted for a range of offences such as murder, culpable homicide, reckless endangerment, assault, breach of the peace.

² Section 2(1) of the Suicide Act 1961 (as amended by section 59(2) of the Coroners and Justice Act 2009).

³ Section 13 of the Criminal Justice Act (Northern Ireland) 1966.

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13. Prosecutors in England and Wales,⁴ and in Northern Ireland,⁵ produced specific guidelines on when they would choose to prosecute. The guidelines followed the legal case of R (Purdy) v DPP,⁶ which established that Human Rights legislation requires prosecutors to issue guidance about the circumstances in which they will prosecute people who assist others to take their own lives. Following consultation, the Crown Prosecution Service (CPS) published updated prosecution guidance on homicide in October 2023.⁷ The guidance has been updated to assist prosecutors considering the public interest when dealing with suspects in deaths arising out of mercy killings and failed suicide pacts. The updated guidance amends relevant public interest factors on mercy killing and suicide pacts in the context of mercy killings. While the CPS stated that, “The homicide guidance, which has been refreshed as a whole, does not touch on ‘assisted dying’ or other similar scenarios which are treated separately in law” there can be some similarities in instances of assisted dying/suicide, mercy killing and suicide pacts. One of the amendments made to the public interest factors included a factor against prosecution which states that, “The victim had reached a voluntary, clear, settled and informed decision that they wished for their life to end.”.

14. The Lord Advocate in Scotland⁸ has declined to produce any specific prosecution guidelines.⁹ The Court of Session in Scotland refused a challenge that this decision contravened Convention rights.¹⁰ However, it remains unclear what forms of assistance to die a medic, family member or friend may give to a terminally ill person without fear of being prosecuted.

Previous attempts to legislate in Scotland and the rest of the UK

15. Two previous Member’s Bills have been introduced in the Scottish Parliament related to this general policy area, in 2010 and 2013 respectively.¹¹ Both Bills fell at stage 1 of the Parliament’s legislation scrutiny process after failing to secure enough votes from MSPs in support of the general principles of the Bill. Also, in 2005, Jeremy Purvis MSP lodged a proposal for a Member’s Bill¹² to “...allow capable adults with a terminal illness the means to die with dignity.” Mr Purvis consulted on a draft proposal,

⁴ CPS, Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide See: <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide>

⁵ PPS, Policy on Prosecuting the Offence of Assisted Suicide.

⁶ R (Purdy) v DPP [2009] UKHL 45.

⁷ [Homicide: Murder, manslaughter, infanticide and causing or allowing the death or serious injury of a child or vulnerable adult | The Crown Prosecution Service \(cps.gov.uk\)](#).

⁸ The Lord Advocate in Scotland (currently Rt Hon Dorothy Bain KC) is the principal legal adviser of the Scottish Government and the Crown in Scotland for civil and criminal matters that fall within the devolved powers of the Scottish Parliament, and is the Ministerial head of the Crown Office and Procurator Fiscal Service.

⁹ Elish Angolini declined to produce guidelines after the R (Purdy) v DPP 2009 case and subsequent Lord Advocate’s (Frank Mulholland, James Wolffe) have upheld this.

¹⁰ [Ross v Lord Advocate \(2016\) CSIH 12](#).

¹¹ [End of Life Assistance Scotland Bill | Scottish Parliament Website](#) – introduced 20 January 2010; and the [Assisted Suicide \(Scotland\) Bill - Parliamentary Business : Scottish Parliament](#) – introduced 13 November 2013.

¹² [Right to Die for the Terminally Ill Bill - Parliamentary Business : Scottish Parliament](#).

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and lodged a final proposal to introduce a Bill, but did not gather sufficient support to earn the right to introduce a Bill, and the proposal fell.

16. There are several key and fundamental differences between this Bill and the previous Bills introduced in the Parliament, particularly in the details of the process for accessing assisted dying and the extent of the safeguards in place to protect those involved. In addition, previous Bills focussed on the decriminalisation of providing assistance to a person to end their life, but did not establish a legal, health professional led process for assisted dying to take place.

17. A significant difference between this Bill and previous Bills relates to who will be able to access assisted dying. In terms of a qualifying medical condition, the 2010 Bill allowed access not only to a person who was terminally ill but also to a person who was “permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable”.¹³ The 2013 Bill limited access to those with an illness (from which there was “no prospect of any improvement in the person’s quality of life”) that was either “terminal or life-shortening”, or a condition that was, for the person, “progressive and either terminal or life-shortening”.¹⁴ This Bill only permits access for those who have an advanced and progressive terminal illness which is expected to cause their premature death.

18. The previous Bills introduced in the Scottish Parliament also did not establish a process which was to be delivered by healthcare professionals as this Bill does. The previous Bills made no provision for how assisted dying would actually be facilitated in practice (e.g. provision of a life ending substance by healthcare professionals) or for any form of conscientious objection for healthcare professionals.

19. There have been several recent attempts at the UK Parliament to legislate for assisted dying in England and Wales via Private Member’s Bills. These include Bills introduced by Lord Falconer¹⁵ (2014), Rob Marris¹⁶ (2015), and Baroness Meacher¹⁷ (2021). The Bills by Lord Falconer and Baroness Meacher both fell due to running out of parliamentary time. Rob Marris’ Bill was defeated at its Second Reading.

20. In the current UK Parliament (2019-2025), in 2022, the House of Commons Health and Social Care Committee launched an inquiry into Assisted dying/assisted suicide.¹⁸ A public call for views ended on 20 January 2023 and oral evidence sessions began on 28 March 2023. The Committee stated, before its first oral evidence session, that: “Questions are likely to examine Parliament’s role in the debate, protections for vulnerable groups and research on the impact of assisted dying/assisted suicide. During the inquiry, MPs are expected to consider, what conclusions can be drawn in evidence

¹³ End of Life Assistance (Scotland) Bill. Section 4(2)(b). Available at: [b38s3-introd.pdf \(parliament.scot\)](#).

¹⁴ Assisted Suicide (Scotland) Bill. Sections 8(4) and 8(5). Available at: [Bill As Introduced Contents \(parliament.scot\)](#).

¹⁵ [Assisted Dying Bill \[HL\] - Parliamentary Bills - UK Parliament.](#)

¹⁶ [Assisted Dying \(No. 2\) Bill - Parliamentary Bills - UK Parliament.](#)

¹⁷ [Assisted Dying Bill \[HL\] - Parliamentary Bills - UK Parliament.](#)

¹⁸ [Assisted dying/assisted suicide - Committees - UK Parliament.](#)

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from jurisdictions where assisted dying/assisted suicide is legal and whether there have been any new developments since the House of Commons last considered legislation on the subject in 2015.” At an evidence session on 4 July 2023,¹⁹ Helen Whatley MP, the Minister of State at Department of Health and Social Care, told the Committee that the UK Government is following progress of Liam McArthur’s Bill. The Committee published its report on 29 February 2024.²⁰

Assisted dying/suicide and euthanasia legislation around the world

21. It is estimated that between 200 and 350 million people in the world have legal access to a form of assistance to die. The countries and jurisdictions that have legalised a form of assisted dying or suicide are: ten American States (Oregon, California, Hawaii, Washington, Colorado, Vermont, Montana, New Jersey, New Mexico, Maine), Washington DC (a district - the capital of the US), all six Australian States²¹ (Victoria, Tasmania, Queensland, New South Wales, South Australia and Western Australia), New Zealand, Canada, Colombia, Belgium, the Netherlands, Luxembourg, Switzerland and Spain.

22. In addition, it is understood that many other countries and jurisdictions are engaged in active considerations to legalise forms of assisted dying or suicide, including Germany, Ireland, France, Portugal, Austria, Italy, and various other American States. There has also recently been notable activity in parts of the British Isles, with the Isle of Man and Jersey both taking significant steps towards legislating for forms of assisted dying.

23. In November 2021, Jersey’s States Assembly became the first parliament in the British Isles to decide ‘in principle’ that assisted dying should be allowed and make arrangements for the provision of an assisted dying service²². An ‘in principle’ decision means the States Assembly wants to receive more information before confirming how an assisted dying service in Jersey should operate. A consultation on specific proposals ran until 23 January 2023. The Council of Ministers agreed that the policy proposals should be informed by experts via an external ethical review process, the results of which were published in November 2023.²³ The States Assembly is scheduled to debate assisted dying on 21 May 2024. If the proposals are approved by the States Assembly work is expected to begin on drafting of an assisted dying law. Currently, it is expected that, subject to approval, drafting could begin later in 2024, and may complete 12-18 months later. If a draft law is approved by the States Assembly, it is expected

¹⁹ committees.parliament.uk/oralevidence/13397/html/.

²⁰ [Assisted Dying/Assisted Suicide \(parliament.uk\)](https://committees.parliament.uk/evidence/13397/html/).

²¹ In addition to the six federal states, Australia has two self-governing internal territories (Northern Territory and Australian Capital Territory). Assisted dying is not legal in either territory – federal laws prohibited either territory from being able to legislate to provide for assisted dying. However, these laws were repealed in 2022 and it is understood that both territories are now considering legislating to provide for a model of assisted dying.

²² [Assisted dying in Jersey \(gov.je\)](https://www.gov.je/assisted-dying/).

²³ [Assisted Dying in Jersey Ethical Review Report.pdf \(gov.je\)](https://www.gov.je/assisted-dying-ethical-review-report/).

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there would be an 18-month implementation period before assisted dying became available.

24. The Assisted Dying Bill 2023²⁴ (a Private Members Bill) was introduced by Dr Alex Allinson MHK in the Tynwald, the Parliament of the Isle of Man, in 2023. The Bill had its first reading on 27 June 2023 and second reading on 31 October 2023. The Bill was supported at its second reading and, following a debate on 7 November 2023, the Bill is being scrutinised by an ad hoc Bill committee,²⁵ which was due to report to the House of Keys (the directly elected part of the Tynwald) by the end of February 2024 (however, there have been reports that the report may be delayed until the end of March 2024²⁶). The Bill is then expected to be considered by the House of Keys to debate the clauses of the Bill and put forward any amendments, before it receives a Third Reading and then progresses to the Legislative Council. It is expected that the Bill may be passed by the end of 2024, with assisted dying potentially being available in the Isle of Man from 2025.

25. There are various differences in the models of assistance provided for in different parts of the world. There are also parts of the world where forms of euthanasia are legal in certain circumstances. In broad terms, some jurisdictions limit assisted dying to those with a terminal illness who can be provided with the means to end their life which they must administer themselves. Some jurisdictions have a wider approach, including not limiting access to those with a terminal illness (assisted suicide) and/or by not requiring the person to self-administer the end-of-life process (euthanasia). The latter is sometimes the result of an inability to self-ingest and not simply because of patient/practitioner preference.

26. Some jurisdictions have passed legislation and then passed subsequent amending legislation to alter the criteria for accessing assisted dying. One example is Canada,²⁷ which revised its law in 2021 following a court ruling which determined that the initial law did not meet the Canadian Charter of Rights and Freedoms. The law was amended to allow access to those with “a grievous and irremediable medical condition”. Such a condition is described as being a serious illness, disease or disability. There has been discussion in Canada about allowing access to those with a mental illness, but a decision on this has been deferred until at least 2027. It should be noted that Canada did not begin with legislation being limited to the terminally ill – its legislation always had a wider eligibility. Some jurisdictions, such as Canada and the Netherlands, which have altered the eligibility of access to assisted dying/suicide, started from a position of eligibility not being limited to the terminally ill in the first place. Other jurisdictions which legislated to limit access to the terminally ill from the start, such as the American states of Oregon and California, and states across Australia, have not extended access beyond those who are terminally ill.

²⁴ [Assisted Dying Bill 2023 \(tynwald.org.im\)](https://www.tynwald.org.im).

²⁵ House of Keys Committee on the Assisted Dying Bill. Information available at: [Tynwald - House of Keys Committee on the Assisted Dying Bill](#).

²⁶ [Proposed Isle of Man assisted dying laws report delayed - BBC News](#).

²⁷ [Medical assistance in dying - Canada.ca](https://www.canada.ca).

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27. There have been examples of the law in other parts of the world being amended in response to issues identified by Governments and health professionals in the operation of legislation, such as in Oregon, which recently changed the process to allow the waiting period to be shortened where life expectancy was expected to be shorter than the required waiting period, and to residency requirements.

28. Liam McArthur's Bill has most in common with the legislation and process in Oregon, other American States, Australia, and New Zealand, where legislation follows the model of self-administered assisted dying for the terminally ill with strict safeguards, rather than, for example, the legislation in the Benelux²⁸ countries, which leans more towards euthanasia, and where access extends beyond those who are terminally ill.

Public opinion

29. There have been several public polls carried out on the issue of assisted dying in recent years which have shown strong levels of support for assisted dying to be introduced in Scotland. A Populus survey for Dignity in Dying in 2019²⁹ showed 87% support for assisted dying. In June 2021, the polling company Panelbase carried out a survey on behalf of the Sunday Times newspaper,³⁰ which polled those aged 16 and over and asked, "Whether or not you would want the choice for yourself, do you support or oppose this proposal (as had been detailed in the newspaper – a proposal similar to that made by Liam McArthur in the consultation on his proposed bill) for assisted dying becoming law?". Overall, 72% of respondents supported the proposal, 14% opposed it and 14% said they didn't know. In July 2023, a YouGov poll for Dignity in Dying³¹ showed overall support for assisted dying in Scotland of 77%.

30. There has been significant and increased media coverage and societal discussion and debate on the issue of assisted dying in Scotland and the rest of the UK over the last two years. This largely seemed to be fuelled by the Bills proposed/introduced in Jersey and the Isle and Man, as well as the proposals for this Bill being lodged and activity (such as a committee inquiry) at the UK Parliament. An aspect of this has also been various well-known people commenting on the issue. On the back of some of those calling for assisted dying to be introduced in the UK (for example, the broadcaster Dame Esther Rantzen) various media outlets conducted polls asking whether assisted dying should be supported/introduced and/or began petitions calling for the introduction of assisted dying. One example is a poll carried out by Deltapoll, commissioned by the Daily Mirror newspaper, in which 71% of respondents supported the introduction of assisted dying.³²

²⁸ Netherlands, Belgium and Luxembourg.

²⁹ Populus 2019, Dignity in Dying Scotland fieldwork 11-24th March 2019, at p.1 see: [OmDignity-Scotland- Q1+2.wyp \(yonderconsulting.com\)](https://www.yonderconsulting.com/Scotland-Q1+2.wyp).

³⁰ [ST-tables-for-publication-v2-050721.pdf \(norstat.no\)](https://www.norstat.no/ST-tables-for-publication-v2-050721.pdf).

³¹ YouGov/Dignity in Dying Scotland Survey Results 25-31 July 2023. Available at: [Survey Report \(d3nkl3psvxxpe9.cloudfront.net\)](https://www.surveymonkey.com/YouGov-Dignity-in-Dying-Scotland-Survey-Results-25-31-July-2023).

³² [Deltapoll-Mirror231229.xlsx](https://www.deltapoll.com/2023/07/31/deltapoll-mirror-231229.xlsx).

Detail of the bill

31. The Bill allows terminally ill adults in Scotland to request, and, if eligible, be provided with assistance to end their life, and establishes a process, delivered by health professionals to enable people in Scotland to legally and safely access assisted dying. This is restricted to those who meet various eligibility criteria set out in section 3 of the Bill. To be eligible, a person must be: terminally ill; aged 16 or over; resident in Scotland for at least 12 continuous months; registered with a GP in Scotland; and have the mental capacity to make the request. Other parts of the process also require that a person must have had health and social care information/options (for example palliative and hospice care), and information about assisted dying, explained prior to making a final decision on assisted dying and that the person makes the decision of their own free will, without coercion or undue pressure (to the reasonable satisfaction of healthcare professionals). It is fundamental to the Member's policy that a person is making a settled, voluntary choice to end their life, to be, if assessed as being eligible, legally provided with assistance to do so, which they must administer themselves.

32. The meaning of "terminally ill" for the purposes of the Bill is a person who has an advanced and progressive³³ disease, illness or condition³⁴ from which they are unable to recover, and that can reasonably be expected to cause their premature death. While the Bill does not define "terminally ill" by reference to a period of life expectancy, the definition requires a person to be in an advanced stage of terminal illness (i.e. close to death). Whilst the member has deep empathy for, and understanding of, people suffering intolerably for many years who are not at the end of life, he believes parameters must be drawn that are most appropriate for the diseases, illnesses and conditions affecting the people of Scotland, and after careful reflection decided that assisted dying for people in the end stages of life is most appropriate. It is not the intention that people suffering from a progressive disease/illness/condition which is not at an advanced stage but may be expected to cause their death (but which they may live with for many months/years) would be able to access assisted dying.

33. The Bill includes numerous safeguards to ensure the process is proportionately and appropriately safe and requires data to be collected and reported to inform knowledge, understanding and any future decision-making. Relevant data on those seeking, and receiving, an assisted death is to be provided to Public Health Scotland and then relevant statistics reported to the Scottish Government by Public Health Scotland. The Scottish Government must report annually on the provision of assisted dying and a detailed review of the legislation must take place five years after it comes into force.

³³ i.e. a disease, illness or condition which is worsening, growing and/or spreading in the body.

³⁴ The definition of "terminal illness" makes reference to "disease", "illness" and "condition". "Disease" being the specific form of pathology, "illness" being the manifestation of that in certain cases and "condition", which includes disorders (such as a collection of physiological symptoms) and can describe a state of health. All three terms are used across NHS materials and by health professionals and are included in the definition for completeness.

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34. No-one is required by or under the Bill to play an active participative role in the assisted dying process if they have a conscientious objection to doing so. Those participating will also be exempt from criminal or civil liability for carrying out activities authorised in the Bill in line with the Bill's provisions.

Eligibility and related safeguards

35. The eligibility criteria address various policy priorities and establish important safeguards as follows:

- a person needs to be assessed by two doctors as being terminally ill. This will prevent those not terminally ill from being able to access assisted dying and helps address concerns from some groups and individuals that assisted dying would pose a threat to, for example, those with a disability, or who are suffering from a mental illness, or to older people;
- only adults, aged 16 and over, are able to access assisted dying. This will ensure that only those who have reached the age of majority (i.e. have full legal decision-making capacity) in Scots law can access assisted dying. This ensures children aged under 16 will not be able to access assisted dying;
- a person must have been ordinarily resident in Scotland for a minimum period of 12 months. This will help to ensure that Scotland does not have a process which encourages or easily facilitates those not normally resident in Scotland, such as those from other parts of the UK where assisted dying remains illegal, to travel to Scotland to have an assisted death. The Member believes that a minimum 12-month residency requirement is proportionate and achieves a fair and reasonable balance between limiting access to those usually resident in Scotland (being reassured that the residency is permanent) and ensuring that access is available to those who wish to access it. The Bill specifies that someone needs to be "ordinarily" resident in Scotland for at least 12 months. This means a person living in Scotland lawfully, voluntarily, and for settled purposes as part of the regular order of their life for at least 12 months;
- a person must be registered with a GP in Scotland. This will ensure that only those who are registered with a GP and therefore who are known to the NHS, have medical records, and are likely receiving care will be able to access assisted dying. It also provides an additional reassurance to the Doctors managing the process as to the identity of an individual. Again, the Member considers this strikes an appropriate balance between ensuring assisted dying is accessible to those who need it without undue barriers, whilst ensuring that those who wish to have an assisted death are known to the health service;
- a person must understand the decision they are making. It is essential that a person deciding to have an assisted death understands the decision they are making, which includes understanding their own situation (including medical diagnosis, treatment and care) as well as the context of their decision (for example, the effect their decision may have on family and friends). The Bill therefore requires two doctors to be satisfied that a person has sufficient mental capacity to make the decision (including being able to refer to a mental health

specialist if they have any doubts) and guards against a person without appropriate mental capacity from being able to access assisted dying.

36. The eligibility criteria in the Bill therefore include inherent safeguards, ensuring that only an appropriately narrow cohort of people will be able to access assisted dying and protecting all others (such as those who are not terminally ill (including those who may feel particularly vulnerable such as disabled or older people), those under 16, and those who lack capacity) by not allowing them legal access to an assisted death.

37. The Bill allows for support to access assisted dying to be provided to those who require it. A proxy (a solicitor, member of the Faculty of Advocates or Justice of the Peace) can be appointed to sign a first and/or second declaration form on behalf of a person who is not able to do so themselves due to a physical impairment. While not specified in the Bill, the NHS already provides for interpreters to be provided to support anyone who requires language assistance to communicate in matters relating to their care.³⁵

Further safeguards

38. The process for accessing assisted dying and being given assistance to end life contains numerous safeguards to ensure that an appropriate balance is achieved between protecting all involved from any unintentional consequences and ensuring that those who qualify for, and wish to have an assisted death, are able to do so without undue bureaucratic hurdles and/or distressing delays which can result in further suffering.

39. Several safeguards relating to the eligibility criteria have been set out previously in this Memorandum. Additional safeguards in the Bill include that:

- two doctors (independent of each other) must determine that a person is eligible and can be given assistance to end their life (the first of these is the “coordinating doctor” which is the registered medical practitioner to whom the person has first indicated that they are seeking an assisted death, and who has agreed to be the coordinating doctor, who will provide consistency during the process);
- a person must make the decision of their own free will, without being coerced or unduly pressured. The Bill therefore requires healthcare professionals to be satisfied throughout the process that a person is acting of their own free will and voluntarily wishes to proceed. Requiring doctors to be satisfied, throughout the process, that coercion or inappropriate influence is not taking place (something that healthcare professionals already have guidance on,³⁶ and experience in assessing) will ensure an appropriate balance between a person being able to access assisted death if they meet the criteria, and healthcare professionals

³⁵ For example, see: NHS Scotland Interpreting, Communication Support and Translation National Policy. Available here: [Interpreting, communication support and translation national policy \(healthscotland.scot\)](https://www.healthscotland.scot/interpreting-communication-support-and-translation-national-policy).

³⁶ [Decision making and consent - professional standards - GMC \(gmc-uk.org\)](https://www.gmc-uk.org/guidance/decision-making-and-consent-english) and [gmc-guidance-for-doctors---decision-making-and-consent-english pdf-84191055.pdf \(gmc-uk.org\)](https://www.gmc-uk.org/guidance/decision-making-and-consent-english/pdf-84191055.pdf).

being able to refuse assistance if they have concerns that the person is not acting of their own free will. The Bill also makes it an offence to coerce or pressure a person into making a first or second declaration to have an assisted death;

- a person must have been informed of (and ideally have discussed) their situation, and the options open to them (for example palliative, hospice and other care options), with a registered medical practitioner before deciding to have an assisted death. The Member believes it is of vital importance that a person wishing to have an assisted death has made an informed decision, is aware of their situation and all the options available to them and had the opportunity to ask questions and explore options. It will also be possible for a person to discuss the possibility of assisted dying with a registered medical practitioner before the formal part of the process provided for by the Bill is undertaken, if they choose to do so. The Member believes this initial conversation presents an opportunity for RMPs to triage and signpost to other useful services that the patient may benefit from before proceeding with assistant dying;
- if either doctor is unsure about the person's illness and/or capacity to request an assisted death, the person can be referred to an appropriate specialist (such as a specialist in the particular disease, illness or condition, or to a psychiatrist or psychologist or other mental health expert) to give an opinion which must be taken into account (and assistance will only be provided if both doctors are satisfied);
- before being assessed for eligibility, the person must sign a written declaration of their request to have an assisted death, which must be witnessed and signed by the coordinating doctor and another witness;
- a minimum waiting period of 14 days (unless death is expected in less than 14 days) must elapse before a person can sign a second declaration. This will allow the person time to reflect on their decision. This timeframe can be shorter if the person is expected to die within 14 days (but it must be at least a minimum of 48 hours in all circumstances);
- after the waiting period has elapsed, to proceed a person must sign a second, final, declaration of their wish to have an assisted death. As with the first declaration form, this must be witnessed and signed by the coordinating doctor and another witness;
- the coordinating registered medical practitioner or an authorised health professional³⁷ must bring the substance, check the person continues to retain their capacity, wishes to proceed and is acting of their own free will;
- the person must administer the life-ending substance themselves, and the coordinating registered medical practitioner or authorised health professional must remain with the person until they have decided to take the substance and, if so, until they have died;

³⁷ A health professional (registered medical practitioner or registered nurse) authorised by the coordinating registered medical practitioner for the purposes of the provision of assistance.

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- the person can stop the process at any point and cancellations will be recorded on a person's medical records;
- it would continue to be a criminal offence to end someone's life directly. There is also no change in the law for any action to assisted dying outside of the process provided for in the Bill;
- every assisted death must be recorded and reported for safety, monitoring, and potential research purposes. Annual reports will be published on the operation of assisted dying, and the legislation will be reviewed after 5 years.

Process for accessing assisted dying

40. The process those eligible for assisted dying must follow to be enabled to access assistance to voluntarily end their life will ensure there is suitable accountability and transparency, and that an appropriate balance is achieved between a person being able to have an assisted death without undue delay and further suffering and ensuring appropriate safeguarding measures are in place.

41. The process in the Bill broadly consists of a person indicating to a registered medical practitioner (likely to be their GP or doctor in charge of their treatment and care) that they wish to have an assisted death. If, provided the registered medical practitioner is content to participate and following discussion, the person should wish to proceed, they will be given (or be directed to) a first declaration form. The first declaration form must be signed by the person seeking assistance to end their life, the doctor they spoke to about having an assisted death – who becomes the “coordinating” doctor for the assisted dying process (if they agree to participate) - and another witness. On the first declaration form, a person is recording their personal details and declaring that they wish, of their own free will, to proceed with the process for accessing an assisted death, and having that declaration witnessed. The doctor and the witness should be satisfied that the person is acting of their own free will and not being coerced or unduly influenced. This is an opportunity for any initial and more obvious concerns about coercion to be addressed, however, independent decision-making will be further, formally assessed during the next stage of the process.

42. Following the signing of the first declaration form, the minimum waiting period that must elapse before a second declaration can be signed begins. This is 14 days, except in circumstances where death is expected by the assessing doctors to occur in less than 14 days, in which circumstance the period may be shortened but must not be shorter than 48 hours (this is to ensure time for some reflection). The medical assessment process can also begin. The person will first be assessed by the coordinating doctor to ensure that they meet all of the eligibility criteria explained previously and are not being coerced or unduly influenced. If the coordinating doctor is satisfied, they make a referral to a second, independent, doctor to assess the person to determine whether they meet the eligibility criteria relating to terminal illness and capacity and are not being coerced or unduly pressured. If either doctor is not satisfied on one or more of the criteria relating to terminal diagnosis and capacity, additional specialist assessment and input can be sought (for example, if there are doubts on capacity a referral can be made to a psychiatrist or other mental capacity expert). If both

doctors determine that the person is eligible for assisted dying and is not being coerced or unduly influenced, and the minimum waiting time has elapsed since the first declaration was signed (14 days unless both doctors have agreed it should be at least 48 hours) then the person can sign a second, final, declaration form confirming they wish an assisted death to take place. If either doctor is not satisfied, then the process stops, and assistance to end life will not be provided (and existing palliative/end-of-life care would continue).

43. The second, final, declaration form must be signed by the person, the coordinating doctor and another witness, for the person to be allowed to proceed. This provides a further opportunity for the process to be stopped if the doctor has concerns around illness, capacity and/or free-will. If all the required parts of the process have been met successfully, the person decides where and when they wish to die and arrangements can be made for the person to be assisted to die on that day, by self-administered means.

44. On the day of the assisted death, the coordinating registered medical practitioner or a health professional authorised by that coordinating doctor will attend and provide the person with an approved substance³⁸ which they will take to end their life. It may be that other health professionals also attend if the coordinating registered medical practitioner or authorised health professional think it necessary (the Bill defines a health professional for this purpose as also including registered pharmacists, in addition to registered nurses and registered medical practitioners). Before doing so, the coordinating registered medical practitioner or authorised health professional must check that the person wishes to proceed and consider again whether they have capacity to make the decision and are doing so of their own free will. A person can decide not to proceed at any time. Note that there is no time limit by which a person who has made a second declaration must have decided on a date/time to have an assisted death. This is not considered necessary because of the final checks required to be made by the attending health professional present at the assisted death and because a person can decide not to proceed at any point in the process. It is also considered that including a time limit may put unnecessary pressure on the terminally ill adult.

45. It will be for the Scottish Government to make regulations about which substances/drugs are approved for use for assisted dying purposes (see the commentary in this memorandum relating to the limitation on the effect of the Bill).

46. After a death resulting from assisted dying as provided for by the Bill, the coordinating registered medical practitioner completes a “final statement” noting all relevant details of the death (such as the date, time and cause of death, and the time between taking the substance and death occurring). The cause of death listed should be the underlying terminal illness the adult had, which is also the case with the death

³⁸ An “approved substance” is one which has been approved for use in assisted dying by regulations laid by the Scottish Ministers. See also the commentary in this memorandum relating to limitations on the effect of the Bill.

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certificate, which should also record the primary cause of death as the terminal illness the adult had.

Involvement of healthcare professionals and Scottish Government guidance

47. The Bill provides for specific roles for registered medical practitioners and health professionals (defining a “health professional” for the purposes of the Bill as a registered nurse and a registered pharmacist, as well as a registered medical practitioner).

48. The Interpretation and Legislative Reform (Scotland) Act 2010³⁹ defines a “registered medical practitioner” as “... a fully registered person within the meaning of the Medical Act 1983 (c.54)⁴⁰ who holds a licence to practise under that Act.” Under the Medical Act 1983, the General Medical Council (GMC) manages the medical register.⁴¹

49. Under the Nursing and Midwifery Order 2001,⁴² the Nursing and Midwifery Council (NMC) maintains a register of all nurses, midwives and specialist community public health nurses and nursing associates eligible to practise within the UK.

50. The Bill establishes the role of “coordinating registered medical practitioner” as previously explained. The coordinating registered medical practitioner and an independent registered medical practitioner are the doctors who will assess a terminally ill adult’s eligibility to be provided with assistance to end their own life, and the Bill allows the Scottish Ministers to regulate for any particular qualifications and/or experience that a registered medical practitioner should have to perform these roles. This will ensure that if a certain level of experience (for example, that a doctor should have completed foundation year two, or that one of the who doctors should be a specialist in the person’s terminal illness) is considered appropriate that Ministers can require it, thus ensuring that the public and those wishing to access assisted dying can have confidence that the process is carried out in the safest way possible.

51. As set out elsewhere in the Memorandum, the Member believes that it is important that the concept of personal autonomy which underpins the Bill applies to anyone directly involved in providing assistance, as well as to those who are terminally ill. No-one, including registered medical practitioners and other health professionals, should therefore be required to play a hands-on part in providing assisted dying if they have a conscientious objection to doing so. This mirrors the approach taken to abortion and some end of life care, where health professionals with a direct hands-on capacity in the treatment process can opt out of participating if they have a contentious objection to doing so.

³⁹ [Interpretation and Legislative Reform \(Scotland\) Act 2010 \(legislation.gov.uk\)](#).

⁴⁰ [Medical Act 1983 \(legislation.gov.uk\)](#).

⁴¹ [A guide to the medical register - GMC \(gmc-uk.org\)](#).

⁴² [The Nursing and Midwifery Order 2001 \(legislation.gov.uk\)](#).

52. If a person approaches a registered medical practitioner about having an assisted death, and the practitioner objects to taking part, then, as is the case with abortion the practitioner should refer the person to another registered medical practitioner who is content to participate. The member understands that this is consistent with established medical practice. Indeed, in the UK Supreme Court judgment (*Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland)*)⁴³ in the context of abortion, the justices held that:⁴⁴

“Whatever the outcome of the objectors’ stance, it is a feature of conscience clauses generally within the health care profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional’s duty of care towards the patient. Once she has assumed care of the patient, she needs a good reason for failing to provide that care. But when conscientious objection is the reason, another health care professional should be found who does not share the objection.”

53. The Member anticipates that relevant regulatory bodies, such as the General Medical Council (GMC - the independent regulator of doctors in the UK), or the NMC, the Health and Care Professions Council (HCPC - a regulator of health and care professions in the UK) and the General Pharmaceutical Council (GPhC - the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain) will ensure suitable training is provided for health professionals who will be involved in supporting the assisted dying process to ensure that they are familiar with the process set out in the Bill. Support may also be provided by relevant representative and membership organisations, such as the British Medical Association (a trade union for Doctors in the UK) and the Royal College of Nursing (RCN – a membership body for registered nurses, midwives, health care assistants and nursing students), the Health and Care (Staffing) (Scotland) Act 2019 places a duty on every Health Board in Scotland, as well as the Common Services Agency for the Scottish Health Service, to ensure staff are suitably trained. It is further expected that such organisation may issue guidance relating to some of the clinical aspects of the Bill.

54. The Member also notes that some other jurisdictions that have legalised a form of assisted dying have established (often via third sector initiative) support and navigation networks for those involved in the process (including health professionals, patients, and family and friends) and that something similar may emerge in Scotland once the Bill has been passed and the Act is operational. It is understood that organisations such as Friends at the End and Humanist Society Scotland have indicated that they would support implementation/operation by providing guidance, support, counselling, and other navigation for patients.

55. The Bill allows the Scottish Ministers to issue and publish guidance relevant to the practical operation of the Bill and requires Ministers to consult with relevant others as appropriate. The Member believes this is important as it will allow for collaboration

⁴³ [Greater Glasgow Health Board \(Appellant\) v Doogan and another \(Respondents\) \(Scotland\) \(supremecourt.uk\)](https://www.supremecourt.uk/).

⁴⁴ [Greater Glasgow Health Board \(Appellant\) v Doogan and another \(Respondents\) \(Scotland\) \(supremecourt.uk\)](https://www.supremecourt.uk/).

between Ministers and relevant bodies, such as the NHS and regulatory and representational health organisations and third sector organisations and ensure that practical experience of the operation of the Bill can help inform and establish helpful practical guidelines.

Data collection, reporting and review

56. The data collected on first and second declarations (and any cancellation of either of these), medical practitioner's statements, and final statements, will form part of a person's medical records and therefore be subject to the same management (including retention periods) as other personal health information held by the NHS in Scotland.⁴⁵

57. The Member believes it is also important that relevant anonymised statistical data is reported and published on access to, and use of, assisted dying in Scotland. It will be important for transparency and to aid understanding to collect and report data such as:

- how many people are requesting assisted dying and why (broken down by numbers accessing the first and second stages of the process);
- how many people are deemed eligible for assisted dying;
- how many people are being refused assisted dying and on what basis;
- how many people decided not to proceed, and for what reasons;
- how many assisted deaths take place;
- what substance or substances have been used to provide an assisted death;
- where the death took place; and
- anonymised personal data such as age, gender, ethnicity, nationality, area of residence, and type of disease/illness/condition.

58. The Bill therefore requires the Scottish Ministers to make regulations which provide for relevant data to be provided to Public Health Scotland⁴⁶ for the purpose of producing assisted dying statistics, which Public Health Scotland is required to report annually to the Scottish Government, and for the Scottish Government to publish the data on an annual basis and lay a report before the Scottish Parliament. There are several policy reasons for data to be collected and reported. Firstly, the Member wishes assisted dying to be a transparent, accountable process, with relevant anonymised statistical information recorded and made publicly available to all, in the public interest. Secondly, the Member believes that the data collected will aid and inform knowledge and understanding about the impact and effect of the legislation.

⁴⁵ [How the NHS handles your personal health information | NHS inform.](#)

⁴⁶ Public Health Scotland is the national public health body for Scotland. It is an NHS Health Board which is jointly accountable to both the Scottish Government and the Convention of Scottish Local Authorities (COSLA).

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59. The Bill also requires the legislation to be reviewed after five years and for the Scottish Government to publish a review report and lay it before the Scottish Parliament. The five-year review report will be informed by the data collected and published in the previous annual reports, and any other information gathered by, or on behalf of, the Scottish Government, regarding the experiences of several years of operation of assisted dying in Scotland. The review will give the Scottish Parliament, the health and care professions, and Scottish society more widely, an opportunity to take stock of the practical experience of assisted dying over a five-year period. The report may contain recommendations and/or proposals for amending aspects of the process as a result of the experience of health professionals, patients, and their support networks.

60. The Bill aims to achieve an appropriate balance between collecting data to better understand and inform consideration of the Bill's implementation, while ensuring that only necessary data is collected. Under the Bill, all data collection will be done through Public Health Scotland, the body responsible at national level for the public health domains of health improvement, health protection and health care improvement, and which is already supported by a range of data and intelligence functions. Public Health Scotland has extensive experience of gathering and using patient data for the purpose of abortion statistics, and the member envisages that the data gathering for assisted dying purposes will likely follow similar established routes. The Member notified and consulted the Information Commissioner's Office (ICO) as part of the consultation on his draft proposal for a Member's Bill. The ICO provided comments to the Member on his proposal which have been taken into consideration in the drafting of the Bill's provisions relating to data collection and reporting (for example, by ensuring that reported data is anonymised). As noted above, there are well-established processes for the management of medical records within the health service.

Alternative approaches

61. As the Member is seeking a significant change to the law to allow for a regulated process of assisted death in certain circumstances it was considered that there was no credible alternative to primary legislation. As set out elsewhere in this Memorandum, the Member does not accept that the law as it stands is either appropriate, in terms of it currently being possible to assist a death and face prosecution, or is sufficiently clear, well understood and supported by a majority of people in Scotland.

62. The need to legislate to bring about the desired policy change is further evidenced by the number of other countries and jurisdictions legislating for assisted dying around the world, and also by the previous attempts to legislate, both in Scotland and in the rest of the United Kingdom. The proposed legislation in Jersey and the Isle of Man, and considerations in the UK Parliament, are further evidence of the acceptance that legislation is required to safely and legally provide for assisted dying.

63. The Member believes that the consistent provision of, and accessibility to, high quality palliative care is essential for the people of Scotland, and that every effort should

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be made to improve the quality of, and access to palliative care.⁴⁷ It should be noted, however, that the Member does not consider that further investment in, and availability of, palliative care in Scotland is an alternative to the provision of assisted dying as set out in the Bill. The Member believes that assisted dying and palliative care are not mutually exclusive, and that assisted dying should be an option for terminally ill adults alongside the continued, and improved, provision of palliative care. He believes that terminally ill adults in Scotland should have the option of both high quality and accessible palliative care and being provided with assistance to end their life if they wished. Experience from jurisdictions where a model of assisted dying is lawful is that a high number of those who had an assisted death were receiving palliative care. A report on Assisted Dying/Assisted Suicide published by the House of Commons Health and Social Care Committee on 29 February 2024⁴⁸ stated, in paragraph 142, “In the evidence we received we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD/ AS; indeed the introduction of AD/AS has been linked with an improvement in palliative care in several jurisdictions.”.

64. Previous proposals for Member’s Bills in the Scottish Parliament have been brought forward on the issue of assisted suicide. As explained elsewhere, while the broad policy intention is similar (to allow those suffering from a disease/illness/condition to be assisted to end their life) there are important policy differences between both of those previous Bills, and this Bill. Among the most notable of those is that this Bill has more rigorous criteria for accessing assisted dying (limited only to those adults with capacity who are suffering from an advanced and progressive terminal illness) and more stringent safeguards to protect all involved and to limit as far as possible any potential concerns about abuse of the process.

65. Whilst the Member was not convinced that there were credible alternative approaches to legislation to achieve his aims, he did consider various alternate/different legislative options for delivering the policy. This included decisions such as limiting assisted dying to those who are terminally ill only and ensuring that numerous safeguards were established in every part of the process.

66. The Member also considered how to define terminal illness most appropriately for the purposes of the Bill. It is not uncommon, in assisted dying legislation in other jurisdictions, for the term to be defined by reference to a maximum period a person is expected to live, such as six or twelve months. The Member consulted international evidence which shows that even when a time limit is included, it does not alter the way in which assisted dying is accessed, and that people still access it in their final weeks/days of life and primarily for cancer. It has been shown⁴⁹ that including a time limit can result in 'undesirable outcomes' for patients, without having the perceived desired effect of acting as an additional safeguard. The Member believes that not including a time frame means that a terminally ill adult would not be rushed into making

⁴⁷ Palliative care aims to relieve suffering and improve quality of life for people with serious, often terminal, illnesses.

⁴⁸ [Assisted Dying/Assisted Suicide \(parliament.uk\)](https://www.parliament.uk/publications/2024/02/assisted-dying-assisted-suicide/).

⁴⁹ The University of New South Wales Law Journal. Who Is Eligible for Voluntary Assisted Dying? (2022). Available at: [Issue-451-White-et-al.pdf \(unsw.edu.au\)](https://www.unsw.edu.au/law/journal/issue-451-white-et-al.pdf).

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a decision because time is running out, meaning exploring the option of assisted dying is likely to be a more balanced and thoughtful process. It gives patients more time to deliberate, discuss their options, and explore other therapies. It also reduces the risk of the person losing capacity during the decision-making process and for safeguarding checks to be carried out over a period of time instead of under a tight timeline. The Member also considered that including an expected life expectancy within the definition would place unreasonable pressure on healthcare professionals who will be assessing people who wish to have an assisted death and could result in excluding some terminally ill people from the process inappropriately.

67. The Bill does not define terminal illness by reference to an expected period of time a person will live, but access is constrained by the need for a person's condition to be advanced and progressive. The Member also was mindful of responses to the consultation on his draft proposal which included many comments about the difficulties in prognosis and assessing how long a person may have to live. Therefore, rather than defining terminal illness by a period of life expectancy, the member decided to focus on whether a registered medical practitioner considers a person to have an advanced and progressive illness from which they will not recover, and which is expected to cause their premature death.

68. Another notable policy choice involved the body which is to be responsible for collecting and reporting statistical data on assisted dying. The Member considered either establishing a new body specifically for the role or adding the responsibility to an existing body and decided that it would be most efficient and appropriate for a duty to be placed on Public Health Scotland to perform the role.

Consultation

69. Liam McArthur consulted on a draft proposal⁵⁰ lodged on 22 September 2021. The consultation⁵¹ ran from 23 September 2021 until 22 December 2021. There were 14,038 responses⁵² (the highest number of responses to date to a consultation on a Member's Bill in the Scottish Parliament), and a summary⁵³ of those responses was published along with a final proposal⁵⁴ on 8 September 2022.

⁵⁰ Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Details available at: [Proposed Assisted Dying for Terminally Ill Adults Scotland Bill | Scottish Parliament Website](#).

⁵¹ Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Consultation document, available at: [Assisted Dying Consultation 2021 - FINAL \(parliament.scot\)](#).

⁵² Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Consultation responses, available at: <https://www.assisteddying.scot/>.

⁵³ Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Consultation summary, available at: [assisteddyingconsultationsummaryfinaldraft.pdf \(parliament.scot\)](#).

⁵⁴ Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Details available at: [Proposed Assisted Dying for Terminally Ill Adults Scotland Bill | Scottish Parliament Website](#).

70. In addition to the 14,038 responses included in the summary, 3,352 emails⁵⁵ were sent to Liam McArthur (on the same day) by the organisation Right to Life, on behalf of individual members of the organisation. These emails were all from the same organisational email address (but copied to different email addresses, seemingly those of individuals) and were all fully opposed to the proposal. Given the responses all came from the same email address (that of the Right to Life organisation), and the identical/very similar nature of the responses, they were not counted as individual responses for the purposes of the summary and were not counted in the data presented in the summary.⁵⁶ A summary of the views expressed in the campaign can be found on page 7 of the summary,⁵⁷ and an example of the contents of the campaign can be accessed online.⁵⁸

71. Eighty-one responses were from organisations and the remaining 13,957 were from individuals (including academics, professionals and members of the public). 9,051 responses (64.5% of all submissions) were published and attributed, 3,665 (26% of all submissions) were published anonymously, and 1,322 (9.5% of all submissions) were not published at the request of the respondent.

72. Views on the proposal to introduce assisted dying for terminally ill competent adults in Scotland were broadly polarised, with strong views expressed both in support and opposition. Only 3% of respondents expressed a view other than full support or full opposition. Among those that did were some representative organisations which did not give a view as opinions amongst the relevant memberships were mixed. Views on the details of the proposal, and how assisted dying should be implemented in Scotland, were more nuanced, with a wide range of issues, questions, and concerns raised by respondents on both sides of the debate.

73. A clear majority of respondents (10,687 - 76%) were fully supportive of the proposal, with a further 244 - 2% partially supportive. Many respondents gave first hand experiences of living with, and caring for, family, friends and patients with a terminal illness who had experienced great pain and suffered what was often described as a traumatic and undignified “bad death”. Many of these respondents believed that assisted dying should be available for people in Scotland, as it is in other parts of the world. They believed that a humane and compassionate society should take steps to avoid people being required to endure unbearable pain and suffering and allow people the autonomy to legally choose to end their lives in a safe, peaceful, and regulated

⁵⁵ A proportion of these respondents also made incomplete responses via a Right to Life organised webpage which linked to the Smart Survey hosting the consultation. To avoid duplication, and as most were incomplete, the Smart Survey responses were discounted. Note that although 3,352 emails were received, these were not verified so it is not known if this figure included multiple responses from the same individual.

⁵⁶ Note that if the 3352 responses that were part of the Right to Life campaign had been included in the overall figures regarding consultation responses, they would read as follows: 17,390 responses; 61.45% fully supportive; 1.40% partially supportive; 0.28% neutral; 0.29% partially opposed; 36.38% fully opposed; 0.17% unsure.

⁵⁷ Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Consultation summary, page 7. Available at: [assisteddyingconsultationsummaryfinaldraft.pdf \(parliament.scot\)](#).

⁵⁸ [Right-to-Life-campaign-example-submission-Assisted-Dying-for-Terminally-Ill-Adults-Scotland-Bill-Consultation.pdf \(assisteddying.scot\)](#).

manner. Some supportive respondents also stated that it would be comforting and reassuring to know that assisted dying was an option, even though many may not decide to take the option. Many supportive respondents believed the proposal was an improvement on previous attempts to legislate for assisted dying and were fully satisfied with the proposed safeguards set out in the consultation document. Many believed that the proposal successfully balances the provision of access to assisted death for competent terminally ill adults with a clear and appropriate set of safeguards built into every step of the process, together with health professionals involved being able to conscientiously object.

74. A proportion of those supportive of the fundamental principle of legalising assisted dying put forward changes they wished to see to the specifics of the proposal. One of the most common changes called for related to concerns about the intended definition of “terminal illness” proposed in the consultation document. Many believed a wider group of people should be able to choose an assisted death than the intended definition would allow for, such as those with potentially longer-term degenerative conditions, such as various neurological conditions and forms of dementia. A significant number of respondents also raised concerns about the proposal that the life ending substance must be self-administered, noting that some people who would wish to choose an assisted death would not be able to take the medicine themselves. Many respondents believed this to be potentially discriminatory and called for a health care professional to be able to administer the drug in certain circumstances, or that there should at least be clarity on how life would be ended in such circumstances.

75. A minority of the overall number of respondents (2,975 - 21%) were fully opposed to the proposal, with a further 52 - 0.4% partially opposed. One of the most common reasons given for opposing the proposal was a fundamental belief, often founded in a particular religion, that human life is sacred and must not be purposefully ended under any circumstances. A large number of those opposed also believed that no safeguards would ever be able to prevent some people from feeling pressure to end their lives, perhaps through fear of being a burden on family, friends, health care services and/or wider society, or even being coerced for various reasons into deciding to choose an assisted death. Fears were expressed that there could never be certainty that a decision was being made solely of the individuals own free will. Many of those opposed also stated their belief that legislating to give effect to the proposal would be a “slippery slope” i.e. that any legislation passed would likely be amended in the future to weaken safeguards and extend the option for assisted death beyond the competent terminally ill adults currently proposed. Such responses often cited other countries and jurisdictions where a form of assisted dying is legal, and where they believe such changes have occurred over time. Fears were also expressed that the proposal would further stigmatise and threaten some of the more vulnerable people in society, such as young people, older people and people with a disability.

76. A majority of the organisations that responded to the consultation were fully opposed to the proposal (47 organisations - 57.5% of organisations) the majority of which (32 - 68% of organisations) were either specifically religious organisations, or were organisations clearly linked to a particular religion. Of the individual respondents that identified as members of the public (which represented 87% of individuals who

responded), a clear majority (over 80%) were fully supportive. There was a more even split amongst those individuals who identified as being professionals with experience in a relevant subject, with 50% of them fully supportive and 46.5% of them fully opposed. Those professionals, both supportive and opposed, included a range of (current, previous and retired) health care professionals (including GPs, doctors, nurses, and social workers – including mental health specialists), religious figures (including priests, ministers and rabbis), pharmacists, vets and legal professionals.

77. Following the close of the consultation, Liam McArthur, invited a group of senior healthcare practitioners to form a working group to advise and inform him ahead of the Bill being introduced. A Medical Advisory Group (MAG) was subsequently established, chaired by Dr Sandesh Gulhane MSP, with ten other group members (professionals/experts/academics). The MAG was formed to explore the healthcare related issues of the proposed assisted dying bill and was asked to consider responses to the Member's consultation and take additional evidence relating to medical practice and the role of health professionals and consider specific aspects of implementation, such as patient pathways, per support and training and pharmaceutical requirements, and to report its findings. The MAG report was finalised in November 2022 and published on 12 December 2022.⁵⁹ The Terms of Reference included in the published report stated: "This report outlines the issues, challenges and opportunities that the medical profession would be presented with should assisted dying be legalised in Scotland." The report was considered as part of the drafting process of the Bill.

Effects on equal opportunities, human rights, island communities, local government, sustainable development etc.

Equal opportunities

78. The Bill provides for assisted dying to be accessible to any person that meets the relevant criteria (a person must be aged 16 or over, terminally ill, mentally competent to make the decision, resident in Scotland for at least 12 months, registered with a GP in Scotland, have had care options explained to them, and be making the decision of their own free will).

79. The consultation on the draft proposal for the Bill received responses from organisations and individuals expressing concerns relating to various protected characteristics on the basis that it made a particular group of people at greater risk of choosing an assisted death due to a temporary period of depression, anxiety or other mental health condition connected to the protected characteristic (for example, examples were given of people struggling with their sexuality or undergoing gender reassignment). As the Bill only allows access to assisted death to adults who are terminally ill, it is not possible for a person to access assisted death only because of any mental health condition. Therefore, there is no risk to anyone, including those with a

⁵⁹ [Medical-Advisory-Group-Report.pdf \(assisteddying.scot\)](#).

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particular protected characteristic, of being eligible for assisted dying solely on the basis of having any mental health condition.

80. In terms of the characteristics protected by law in the Equality Act 2010, those aged under 16 are directly impacted as, due to the focus on terminally ill adults, they will automatically be excluded from access to assisted dying. The Member believes this is entirely appropriate and consistent with many other age restricted activities and practices under Scots law. The Member believes that those aged under 16 are being protected by not being able to access assisted dying.

81. Access to assisted dying provided for in the Bill has the potential, either through the actual provisions in the Bill, or in associated wider perception, to impact on various protected characteristics as follows:

Age

82. In addition to assisted dying only being accessible to those adults aged 16 and over, as outlined above, it is acknowledged that a significant proportion of those likely to meet the criteria for assisted dying may be older people. Evidence and experience from jurisdictions where a form of assisted dying is available shows that a high proportion of those who request an assisted death are older. For example, in Oregon, from 1998-2021, 75% of those who had an assisted death were aged 65 and over.⁶⁰ The Member does not consider this to be a negative impact of the Bill, but a positive impact as it means that, currently, a higher proportion of terminally ill older people are being denied access to an assisted death if they wish to have one. The Member believes that, therefore, a higher proportion of older people may be suffering pain, a loss of dignity, autonomy and severe distress unnecessarily at the end of life and that the Bill will increase the rights of older people in particular. The Member also believes that the assisted dying process as set out in the Bill would be the most safeguarded end of life procedure when considered alongside interventions like palliative sedation and double effect (where pain relief is provided with the knowledge that end of life may be a consequence) which the Member believes may happen without a person's explicit consent if it is considered treatment has become futile and not in the patient's best interests.

83. Some concern has been expressed that some older people may be more vulnerable to being coerced or pressured into choosing to have an assisted death. It is important to keep in mind that simply being of a certain age does not enable access to assisted death. Only terminally ill people who meet all the other criteria are eligible. Therefore, older people who are not terminally ill will not be able to access assisted dying. Older people that are eligible will be protected by all of the safeguarding measures included in the Bill, which cover issues such as capacity and coercion. The Member considers that it would be unjustifiably discriminatory to restrict access, or increase the barriers to, assisted dying for terminally ill adults on the basis of age alone.

⁶⁰ Oregon Death with Dignity Act 2021: Data Summary. Available at: [DWDA 2021 \(oregon.gov\)](https://www.oregon.gov/oha/ohds/odda/2021/summary).

Disability

84. An adult with a disability who is not terminally ill will not be able to access assisted dying. The Bill will apply to any person with a disability that meets all the criteria set out in the legislation for accessing assisted dying (i.e. being terminally ill, aged 16 or over, mentally competent, registered with a doctor in Scotland, and having been resident in Scotland for at least 12 months). Any person with a disability that does not meet these criteria will not be eligible for assisted dying.

85. The Member acknowledges that there is concern amongst some disabled people and organisations, which included responses made to the consultation on his draft proposal by organisations representing people with disabilities, and from disabled individuals, which were opposed to assisted dying. The main concerns of these organisations and individuals included that disabled people face many inequalities which can result in some feeling that their lives are of less value. Some responses to the consultation felt that a lack of equality, including in the provision and availability of care, could lead to disabled people being particularly and disproportionately vulnerable to being coerced/pressured into choosing to have an assisted death (often stating that it is impossible to ever be 100% sure that a person is acting of their own free will).

86. Some respondents were also concerned that allowing assisted dying to be legalised in the way outlined in the proposal (i.e. with strict restrictions on who would be eligible and with numerous safeguards, including on capacity and coercion) would be the start of a “slippery slope”, and that by legislating for a certain cohort of people to be able to be legally assisted to die would begin to normalise assisted dying/suicide more generally and lead to the legislation being amended, or statute being added to, to allow for wider forms of assisted dying and/or suicide and/or euthanasia. The fear being that it may be made legally possible for someone who is not terminally ill, but has a disabling condition, to be legally able to choose to die, and doing so because of pressure/coercion (either directly or from wider society) and/or a belief that they are a burden on those around them, or on society generally.

87. There were also responses made to the consultation by disabled individuals who were fully supportive of the proposal, and the Member believes it is not accurate to frame the debate on assisted dying by stating that all, or most, disabled people are opposed to assisted dying. The Member also believes that it is crucial that the fears and concerns expressed by some disabled groups and individuals are considered by reference to what the Bill actually does, rather than any inaccurate perception of what the Bill may do. The safeguards provided for mean that only a disabled person who had an advanced and progressive terminal illness and met the other criteria would be able to choose an assisted death, and that doctors will be required to be satisfied that a person is capable of making a decision, understands their care options, and is not being coerced. The University of Glasgow School of Humanities published a briefing on the issue of disability and assisted dying laws in 2021⁶¹ and concluded that:

⁶¹ University of Glasgow, School of Humanities (2021). Disability and Assisted Dying Laws Policy Briefing. Available at: [PolicyBriefingDisabilityAndAssistedDyingLaws.pdf](#).

“... assisted dying laws should not be opposed on the basis of the views, welfare, respect or healthcare of people with disabilities. Instead, respect for disabled people’s autonomy gives some reason to legalize assisted dying, at least for people expected to die within six months. This conclusion is supported by four key findings:

1. People with disabilities are not generally opposed to assisted dying laws.
2. Assisted dying laws do not harm people with disabilities.
3. Assisted dying laws do not show disrespect for people with disabilities.
4. Assisted dying laws don’t damage healthcare for people with disabilities.”

88. As well as agreeing with the conclusions reached in the briefing paper by the University of Glasgow School of Humanities, the Member believes that any attempt to prevent or limit access to assisted dying for a terminally ill person, or to introduce additional barriers, purely on the grounds that they have a disability would be discriminatory and unjustifiable.

89. The Bill also allows for a proxy to sign declaration forms if a person is unable, due to having a physical impairment, to do so, and existing NHS policy will ensure that interpreters will be provided for anyone who requires such assistance.

90. The Member believes that the Bill increases the rights of disabled people with a terminal illness by ensuring that people with disabilities will have the same access to assisted dying and ability to make a decision about when and how they wish to die as people without a disability.

Gender

91. Data collected from jurisdictions where a form of assisted dying is in place shows that, on average, slightly more men access assisted dying than women (around a 52% - 48% split). Research has shown that the lack of choice at the end of life disproportionately and detrimentally affects women who continue to be the primary care givers at the end of life.⁶²

Race

92. An American academic study, “Expanded definitions of the “good death”? Race, ethnicity, and medical aid in dying”⁶³ stated that data in the US shows that the rates of use of assisted dying are much higher for people identifying as white. Over almost twenty years, only three percent of people who died after receiving assisted dying in Oregon identify as any race other than white, whereas the most recent statistics on the racial composition of the population of Oregon show 83% of the population identifying as “White” and the remaining 17% as of various non-white races. In California, which is

⁶² Dying in Scotland: A Feminist Issue at: <https://features.dignityindying.org.uk/dying-in-scotland>.

⁶³ Cain CL, McCleskey S. Expanded definitions of the ‘good death’? Race, ethnicity and medical aid in dying. *Sociol Health Illn*. 2019;41(6):1175-1191. doi:10.1111/1467-9566.12903. Available at: [Expanded definitions of the “good death”? Race, ethnicity, and medical aid in dying - PMC \(nih.gov\)](#).

more racially and ethnically diverse than Oregon, the vast majority of those accessing assisted dying are white. The authors of the study believed there were cultural, structural, and interactional explanations for racial and ethnic variability in the use of assisted dying in the US: that cultural and religious differences across racial and ethnic groups affect preferences for end of life care and assisted dying; that people of colour are not given equal access to information and quality care and therefore may not be aware of the option of assisted dying; and that interactions with health professionals may vary for different racial and ethnic groups.

93. The Member believes that this must be taken into account when considering how best to raise awareness of assisted dying and how the process works (for example, it is expected that, as is the case with any new health service, information and education will be provided in a variety of accessible formats, including online and paper based). The Member also believes that a fundamental principle of assisted dying is allowing people to make an informed choice, and if certain people or groups choose not to access it, for cultural, religious or any other reason, that is their decision.

Religion or belief

94. No person will be prevented from accessing an assisted death, if they meet the required criteria, because of their religion or beliefs.

95. The Bill does not require healthcare professionals who would otherwise be actively involved in providing assisted dying to a person to do so if they have an objection on religious and/or belief grounds. It will therefore be possible for a healthcare professional to conscientiously object on such grounds to providing a person with an assisted death.

Human rights

96. Leading legal experts have described the existing law on assisted dying as having an “alarming lack of clarity,” raising basic questions about whether it is compatible with Scotland’s international obligations under the European Convention on Human Rights.⁶⁴

97. The Member believes that the current law does not fully respect people’s rights to control the timing and manner of their own deaths, and their right to a dignified death. To that extent, in the Member’s view, the Bill proposal would enhance a person’s human rights.

98. The Bill has implications for human rights under the European Convention on Human Rights (ECHR) – particularly Article 2 (right to life), Article 8 (right to respect for

⁶⁴ Herald Scotland (2015) “A troubling lack of clarity in Scots law regarding assisted suicide” See: http://www.heraldscotland.com/opinion/13208016.A_troubling_lack_of_clarity_in_Scots_law_regarding_a_ssisted_suicide/.

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private and family life), Article 9 (right to freedom of thought, conscience and religion) and Article 14 (protection from discrimination).

99. There have been various cases brought before the European Court of Human Rights (ECtHR) arguing that the prohibition or lack of availability of assisted dying is a breach of the ECHR. Whilst these cases have not been upheld, the ECtHR has not stated that assisted dying is either compatible or incompatible with the ECHR. The approach of the ECtHR to date has been to recognise that countries/jurisdictions are better placed than the Court to decide on nationally sensitive issues (this is known as the “margin of appreciation”). There have been a number of decisions in Strasbourg as well as in the domestic courts that confirm that the right to private and family life includes the right to decide how and when to die, and in particular the right to avoid a distressing and undignified end to life (provided that the decision is made freely). It has also been well recognised by the courts including the UK Supreme Court that any change in the law on assisted dying is a matter for Parliament.”.

100. Consequently, on 24 May 2023, the UK Parliament House of Commons Joint Committee on Human Rights held an oral evidence session on the human rights legal issues related to assisted dying. The Committee Chair subsequently wrote⁶⁵ to the Chair of the Health and Social Care Committee to inform that Committee’s inquiry into assisted dying/suicide. The letter notes that the evidence the Committee heard:

“... demonstrated the complexity of this area, and showed that, while it is vital that discussions take proper account of our human rights framework, a human rights analysis appears not to currently provide definitive answers as to whether current legislation on assisted dying requires changes. It was clear from their evidence that as things stand, the courts have concluded that whether there is a need for changes to the law on assisted dying is a matter for Parliament, a conclusion with which we agree.”

Island communities

101. The Bill applies uniformly across Scotland and people on island communities will have the same access to an assisted death as people on mainland Scotland.

102. It is acknowledged that there may be challenges for some people in remote and rural parts of Scotland to obtain an assisted death due to the availability of relevant and required healthcare professionals. It is also acknowledged that some healthcare professionals not wishing to participate in providing an assisted death may impact more on remote and rural parts of Scotland, including some island communities, more than on more populated and accessible parts of the country.

103. It is accepted that it is possible that this could result in some people requesting an assisted death but not receiving it within the usual and expected timeframes, or at all. However, it was not considered appropriate to weaken or vary any of the safeguards provided for in the Bill or to differentiate the way the process operates on the basis of

⁶⁵ committees.parliament.uk/publications/40524/documents/197666/default/.

geographical location. The Member is reassured that experience from permissive jurisdictions (including in jurisdictions larger than Scotland and with significant remote and rural areas) is that healthcare professionals willing to play an active part in assisted dying are willing to travel to remote areas to facilitate the process. For example, the Queensland Voluntary Assisted Dying Review Board Annual Report 2023⁶⁶ and Queensland Voluntary Assisted Dying support and pharmacy service reporting shows that every hospital and health service area in Queensland has had patients accessing assisted dying, and that health professionals travel all over the State to ensure access.

Local government

104. The Bill confers no powers or obligations on local authorities and has no other direct impact on local government. No local authorities responded to the Member's consultation on his draft proposal for the Bill. Some terminally ill adults who request an assisted death may be receiving palliative care or otherwise be being cared for in local authority run care homes, but the processes set out in the Bill would not impact notably on a local authority should this be the case as the process will be managed and delivered by registered medical practitioners and health professionals rather than by care professionals or other local authority staff.

Sustainable development

105. There is no reason to suppose that the changes the Bill makes could not be sustained indefinitely. The Bill includes a requirement for the legislation to be reviewed five years after it has been in operation. This will provide an opportunity to assess the impact and effectiveness of the legislation in the first five years of assisted dying being legally available to people in Scotland.

106. The Bill is not expected to have any significant environmental impact (for example, in terms of resource or energy use). However, the Bill has the potential to have a positive impact in many other areas relevant to sustainability, and the Member believes that the Bill will support sustainable development issues by increasing wellbeing, equity and access to justice, and will make a positive contribution to the sustainable development of Scottish society in the years ahead and build towards a more compassionate Scotland.

107. A fundamental aspect of sustainable development is ensuring that economic, cultural and political systems do not favour some people while harming others, and the Member believes that some people are being harmed by assisted dying not being available, and therefore that the Bill will help to mitigate and redress that harm. It is also thought that relationships and trust between doctors and patients in Scotland will likely benefit as a result of assisted dying being legally available. Empowering some patients to take control of their own dying would signal a shift away from paternalism to more positive and autonomous patient centred decision making.

⁶⁶ [Voluntary Assisted Dying Review Board Annual Report 2022-2023 \(health.qld.gov.au\)](https://www.health.qld.gov.au/voluntary-assisted-dying-review-board-annual-report-2022-2023).

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108. Responses to the consultation on the proposal for this Bill included thousands of accounts of trauma experienced by individuals and their families and friends due to a lack of end-of-life choice. This Bill, by providing that choice (whether it is taken up or not), will help reduce anxiety and distress and improve wellbeing for those people and ensure that their wishes are respected and honoured. The consultation also demonstrated that some terminally ill people in Scotland travel abroad to access assisted dying. The cost of this is thought to be at least £12,000 and therefore is not an option for those not able to afford it. The Member believes the Bill will end the need for people to travel abroad, an unsatisfactory, exclusive option, and ensure assisted dying is available for all who are eligible in Scotland.

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Policy Memorandum

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