



SPICe

The Information Centre

SPICe Briefing

Assisted Suicide (Scotland) Bill

08 January 2015

15/02

Kathleen Robson and Sarah Harvie-Clark

The Assisted Suicide (Scotland) Bill seeks to legalise assisted suicide for people with terminal and life-shortening illnesses and conditions. This briefing outlines the current law in Scotland in relation to assisted dying as well as the policy background to the Bill. It also explores public opinion and the frequency of different types of assisted dying in the UK. It then goes on to detail the Bill's provisions as well as some of the issues raised in the Health and Sport Committee's call for written evidence.



The Scottish Parliament
Pàrlamaid na h-Alba

CONTENTS

EXECUTIVE SUMMARY	3
INTRODUCTION	5
ASSISTED DYING TERMINOLOGY	5
THE CURRENT LAW ON ASSISTED SUICIDE	8
THE CRIMINAL LAW IN SCOTLAND	8
<i>An overview</i>	8
<i>Murder</i>	8
<i>Culpable homicide</i>	9
<i>Reckless endangerment</i>	10
<i>The 'double effect' doctrine</i>	10
THE HOUSE OF LORDS/SUPREME COURT CASES	10
<i>The statutory background relating to England and Wales</i>	11
<i>The cases</i>	11
<i>The implications of the Debbie Purdy case for Scotland</i>	13
FREQUENCY OF END-OF-LIFE DECISIONS IN THE UK	15
POLICY BACKGROUND	15
END OF LIFE ASSISTANCE (SCOTLAND) BILL	15
LORD FALCONER'S BILL	17
PUBLIC OPINION	18
CONSULTATION ON THE PROPOSED ASSISTED SUICIDE (SCOTLAND) BILL	19
THE HEALTH AND SPORT COMMITTEE'S CALL FOR EVIDENCE	20
<i>Reasons for support and opposition to the general principle of the Bill</i>	20
THE BILL'S PROVISIONS	21
ELIGIBILITY	21
<i>Qualifying Conditions/Illnesses</i>	21
<i>Registration with a medical practice</i>	22
<i>Age</i>	22
<i>Capacity</i>	22
<i>Key Issues - Eligibility</i>	22
THE APPROVAL PROCESS	25
<i>Stage 1 - Preliminary declaration</i>	25
<i>Stage 2 - First request</i>	25
<i>Stage 3 - Second request</i>	26
<i>Signature by Proxy</i>	26
<i>Key Issues – The approval process</i>	26
THE ACT OF ASSISTED SUICIDE	28
<i>Means of death</i>	28
<i>Licensed facilitators</i>	28
<i>Assistance</i>	28
<i>Key issues – Act of assisted suicide</i>	29
CIVIL AND CRIMINAL LIABILITY	30
<i>Preclusion of civil and criminal liability</i>	30
<i>Savings clause</i>	30
<i>Key Issues – Civil and criminal liability</i>	30
FINANCIAL MEMORANDUM	30
APPENDIX 1 - ASSISTED DYING IN OTHER COUNTRIES	32
SOURCES	36
RELATED BRIEFINGS	40

EXECUTIVE SUMMARY

The Assisted Suicide (Scotland) Bill seeks to legalise assisted suicide for certain individuals.

Eligible individuals would include those with an illness or progressive condition that is terminal or life-shortening. They must also have concluded that their quality of life is unacceptable and see no prospect of any improvement. Such individuals must also:

- be aged 16 or over
- be registered with a Scottish medical practice
- have the capacity to make such a decision

The Bill proposes a three stage approval process consisting of; a preliminary declaration, a first request and a second request. The first and second request would need to be endorsed by two medical practitioners.

The Bill does not specify what means of death would be available to an eligible individual, but the accompanying documents to the Bill envisage what would constitute 'physician assisted suicide', whereby a doctor would provide a prescription for a drug that would end the person's life painlessly. The Bill is clear that the cause of death must be as a result of the individual's own act and no-one else's.

The Bill also creates the role of Licensed Facilitator to carry out roles such as comfort and reassurance, such practical assistance as the person reasonably requests and reporting of the death to the police. [see [pp 28](#)]

The Bill would remove any civil and criminal liability from a person involved in providing assistance. It also contains a 'savings clause' to protect anyone who, acting in good faith and not carelessly, makes a statement or acts in a way that is inconsistent with the Bill.

The legal position relating to assisting a suicide in Scotland has not been clarified by case law. However, there would appear to be a number of possible crimes in Scots law, including murder, culpable homicide and reckless endangerment. [see [pp8-10](#)]

Culpable homicide is the appropriate charge in circumstances including where there was intent to kill but where the accused was suffering from 'diminished responsibility'.

If the accused person is a member of the medical profession, the doctrine of 'double effect', developed by the English courts, may provide a defence to a charge of murder or culpable homicide. However, the position has not been clarified by case law in Scotland. [see [pp10](#)]

South of the border there have been a series of high profile court cases on assisted suicide. These raise issues under the European Convention of Human Rights.

In the Debbie Purdy case in 2009 the Director of Public Prosecutions in England and Wales was ordered by the court to produce a specific prosecution policy for assisted suicide cases. The position of the Lord Advocate and the Crown Office is that there is no need to produce an equivalent policy for Scotland given the existence of the general [Prosecution Code](#).

This view has been challenged by some academic commentators and also, recently, when giving evidence to the Justice Committee, by the Scottish Human Rights Commission. The issue is also currently the subject of a court action before the Court of Session in the case of *Ross v The Lord Advocate*. The case will be heard in May 2015. [see [pp10-14](#)]

The Bill is the second attempt by the late Margo MacDonald MSP to introduce a specific form of assisted dying for people with certain conditions and illnesses but is different in a number of respects to its predecessor (the End of Life Assistance (Scotland) Bill). This includes, for example; that it is restricted to assisted suicide, it has added an additional stage to the approval process and it does not require a psychiatric assessment of capacity. The House of Lords is also currently considering Lord Falconer's Assisted Dying Bill. This differs from the current Scottish Bill in that it is limited to physician assisted suicide for people with 6 months or less to live. [See [pp15-17](#)]

Opinion polls in the UK tend to indicate public support for assisted dying. However, this does vary depending on the type of conditions/illnesses that are eligible, the type of assistance provided and who would be involved in the process. Support is also evident among people with disabilities but other polls indicate that some worry a change in the law may put pressure on disabled people to end their lives prematurely.

Key medical professional bodies tend to oppose a change in the law, although it does appear that opinion is more varied among their members. Similarly, while religious authorities also tend to oppose a change in the law, opposition among those practising a religion appears to be a minority view. [see [pp18-19](#)]

The Health and Sport Committee's call for written evidence found that 73% of respondents supported the Bill, 24% opposed it and 3% either made no comment or were neutral. When broken down by respondent type there was a contrast in view, with 78% of responses from individuals supporting the Bill compared to 16.5% of responses from organisations.

A wide variety of arguments were put in favour and in opposition to the principle of the Bill. Those in support of the Bill substantiated their position by arguing (among other things) that it is inhumane to allow a person to suffer pain and a loss of dignity when their wish is to die.

Among the arguments put by those in opposition to the Bill was that a person's dignity does not diminish because they are ill and that dignity is shaped by external social attitudes. As such, they thought the legalisation of assisted suicide would reinforce a lack of self-worth and legitimise a perceived loss of dignity. [see [pp20-21](#)]

Respondents to the Health and Sport Committee's call for written evidence also raised a number of more specific issues with the Bill's provisions [see [pp 22-30](#)]. These included:

- the clarity of terms relating to eligibility e.g. 'life-shortening'
- the breadth/narrowness of the eligibility criteria and the potential for extension (i.e. concerns that the bill is the start of a 'slippery slope')
- the potential for 'suicide tourism'
- the minimum age for seeking assisted suicide
- the assessment of capacity
- the role of doctors and the lack of a 'conscience clause'
- a perceived lack of clarity over what it means to assist
- the role of the licensed facilitators
- the extent and nature of the savings clause

INTRODUCTION

The Assisted Suicide (Scotland) Bill is the second attempt by the late Margo MacDonald MSP to introduce a form of assisted dying in Scotland. Her previous End of Life Assistance (Scotland) Bill was considered by the Scottish Parliament in session 3 but was defeated after the stage 1 debate by 85 votes to 16, with 2 abstentions.

The current Bill was introduced in November 2013, just six months before Ms MacDonald's death. Patrick Harvie MSP had already been appointed as an additional Member in Charge of the Bill, so took over responsibility after her death.

The objective of the Bill is outlined as:

“[To] provide a means for certain people who are approaching the end of their lives to seek assistance to end their lives at a time of their own choosing, and to provide protection in law for those providing that assistance.” (Scottish Parliament, 2013b, para 2)

If the Bill is enacted, Scotland could become the first part of the UK to legalise assisted suicide.

It is worth noting that forms of assisted dying exist in other countries and jurisdictions outside the UK. These include the Netherlands, Belgium, Switzerland, Luxembourg, the American states of Oregon, Washington, Montana and Vermont and, most recently, the Canadian Province of Quebec. Appendix 1 compares the different systems in operation in the Netherlands, Belgium and Oregon. These jurisdictions were chosen as they are most commonly referred to in the debate on assisted dying, as well as in the evidence received by the Health and Sport Committee. In terms of comparability, the system in Oregon is probably the closest match to what is proposed in the Bill.

ASSISTED DYING TERMINOLOGY

Assisted dying suffers from a confusion of terminology, with different terms often being used interchangeably. There are no universally agreed definitions of any of the terms in question, however the most commonly used terms are 'assisted suicide' and 'euthanasia'. These are commonly understood to mean:

- **euthanasia** - (also sometimes referred to as 'mercy killing') the deliberate taking of another person's life to relieve their suffering
- **assisted suicide** - the situation where a competent person ends their own life but with the assistance of another person to perform the act, for example by providing the means to do so

The distinguishing characteristic between the two is who carries out the act which brings about death. In assisted suicide, it is the person seeking death who carries out the final act, whereas euthanasia requires another person to perform the act that will lead to death.

However, the term 'euthanasia' has become very emotive and its application is contentious. Given this, it is perhaps helpful to move away from such terms and view assisted dying based on the key distinguishing factors of whether the individual consented or not, and whether the death was brought about through active or passive means. The different categories are explained in more detail below:

1. Consent

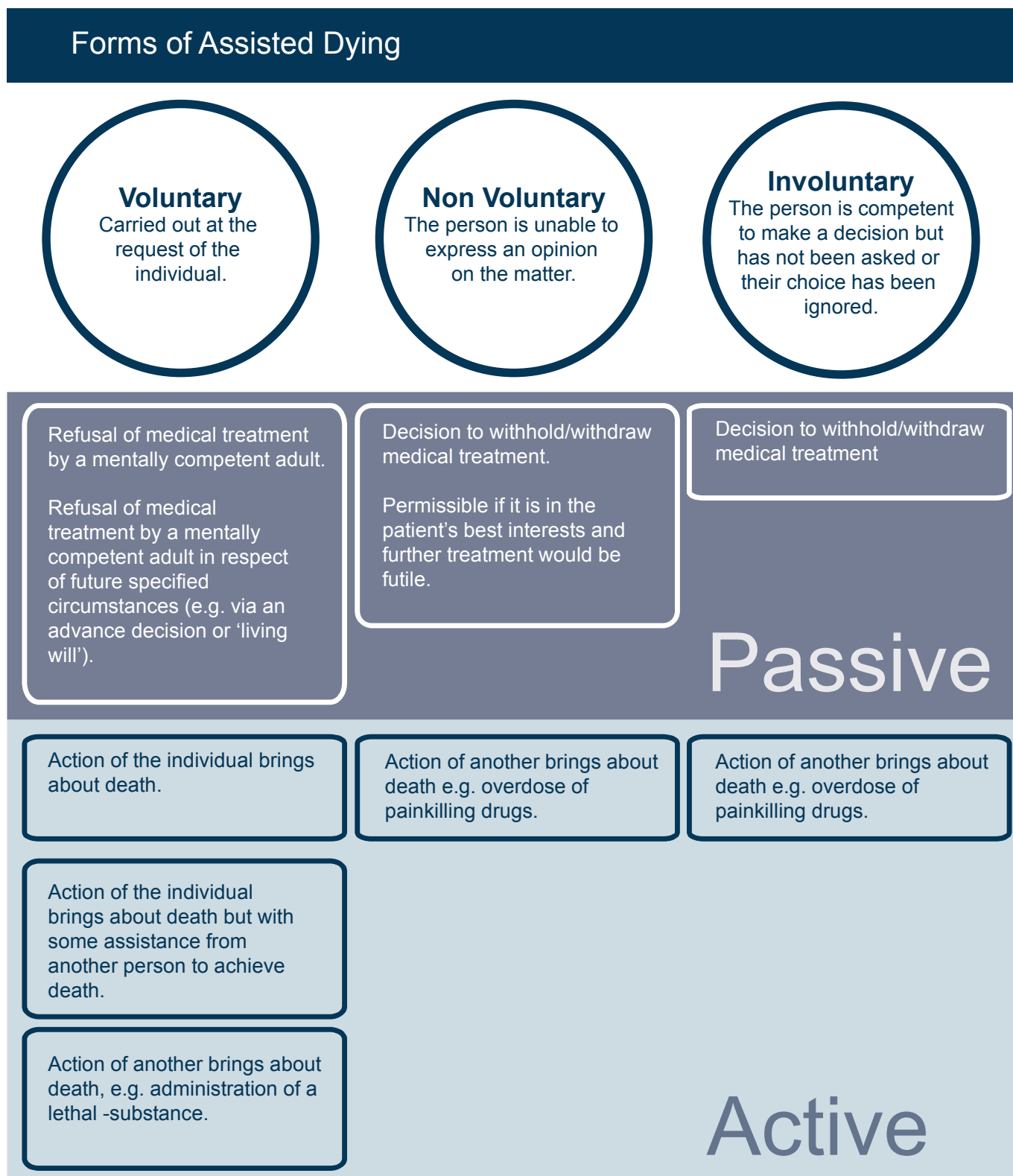
- **voluntary** - meaning carried out at the request of the person in question
- **non-voluntary** - which refers to the situation where the person is unable to express a decision on the matter, for example because of severe brain damage or dementia or because they are in a permanent vegetative state
- **involuntary** - which refers to the situation where the person in question is competent to consent to his or her own death but does not do so, either because he or she was not asked or because his or her choice to live was ignored

2. Means of death

- **active** - where there is a positive action to end life, such as injecting a lethal substance into a person
- **passive** - where there is an omission of an act, for example the withdrawal or withholding of treatment

Figure 1 illustrates different forms of assisted dying based on the above factors. The term 'assisted dying' is being used in this briefing to generally describe ways of hastening death. As a result, figure 1 includes suicide, but it is recognised that some may not consider this to be an 'assisted' death in the sense that no other individual is involved at any point.

Figure 1: Categories of assisted dying



THE CURRENT LAW ON ASSISTED SUICIDE

This section of the briefing considers the criminal law relating to cases of assisted suicide in Scotland (including physician assisted suicide¹). It also summarises a series of high profile cases from England and Wales which have significance for the potential development of the law in Scotland.

THE CRIMINAL LAW IN SCOTLAND

An overview

In Scotland it is not a criminal offence to commit suicide or attempt to commit suicide. Consequently, it is thought that a person cannot be guilty of ‘art and part’ suicide or attempted suicide, that is to say aiding and abetting such acts (Mason and Laurie 2006, para 18.52; Earle and Whitty 2006, para 384).

The legal position relating to assisting a suicide in Scotland has not been clarified by case law. However, there would appear to be a number of possible crimes in Scots law, including murder, culpable homicide and reckless endangerment.² These are considered in more detail below.

Where a breach of the criminal law is alleged in Scotland, the decision whether, or how, to prosecute the alleged offence is one for the [Crown Office and the Procurator Fiscal Service](#) (COPFS). There is no published prosecution policy specifically relating to assisted suicide cases. Instead there is a general [Prosecution Code](#) (Crown Office and Procurator Fiscal Service 2001) which sets out a list of public interest factors to be taken into account both for and against prosecution.

Murder

Murder requires a “wilful act causing the destruction of life”. Furthermore, the accused must have shown a “wicked intent to kill” or a “wicked reckless as to whether the victim lives or dies” (Drury (Stuart) v HM Advocate 2001 SLT 1013 at 1016). A “wicked intent to kill” means an intent to kill where there was no legally relevant factor justifying or mitigating the accused’s actions (Elsherkisi v HM Advocate HCJAC 100; 2011 SCCR 735 at 743D).³

Crucially, the accused person’s motive for the crime (for example, to alleviate suffering) is irrelevant. Likewise, the fact the victim wished to die, or even urged the accused to help him or her accomplish this, is not a valid defence. Neither is it relevant that the person would have died a short time later anyway ((HM Advocate v Rutherford 1947 JC 23; Gordon and Christie 2000–2001, para 23.03; Earle and Whitty 2006, para 382).

On the other hand, the concept of ‘diminished responsibility’ is legally relevant. This topic is explored in more detail in relation to culpable homicide.

¹ Physician assisted suicide refers to where a doctor provides the means for the person to commit suicide but the individual carries out the act that brings about death.

² Whilst the aforementioned offences are thought to be the main ones, acts associated with assisted suicide may be relevant to other offences under the common law (i.e. judge-made law) or statute. These include assault, breach of the peace and various offences under the Misuse of Drugs Act 1971 (c 38).

³ No exhaustive list of “legally relevant” factors was provided by the court though, leaving some remaining uncertainty as to the scope of the existing law (Jones and Christie 2012, para 9-49).

Culpable homicide

Broadly speaking, culpable homicide is committed where death is caused by improper conduct but the guilt is less than murder (Fergusson 1998, p 293). Consequently, even if it did amount to murder in legal terms, in practice an act of assisted suicide might be prosecuted as the lesser offence of culpable homicide because the Crown is satisfied that murder is not the appropriate charge.

The unreported euthanasia case of *HM Advocate v Brady* (October 2006) may provide some insight here. In *Brady*, at his brother's request, the accused killed his brother who was in the final stages of Huntington's disease. He was found guilty of culpable homicide. On sentencing, the judge had regard to the victim's heartfelt request that his brother kill him. Brady was admonished, that is to say verbally disciplined without any other punishment being imposed (Ferguson 1998, pp 294–295).

Culpable homicide is also the appropriate charge in the specific situation where there was intent to kill but where the accused was suffering from diminished responsibility (Criminal Procedure (Scotland) Act 1995 (c 46) ('the 1995 Act'), section 51B). Diminished responsibility is a state of mind where the accused's ability to determine or control his or her conduct is "substantially impaired" by reason of an "abnormality of mind". "Abnormality of mind" is not defined in the 1995 Act, except that it includes "mental disorder"⁴ (1995 Act, section 51B(3)).

In assisted suicide cases witnessing the victim's suffering may have created the requisite state of mind for some accused, where the accused is a relative or very close friend of the victim. However, it would require psychiatric evidence to this effect to be presented in court. McLean *et al* (2009) offer one view on this, as follows:

"reliance on diminished responsibility in these circumstances is not unproblematic for family members, due to the need to present psychiatric evidence... The necessity to present a compassionate act as one based on mental abnormality appears to stretch legal principle beyond the limits of logic" (p 277).

There is also a specific strand of Scottish case law suggesting that the reckless act of supplying someone with an illegal (or legal) substance capable of causing harm could form the basis of a charge for culpable homicide (*Khaliq v HM Advocate* 1984 JC 23; *Ulhaq v HM Advocate* 1991 SLT 614; Lord Advocate's Reference (No. 1 of 1994) 1996 JC 76; *MacAngus v HM Advocate*; *Kane v HM Advocate* [2009] HCJAC 8). A range of academic authors have suggested this case law potentially could apply in respect of assisted suicide cases (Ferguson 1998, pp 304–305; McLean *et al* 2009, pp 278–280; Kerr 2011, pp 37–43).

However, culpable homicide and murder are crimes in which the prosecution must prove a 'causal link' between the acts of the accused and the death of the victim; in other words, that the accused's behaviour *caused* the death.

Numerous academic authors have explored whether the victim's act of taking his or her own life amounts to an act breaking the chain of causation between the accused's assistance and the victim's death (Ferguson 1998, pp 299–305; McCall Smith and Sheldon 1997, pp 171–172; Earle and Whitty 2006, para 384; McLean *et al* 2009 pp 278–280).⁵

⁴ "Mental disorder" is defined by reference to the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), section 328(1): "(a) mental illness; (b) personality disorder; or (c) learning disability".

⁵ The legal term for this is a 'novus actus interveniens'.

A recent case has provided some clarification on this point, at least in the context of culpable homicide (although not on assisted suicide specifically). In *MacAngus v HM Advocate* (2009)⁶ the court said that “the adult status and deliberate conduct” of a person to whom drugs were supplied can, but does not necessarily, sever the causal link between the person and the accused. Instead the court would make a judgement based on the whole circumstances of the case.

Reckless endangerment

Where no injury is caused by reckless behaviour, but that behaviour is objectively dangerous to other people, an individual can be charged with the offence of recklessly endangering human life.

Several academic authors (e.g. Ferguson 1998, pp 298–299) have suggested that this offence has a potential application to assisted suicide cases if the suicide itself was unsuccessful.

More generally, it seems that, in practice, the offence has been charged where there has been some degree of injury. Drawing on the cases concerned, the authors of a leading criminal law textbook suggest that it may be a suitable criminal charge where the causal link between the acts of the accused and the actual injury to another is weak or difficult to prove (Jones and Christie 2012, para 9-35). This has led academic authors writing about assisted suicide (e.g. Ferguson 1998, p 299) to suggest a potential application of this branch of the law to assisted suicide cases more generally.

The ‘double effect’ doctrine

In England and Wales, if the accused person is a member of the medical profession, the principle of double effect may provide a defence to a charge of murder or culpable homicide. If a doctor can show that his or her primary intention was to alleviate suffering rather than hasten the death of the patient, the administration or supply of potentially lethal drugs will not be criminal. This applies even where the doctor realises that a likely consequence of alleviating pain is that this will result in the death of the patient (*R v Adams* ([1957] Crim LR 365).⁷

Some academic authors have suggested that this doctrine probably also applies in practice in Scotland (Ferguson 1998, p 295; Gordon and Christie 2000–2001, para 23.03 (footnote 13); Earle and Whitty 2006, para 385). However, in the absence of reported Scottish case law on the doctrine, the position is uncertain.

THE HOUSE OF LORDS/SUPREME COURT CASES

The high profile court cases on assisted suicide south of the border raise issues under the European Convention of Human Rights (‘the Convention’). As with the rest of the UK, Convention rights are part of Scottish domestic law. So far as the House of Lords, and subsequently the UK Supreme Court, have determined matters of general interest and importance in relation to Convention rights in these cases, it can be anticipated that the rulings will be followed in future by the Scottish courts.

However, the English criminal law and prosecution policy which was being considered by the courts is distinct from that which applies in Scotland and this should be borne in mind when considering the impact of these cases in Scotland.

⁶ The full name of the case is *MacAngus v HM Advocate*; *Kane v HM Advocate* [2009] HCJAC 8.

⁷ This can be contrasted with the situation in *R v Cox* ((1992) 12 BMLR 38), where a doctor was found guilty of attempted murder. He was not able to rely on the defence of double effect because the drug with which he injected his patient, potassium chloride, had no pain-killing purpose.

The statutory background relating to England and Wales

The traditional attitude of the law of England and Wales was to treat suicide as contrary to the criminal law. Section 1 of the Suicide Act 1961 (c 60) changed the law to provide that suicide is not a criminal offence. However, section 2 (along with section 2A and 2B) of the 1961 Act makes it a statutory offence to encourage or assist a suicide or attempted suicide.⁸ The offence carries a penalty of up to fourteen years' imprisonment.

Under section 2(4) of the 1961 Act, the consent of the [Director of Public Prosecutions](#) (DPP) is required to begin proceedings for a prosecution relating to the above offence. The DPP's role in this regard has been an important feature of the high profile cases discussed below.

The cases

*The Diane Pretty case (2001)*⁹

Diane Pretty suffered from motor neurone disease and was unable, without help, to take her own life. She sought an advance undertaking from the DPP that, if her husband aided her, the DPP would not consent to his prosecution. She challenged the DPP's refusal to give an advance undertaking citing various articles of the Convention. The case went all the way to the House of Lords which unanimously dismissed her appeal. Ms Pretty then took her case to the [European Court of Human Rights](#) which ruled unanimously that the UK Government had not violated the Convention.

Daniel James (2008)

As a result of injury during rugby training, 23 year old Daniel James lost the use of his body from the chest down. He ended his life at the Dignitas clinic in September 2008. His parents and a family friend assisted with the travel and financial arrangements for this and his parents accompanied him on the flight. In December 2008, the DPP announced that, while there was sufficient evidence for a realistic prospect of conviction of his parents and the family friend, such prosecution was not in the public interest and no further action would be taken against them. The DPP [published](#) his full decision, the first time the full reasoning behind a decision not to prosecute an assisted suicide offence had been made public.

*The Debbie Purdy case (2009)*¹⁰

Debbie Purdy suffered from multiple sclerosis, for which there is no known cure.¹¹ She said that when her condition became unbearable, she hoped to end her life at the Dignitas clinic in Switzerland. Her husband (Omar Puente) was willing to help her and, if necessary, face a prison sentence; however, she said that she was not prepared to put him in that position. She argued, based on article 8 to the Convention (right to respect for private life), that the DPP should formulate a specific policy for cases of assisted suicide, rather than considering each case individually in deciding whether or not to prosecute. The House of Lords agreed and ordered the DPP to create such a policy.

⁸ The wording of section 2 of the 1961 Act was substantially amended in February 2010 by the coming into force of section 59 (for England and Wales) and section 60 (for Northern Ireland) of the Coroners and Justice Act 2009 (c 25). Sections 59 and 60 also inserted sections 2A and 2B into the 1961 Act. Section 61 of the 2009 Act made other changes to provisions of the 1961 Act relating to assisted suicide.

⁹ *Pretty v DPP and Secretary of State for the Home Department* [2001] UKHL 61; *Pretty v United Kingdom* 2346/02 [2002] ECHR 427.

¹⁰ *R v DPP ex p Purdy* [2009] UKHL 45; 2010 1 AC 345.

¹¹ Debbie Purdy died on 23 December 2014.

The current version of the policy (last updated in October 2014) can be accessed [here](#). It does not apply to Scotland. In 2010 a [policy](#) (Public Prosecution Service for Northern Ireland 2010) was also published for Northern Ireland.

*The Tony Nicklinson, Paul Lamb and AM case (2014)*¹²

This latest case concerned two men with 'locked in' syndrome (Tony Nicklinson and Paul Lamb), along with another man (referred to as 'Martin') who was virtually unable to move following a brain stem stroke. All wished to end their lives but, other than ending their lives by self-starvation, would have required either a doctor to perform the fatal act or would have required significant assistance in order to commit suicide.

Mr Nicklinson's widow¹³ and Mr Lamb argued before the Supreme Court that the current law on murder and assisted suicide in England was incompatible with article 8 of the Convention (the right to respect for private life).

The Supreme Court unanimously agreed that the issue was within member states' 'margin of appreciation', a concept that recognises that the Convention will be interpreted differently in different member states and gives national authorities some space for manoeuvre in this regard. However, the justices were divided on the issue of whether the Supreme Court had constitutional authority to declare the law on assisted suicide incompatible with article 8, or whether it was appropriate that the matter should be left to Parliament. A majority (five to four) were in favour of it being competent for them to grant a declaration of incompatibility. However, only two justices would have done so in the particular instance. Accordingly, the Supreme Court dismissed the Lamb/Nicklinson appeal by a majority of seven to two.

Martin had been partially successful before the Court of Appeal. His argument (also based on article 8 of the Convention) was that the DPP should clarify its policy on assisted suicide. He wanted it be clearer whether people with no personal connection to him who might be willing to help on compassionate grounds – for example, members of the public, health professionals or solicitors – would be likely to face prosecution.

The Supreme Court unanimously found in favour of the DPP on appeal, concluding that it was one thing to require the DPP to publish a policy; it was another to stipulate what should be in that policy. The Court concluded that the exercise of judgment by the DPP; the variety of relevant factors; and the need to vary the weight to be attached to them according to the circumstances of each individual case; are important parts of the system of prosecution in the public interest (with which the Court should not interfere).

The DPP updated its [policy](#) in October 2014 to clarify the position where prosecution was being considered in relation to a healthcare professional. See further the associated [news release](#) (DPP 2014).

¹² R on the application of Tony Nicklinson v Ministry of Justice [2012] EWHC 2381; R on the application of Nicklinson and Lamb v Ministry of Justice [2013] EWCA Civ 961; R (on the application of Nicklinson and another)(Appellants) v Ministry of Justice (Respondent); R (on the application of AM)(AP)(Respondent) v The Director of Public Prosecutions (Appellant) [2014] UKSC 38.

¹³ Mr Nicklinson died after refusing food and water following a Court of Appeal judgement which was not in his favour. His widow joined the appeal to the Supreme Court.

The implications of the Debbie Purdy case for Scotland

In Scotland, as already mentioned, there is no published prosecution policy specifically relating to assisted suicide cases.

Following the publication of an interim prosecution policy specific to assisted suicide cases in respect of England and Wales (later replaced by the final [policy](#)) the Lord Advocate issued the following statement in relation to Scotland:

“The guidance issued by the Director of Public Prosecutions for England and Wales will only apply to cases where an offence of assisted suicide takes place within England and Wales. It will not apply to Scotland.

The DPP’s guidance follows the decision of the House of Lords in the English case of Purdy. This case applies only to England and Wales and to the statutory offence of assisting the suicide of another under section 2 of the Suicide Act 1961. This offence does not apply in Scotland, where, depending on the particular facts and circumstances of the case, the law of homicide may apply.

The Crown Office and Procurator Fiscal Service will give careful consideration to the implications of the DPP’s guidance, the outcome of his public consultation and developments in other jurisdictions.

The Crown recognises the importance of this issue, but any change in the current law related to homicide is properly a matter for the Scottish Parliament”¹⁴

The case of Debbie Purdy and the statement by the Lord Advocate have been the subject of some academic commentary in Scotland (Chalmers 2010; McLean *et al* 2009). For example, Chalmers argues:

“Were Ms Purdy and Mr Puente Scottish residents, they would face an even more unpalatable risk than Mr Puente’s potential prosecution for complicity in suicide: a potential prosecution for murder (...) it surely cannot be the case that because the potential consequences for an individual are *more* severe in Scotland than under English law, the case for prosecutorial guidelines is weakened (...)

(...) the only relevant difference between the position in England and Scotland is that the Director of Public Prosecutions has been obliged by court order to produce guidelines on the prosecution of assisted suicide, and the Lord Advocate has not. Given that the order made by the House of Lords was a consequence of the application of the [Convention] it should be self-evident that this difference cannot and does not justify the absence of such guidelines in Scotland.” (Chalmers 2010, pp 299–300)”

In a similar vein McLean *et al* have observed:

“...if we accept that art 8 rights are engaged in cases of assisted suicide, this must equally be the case in respect of citizens of Scotland, since the 1998 Act applies throughout the United Kingdom. It follows logically that Scottish prosecutorial policy should be in accordance with art 8(2), thereby demanding a certain level of clarity...

At present, those who assist in a suicide *in Scotland* would – without modification or further elucidation of the current situation – remain vulnerable to the exercise of a prosecutorial discretion as to whether or not to bring charges that is opaque and is,

¹⁴ This statement was reproduced in MacQueen and Wortley 2010, p 12.

therefore, potentially in breach of the human rights legislation”.(McLean *et al* 2009, pp 281–282)

The Bill was [considered](#) by the Justice Committee on 28 October 2014 in its capacity as the designated secondary parliamentary committee on the Bill. On that occasion Professor Miller on behalf of the [Scottish Human Rights Commission](#) made a similar point:

“In the recent United Kingdom Supreme Court case involving Debbie Purdy, it was decided that there was a lack of accessibility and foreseeability in the criminal law, and as a result the director of public prosecutions had to issue quite detailed directions that gave people a better understanding of where they were in a grey situation. Conditions are certainly ripe in Scotland for a challenge with regard to that lack of understanding in the current system. If such understanding does not exist, an individual will simply not know whether they will be in breach of the law. Given the very difficult set of emotional circumstances that such people are in, the last thing that they need is a lack of clarity on the legal position.”

On the other hand, when giving evidence to the Justice Committee, the COPFS said that there was no need for the Lord Advocate to issue interim prosecution guidelines specific to assisted suicide cases for Scotland:

“That is not necessary because of the factors that are set out in the prosecution code. The Purdy judgment, which is not binding in Scotland, must be seen in its context. The case was brought because Mrs Purdy wished to travel abroad to end her life, wanted her partner to help her in that and wanted to know whether she was vulnerable to prosecution under the Suicide Act 1961.

Mrs Purdy’s case came shortly after another case. I think that it was the case of Daniel James, who was a 24-year-old rugby player with spinal injuries... The factors on which the DPP relied in deciding not to take proceedings were factors that, for the most part, were outwith the code for Crown prosecutors in England and Wales. Therefore, when Mrs Purdy said that her rights to a family life under article 8 of the European convention on human rights were being interfered with, the question for the court was whether that was in accordance with law. Because the factors that the director of public prosecutions took into account were not covered by the code for Crown prosecutors, the court said that it was not in accordance with law, which is where the director’s guidance in England and Wales came in.

The judgment is specific to that context in that there was a code that bore on the factors that were taken into account when the prosecutorial decision was taken in England and Wales, but they were not the factors that the director took into account in the James case, which caused Mrs Purdy’s uncertainty as to what the law was in England and Wales.”

The fact that there is no specific prosecution guidance on assisted suicide in Scotland is currently the subject of a court action for judicial review¹⁵ before the Court of Session in the case of *Ross v The Lord Advocate*. The case will be heard in May 2015.

¹⁵ An action for judicial review is a type of court action which allows individuals and organisations to challenge the exercise of powers by public bodies. The high profile English cases discussed in the briefing also took the form of judicial review actions.

FREQUENCY OF END-OF-LIFE DECISIONS IN THE UK

Early studies give the impression that doctor assisted voluntary euthanasia may have been a fairly widespread practice in the UK. For example, a 1994 anonymous survey of doctors in England found that 32% of those that had faced a request for euthanasia reported that they had complied with such a request. This represented 12% of the total respondents (Ward and Tate, 1994).

However, later studies cast doubt on how widespread voluntary euthanasia might be. In a 2009 study (Seale, 2009b) estimates were made of the frequency of different end-of-life decisions in deaths attended by doctors in the UK. Voluntary euthanasia had a low prevalence (0.21%) and no respondents reported experience of assisted suicide.

This survey also found that non-treatment decisions (i.e. withholding or withdrawing life prolonging treatment) occurred in 21.8% of deaths and measures with potential life shortening effects were taken in 17.1% of deaths. Continuous deep sedation¹⁶ (CDS) was also found to be a fairly common practice, occurring in 16.5% of deaths. This finding was replicated in a later study which found that CDS occurred in 17% of hospital deaths and 19% of deaths in a home setting (Anquinet et al, 2012).

In relation to people seeking assisted dying outwith the UK, figures from the Swiss organisation Dignitas show that between 1998 and 2013, it assisted 244 Britons to end their life (Dignitas, 2014). Dignity in Dying has calculated that this equates to one Briton every two weeks.

A briefing paper prepared for the Commission on Assisted Dying also highlighted Home Office statistics which reported around 4 'mercy killings' are identified each year. Statistics on suicides with assistance from friends or family are not available although the paper does highlight the occasional incidence of high profile examples (Demos, 2010).

POLICY BACKGROUND

END OF LIFE ASSISTANCE (SCOTLAND) BILL

The current Bill is the second attempt by the late Margo McDonald MSP to introduce a form of assisted dying in Scotland. It is different to its predecessor in a number of ways. The key differences are outlined in table 1 below:

¹⁶ Continuous deep sedation refers to the use of sedative drugs to decrease a person's level of consciousness in order to relieve suffering from distressing symptoms. Whether it hastens death is contended and may be dependent on practices employed.

Table 1: Comparison of key changes between the End of Life Assistance (Scotland) Bill and the Assisted Suicide (Scotland) Bill

	End of Life Assistance (Scotland) Bill	Assisted Suicide (Scotland) Bill	Notes on the Change
Type of assisted dying	Assisted suicide and voluntary active euthanasia	Assisted suicide	The change means that only the individual requesting assistance could carry out the final act.
Qualifying illnesses and conditions	<p>Has a terminal illness (with less than 6 months to live) and finds life intolerable</p> <p>Or</p> <p>Is permanently physically incapacitated, cannot live independently and finds life intolerable.</p>	<p>Has an illness that is, for the person, either terminal or life-shortening</p> <p>Or</p> <p>Has a condition that is, for the person, progressive and either terminal or life-shortening.</p> <p>In either case, the person must see no prospect of improvement in the quality of their life and have concluded that the quality is unacceptable.</p>	<p>The current Bill has no stipulation that the person must have six months or less to live.</p> <p>The current criteria are intended to prevent people with disabilities being eligible simply by virtue of their disability.</p>
Process	<p>Required 2 formal requests and a written agreement on the provision of assistance.</p> <p>Needed the approval of one medical practitioner.</p>	<p>Sets out a 3 stage process and the forms to be used at each stage. Includes a preliminary declaration which must be made before a formal request can be made.</p> <p>Requires the approval of two medical practitioners at the formal request stage.</p>	<p>The preliminary declaration is intended to provide an additional safeguard that no-one will opt for assisted suicide without careful consideration over time. The requirement for approval from a second medical practitioner is also meant to act as an additional safeguard.</p>

	End of Life Assistance (Scotland) Bill	Assisted Suicide (Scotland) Bill	Notes on the Change
Psychiatric assessment	Required a psychiatrist to meet with the person at both the first and second request and report back to the medical practitioner that the person had capacity, was acting voluntarily and was not under undue influence.	Capacity should be confirmed by the two medical practitioners at each request.	No assessment by a psychiatrist is required in the current Bill.
Persons present at the death	The Bill would have required the doctor who granted the request to be present at the death. Friends and family would also have been allowed to be present.	The Bill does not require any doctor to be present but it would create the role of licensed facilitator who could provide assistance, comfort and reassurance to the individual. Friends and family could also be present.	
Time between approval and suicide	Once approval had been given, the person would have had 28 days to make use of the assistance given.	Once approval has been granted, the person would have 14 days to make use of the assistance given.	The Policy Memorandum explains that the 14 day time period is to safeguard against the person's capacity diminishing after the second request is approved.

LORD FALCONER'S BILL

After chairing the Commission on Assisted Dying, Lord Falconer of Thoroton introduced the Assisted Dying Bill as a private member's Bill in the UK Parliament (Commission on Assisted Dying, 2012; House of Lords, 2014). The Bill would allow terminally ill individuals to seek assistance in committing suicide and is similar to the Assisted Suicide (Scotland) Bill in that it would not permit euthanasia. That is, the act that would bring about death would need to be performed by the individual seeking assistance and no-one else.

However, it differs in two key respects from the Scottish Bill in that only those with a terminal illness and 6 months or less to live would be eligible for assistance. The Bill is also clearly only proposing 'physician assisted suicide' in that the means of assistance would be a doctor prescribing a medicine for the purpose of ending the person's life. The Assisted Suicide

(Scotland) Bill does not specifically propose physician assisted suicide on the face of the Bill, although what the Policy Memorandum to the Bill envisages would essentially be the same as Lord Falconer's Bill (see '[Means of Death](#)').

The Bill did not proceed beyond First Reading in the House of Lords in the 2013-14 session, but was reintroduced in 2014-15. Amendments were discussed in November 2014 and the committee stage will continue in January 2015.

PUBLIC OPINION

The conclusions of opinion polls and surveys on people's attitudes to assisted dying are often variable, depending to a large extent on the questions asked. In 2005, the British Social Attitudes Survey (Park & Clery, 2008) found the acceptability of assisted dying varied substantially depending on:

- The nature of the person's illness;
- The type of assistance provided;
- The individuals that would be involved in the process.

In this survey, 80% of respondents felt that there should be a change in the law to permit voluntary euthanasia to be carried out by a doctor for a patient with a painful, incurable and terminal disease, such as cancer. This increased to 82% when the question was repeated in 2008.

However (in the 2005 survey) support fell to 45% if the illness was painful and incurable but not terminal. Support was also lower for assisted suicide and varied depending on who would be involved, with 60% supporting physician assisted suicide¹⁷ and 44% supporting relative assisted suicide.

While this appears to indicate that the public is more comfortable if a doctor is involved, this is at odds with medical professional bodies which generally oppose a change in the law.

It is difficult to gauge medical opinion on assisted suicide specifically, as the available polls tend to focus on euthanasia or on 'assisted dying' more generally. However, the professional bodies and unions (e.g. Royal College of General Practitioners, British Medical Association) tend to oppose assisted dying generally, although this opposition has been contended in some quarters. For example, a recent survey found that two thirds of GPs did not support the Royal College of General Practitioner's opposition to assisted dying (Price, 2013). A poll conducted by the Royal College of Physicians found that an increased proportion of doctors polled (32.3%) supported a change in the law to permit physician assisted suicide for the terminally ill. More than 21% said they would personally participate in helping a patient end their life (Royal College of Physicians, 2014). However, it should be noted that a majority of respondents (57.5%) still opposed such a change in the law.

The 2005 British social attitudes survey also found that certain societal groups in the UK were consistently opposed to forms of assisted dying. The research suggested that the act of practising religion (rather than the form of religion *per se*) had the greatest influence on social attitudes. Views on assisted dying were also closely related to views on other controversial issues including abortion, suicide and capital punishment. However, a review of polls and surveys has found that even among those engaged in a religion, opposition to euthanasia tends to be a minority view (Clements, 2014). This is usually at odds with their church's position.

¹⁷ Physician assisted suicide refers to where a doctor provides the means for the person to commit suicide but the individual carries out the act that brings about death.

When people with disabilities were surveyed in the 2012 British Social Attitudes Survey, 80% of those with a disability supported a change in the law to allow a doctor to end the life of a person with a painful incurable disease if they requested it. This was slightly lower than for respondents without a disability (81%) (NatCen, 2015). However, a more recent survey for SCOPE found that 62% of disabled people were worried that a change in the law to permit assisted suicide would put pressure on people with a disability to end their lives prematurely. 55% also believed that the current legal status of assisted suicide protects vulnerable people from pressure to end their lives (SCOPE, 2014).

In recent years there has been a plethora of opinion polls on assisted dying, perhaps as a result of high profile court cases and Lord Falconer’s Bill. It can be difficult to compare these polls as the questions and parameters usually differ. Also, as with any poll, it is useful to bear in mind who it has been commissioned by.

Nevertheless, a search of recent polls specifically asking about Lord Falconer’s Bill shows public support ranging from 70% (Comres, 2014) to 76% (YouGov, 2013). However, other polls have shown that opinion can be dependent on the provision of other information. In one poll, support for Lord Falconer’s proposals fell when respondents were told certain things, for example, that most medical organisations oppose a change in the law. In this instance, support fell from 73% to 65% (ComRes, 2014b).

In summary, it would appear that public opinion is influenced by a multitude of factors such as religion, whether the person’s illness is terminal or not, the form of assisted dying proposed and who is involved. Additionally, there appears to be a conflict between the opinions of the public and those of medical professionals and religious authorities.

CONSULTATION ON THE PROPOSED ASSISTED SUICIDE (SCOTLAND) BILL

The consultation conducted by the Member on the proposed Bill proposals was carried out in 2012 and received a total of 848 responses. 64% of those who responded opposed the Bill, 33% supported it and 3% were neutral or did not make their position clear¹⁸.

Table 2: Responses to the Member’s consultation on the proposed Bill by breakdown of opinion

	Supportive	Opposing	No comment	Totals
Number	281	546	21	848
Percentage	33%	64%	3%	100%

When analysed by respondent type, the breakdown of opinion was very similar to the overall opinion. 64% of individuals were against the Bill, 35% were supportive and 1% were neutral or did not make their positions clear. Organisational submissions showed 62% were opposed to the Bill, 9% were supportive and 29% were neutral or did not make their position clear.

¹⁸ Please note that these results cannot be taken to be representative of opinion in the general population as respondents were self-selecting.

THE HEALTH AND SPORT COMMITTEE’S CALL FOR EVIDENCE

The Health and Sport Committee issued a call for written evidence during the summer of 2014, to which it received 886 submissions. The analysis of the responses showed that 73% of respondents expressed support for the Bill, with 24% in opposition and 3% either neutral or making no comment¹⁹. This is in contrast to the findings of the consultation on the proposed Bill and perhaps reflects the proportion of responses which came from the different campaign groups in each consultation.

Table 3 – Responses to the Health and Sport Committee call for evidence by breakdown of opinion

	Supportive	Opposing	No comment	Totals
Number	651	209	26	886
Percentage	73%	24%	3%	100%

When analysed according to respondent type there is a contrast in view. Amongst individuals, 78% supported the Bill, 21.5% were in opposition and 0.5% made no comment. Support within organisational submissions was 16.5%, with 49% opposing the Bill and 34.5% stating neutrality or making no comment.

Table 4 – Health and Sport Committee call for evidence - submissions by breakdown of opinion and by respondent type

	Supportive		Opposing		No Comment		Totals
Individuals	640	78%	176	21.5%	3	0.5%	819
Organisations	11	16.5%	33	49%	23	34.5%	67

Reasons for support and opposition to the general principle of the Bill

The summary of written evidence provides a comprehensive account of the reasons why people oppose or support the general principles of the Bill (Rostant-Bell, 2014). However, the main reasons used by both sides are summarised below.

Dignity & Dependence

A substantial proportion of those supporting the Bill argued that many people at the end of their lives experience a loss of dignity as a result of pain, suffering or a level of dependence that is unacceptable to them. These submissions were generally of the opinion that it is inhumane to force a person to suffer when their wish is to die. They also spoke of the permissibility of medical practices which facilitate a passive death, for example, the withdrawal of treatment, food and/or nutrition and contend that there is no moral difference between these acts and active forms of assisted suicide.

Conversely, those in opposition to the Bill also spoke of dignity, insisting that this does not diminish because a person is ill or requires assistance from others. These responses were of the opinion that a person’s sense of dignity is shaped by external factors and social attitudes. Therefore, they felt that the legalisation of assisted suicide would reinforce a person’s lack of

¹⁹ Please note that these results cannot be taken to be representative of opinion in the general population as respondents were self-selecting.

self-worth and legitimise any perceived loss of dignity. This was also viewed by some as society sanctioning the idea that some individuals' lives are not worth living. Such an idea was considered to be particularly threatening to people with disabilities and to older people.

Human Rights & Autonomy

Human Rights legislation and the 'right to autonomy' is cited frequently both by those supporting and opposing the Bill. Supporters argue that individuals have the right to determine the value of their own lives and to make end of life decisions based on that perceived value. Contrastingly, opponents argue that autonomy is not absolute and legislation can restrict autonomy for the benefit of society. As such, they believe the impact of legislation supporting an individual's autonomy should be assessed for any unintended consequences on society as a whole. These submissions frequently referred to the 'right to life' and were concerned that vulnerable people's right to life could be jeopardised by the Bill.

Palliative Care

The adequacy of palliative care was often mentioned in support and in opposition to the general principle of the Bill. For many, adequate palliative care negates the need for assisted dying. Others believe that no matter how good palliative care is, there will always be some people whom it cannot help.

Some palliative care professionals who responded to the call for evidence worried that the Bill could undermine their work. Several pointed to the level of unmet need for palliative care and thought it inappropriate to introduce laws on assisted suicide before addressing the inadequate provision of palliative care. They felt that addressing this unmet need may reverse a person's wish to die.

Others considered that, no matter how adequate palliative care is, it can never eradicate all of the suffering and loss of dignity associated with some deaths. For these respondents, assisted suicide was seen as a complement to palliative care, not as an alternative to it.

THE BILL'S PROVISIONS

The following section details the main provisions in the Bill alongside a summary of some of the key issues raised in the call for evidence. These issues are not intended to be an exhaustive account of all the points that were raised. For a more in-depth analysis please see the Report on the analysis of submissions (Rostant-Bell, 2014) or view the actual submissions on the Health and Sport Committee [webpage](#).

ELIGIBILITY

The Bill places a number of restrictions on who would be eligible for assisted suicide. These are outlined in more detail below.

Qualifying Conditions/illnesses

The Bill provides that only those with certain illnesses or conditions will be eligible to seek an assisted suicide. Eligible individuals would be those with:

- an illness that is, for the person, either terminal or life-shortening, or
- a condition that is, for the person, progressive and either terminal or life-shortening

The individual must have concluded that their quality of life is unacceptable and also see no prospect of any improvement in it.

Registration with a medical practice

The Bill stipulates that a person seeking assisted suicide must be registered as a patient with a Scottish medical practice.

Age

The Bill would establish 16 years as the minimum age for those seeking assisted suicide.

Capacity

The Bill provides that a person has capacity to make a request if they are not suffering from any mental disorder and they are capable of:

- making a decision to make the request
- communicating the decision
- understanding the decision, and
- retaining the memory of the decision

In relation to the requirement to communicate the decision, the Bill states that a person is not to be treated as lacking capacity if they have communication problems that can be overcome by 'human or mechanical aid'.

Key Issues - Eligibility

Clarity of terms

The terms used to describe the qualifying criteria were considered by some of those who provided written evidence to be too subjective and too difficult for doctors to verify. These comments usually referred to the use of terms such as 'unacceptable quality of life'. Similarly, the use of the term 'life-shortening' caused concern that it could encompass a wide range of chronic illnesses and conditions where death is not imminent. Examples such as diabetes and epilepsy were referred to.

The Bill does not define what would be considered terminal or life-shortening and there are no universally accepted definitions of these terms. In addition, the Bill does not apply any time limit to a terminal illness or condition. This differs from the previous Bill which stipulated that a person must have 6 months or less to live. The Policy Memorandum explains that no time limit has been included because they are arbitrary and may be inappropriate (Scottish Parliament, 2013b, para 30). The Policy Memorandum to the Bill explains:

“The aim here is to capture those diagnoses which involve an on-going deterioration in the person’s ability to live a normal life, regardless of the medical treatment they receive. The way the Bill captures this recognises that some illnesses or conditions affect different patients in different ways; it also recognises that terms such as illness, condition and terminal, while generally understood, can be the subject of some disagreement within the medical profession. Therefore, although each medical practitioner must be clear that the person has a qualifying diagnosis, they need not be specific about whether it is an illness or a condition, or whether it is (for that person) terminal or life-shortening.” (Scottish Parliament, 2013b, Para 28)

Scope of eligibility

There was considerable variance in views on acceptable eligibility criteria for people seeking assistance. Many were broadly in support of the breadth of coverage in the Bill. Others thought the criteria should be broader. Others thought they should be narrower.

The criteria were changed in this Bill following criticisms that the End of Life Assistance (Scotland) Bill may have included people with a disability, simply by virtue of that disability (Scottish Parliament, 2013b, para 29). The same criticisms did not appear to be as prevalent this time round, although some submissions thought that people with disabilities may be included due to the 'life-shortening' criterion. Conversely, others specifically called for people with disabilities to be eligible (Scottish Disability Equality Forum). As highlighted above, some submissions expressed concern that the lack of clarity surrounding terms such as 'life-shortening' could mean that eligibility is much broader than intended.

Slippery Slope

Some submissions expressed hope that the criteria could be extended in the future. For others this was a cause for concern, especially as the Policy Memorandum alludes to the idea that the criteria may be amended in the future:

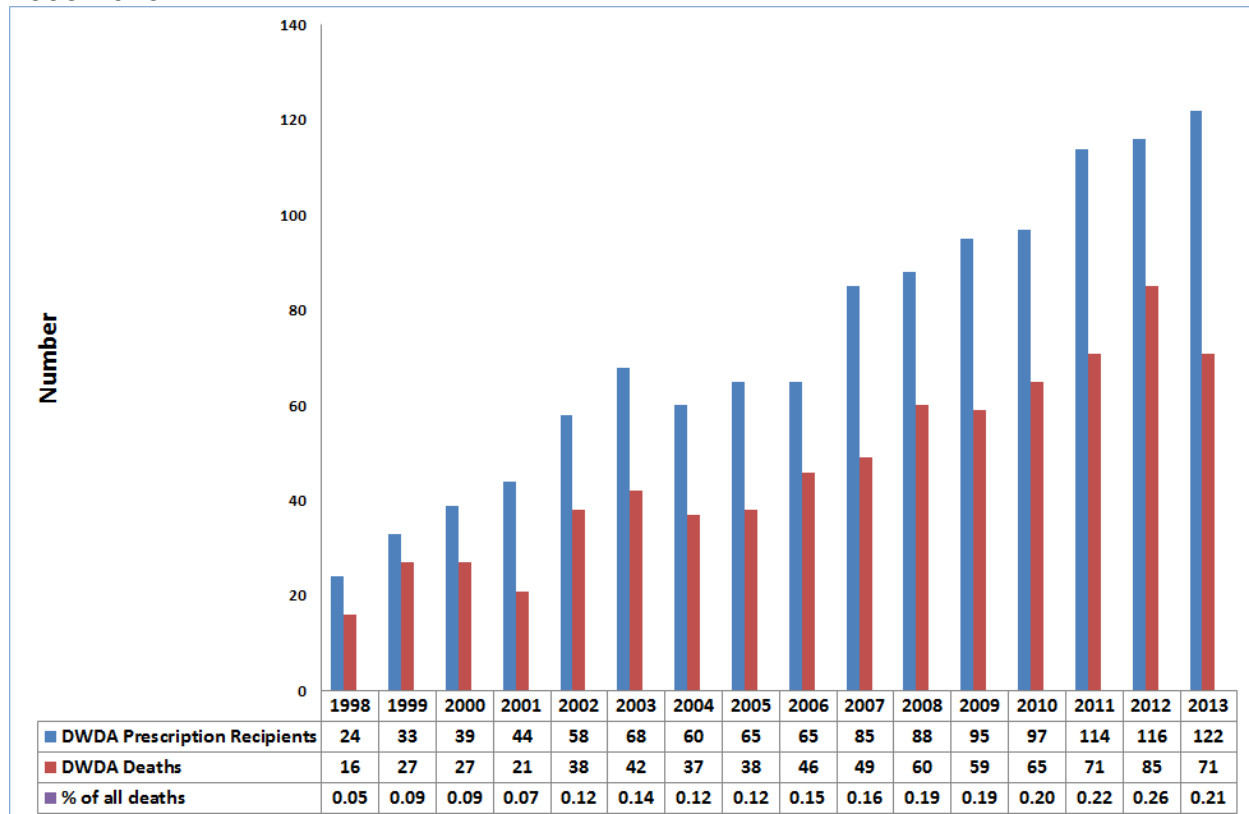
“...once it has been seen to operate effectively for a number of years, there may be an opportunity for further developments in the law that would offer hope to other categories of people seeking assistance to die.” (Scottish Parliament, 2013b, para 54)

This idea of a 'slippery slope' was mentioned by a significant number of submissions that were opposed to the Bill. Often these submissions pointed to other jurisdictions such as Belgium and the Netherlands where the eligibility criteria has been extended (e.g. Care for Scotland). For example, some highlighted that Belgium has recently extended the law to terminally ill children. However, other submissions contended that the eligibility in Oregon has never changed and therefore it is not inevitable that it will happen (e.g. My Life, My Death, My Choice).

Often those using the slippery slope argument pointed to the Abortion Act 1967 as an example of how eligibility criteria can be interpreted liberally so as to include many more people than initially intended (e.g. St Margaret of Scotland Hospice). Some responses pointed to the increasing numbers of people using assisted dying in other countries to illustrate this point. Often the countries referenced were Belgium and the Netherlands but due to changes in the eligibility criteria in these countries it is more difficult to get an idea of trends over time.

However, an examination of the available data from Oregon (where the law does not include euthanasia and eligibility criteria have not changed since introduction) shows that the number and proportion of deaths accounted for by assisted suicide has increased since the introduction of the Dying with Dignity Act 1994 (DWDA). Figure 1 shows that in 1998, deaths under the DWDA accounted for 0.05% of all deaths in Oregon (5.5 per 10,000). By 2013, this had risen to 0.21% of all deaths (20.9 per 10,000 deaths). However, it should be noted that such deaths still account for a relatively small number and proportion of all deaths.

Figure 2: Prescriptions dispensed and deaths under the Oregon Dying with Dignity Act, 1998-2013



Source: Oregon Health Authority (2013 & 2014)

Suicide Tourism

Opinion among respondents was divided on whether the Bill was robust enough to prevent 'suicide tourism'. Some regarded the removal of the 18 month registration period (from the previous End of Life Assistance (Scotland) Bill) as weakening the provision. Some suggested that a minimum period of registration should be added to the criteria (e.g. North Ayrshire Council).

The Policy Memorandum to the Bill explains that the removal of the 18 month stipulation is so that access to the Bill's procedures are not denied to people who may have recently taken up residence in Scotland (for other reasons) and who may be diagnosed with a qualifying condition shortly after arrival. The Policy Memorandum states that the requirement to register will still make it unlikely that a person could register without relocating in the medium to long-term (Scottish Parliament, 2013b, para 55).

The requirement for registering patients in Scotland is set out in regulations²⁰ which stipulate that a GP practice may include a patient on its list whether or not the person is resident in its practice area or registered with any other practice. Therefore the inclusion of a patient on a practice list (including overseas visitors²¹) is at the discretion of the practice. However, to be registered as a permanent patient, the person must be staying in the area for more than 3 months. If a person is in the area for less than 3 months then the practice may register them as a temporary patient. The Bill and its accompanying documents do not specifically say whether temporary patients would be able to use the provisions.

²⁰ The [National Health Service \(General Medical Services Contracts\)\(Scotland\) Regulations 2004](#)

²¹ Someone not ordinarily resident in the UK.

Minimum age

There was objection (from both opponents and supporters of the Bill) to the minimum age of 16 for individuals requesting assistance and for undertaking the licensed facilitators role (see [‘Licensed facilitators’](#) below). It was widely felt by these respondents that 18 should be the minimum acceptable age for requesting assisted suicide. Respondents were less specific about the required aged to be a licensed facilitator but generally questioned whether a 16 year old would have the emotional maturity to carry out the role.

THE APPROVAL PROCESS

The Bill sets out a three stage approval process for assisted suicide.

Stage 1 - Preliminary declaration

At this stage the person need not have a qualifying illness or condition. The Policy Memorandum explains that no-one will be allowed to make a first request without first having made a preliminary declaration. This is intended as a safeguard to ensure that those making a request have given careful consideration to the option of assisted suicide (Scottish Parliament, 2013b, Para 20).

A preliminary declaration can be made at any time by a person who is at least 16 years of age and is registered with a medical practice in Scotland. However, the preliminary declaration must be made at least seven days before the first request (see below). The declaration must be witnessed and recorded in the person’s medical records.

Witnesses must be at least 16 years old and cannot be close family members²², anyone who will gain financially from the death of the individual or a registered medical practitioner /registered nurse involved in the person’s care and treatment.

Schedule 1 details the forms that would be used for the declaration, the witness statement and for inclusion in the medical records. Key features include that the individual and the witness must declare that the person is acting voluntarily and that the witness must have some prior acquaintance with the person. At this stage the Bill does not require any assessment of the individual’s capacity.

The declaration can be cancelled at any time.

Stage 2 - First request

After a preliminary declaration has been made (at least seven days before), an individual who has decided they may wish to have an assisted suicide can then make a first request for assistance. At this stage the individual must have a qualifying illness or condition (see [‘Qualifying conditions/illnesses’](#) above) and have concluded that the quality of their life is unacceptable and they see no prospect of improvement.

The request would take the form of seeking an ‘endorsement’ from two registered medical practitioners. Each doctor must satisfy themselves that the individual has a qualifying illness/condition and the capacity to make the decision. Neither doctor would have to specify what the qualifying illness/condition is but each must decide whether the person’s conclusion about the quality of their life is consistent with the medical facts. If they endorse the decision

²² Disqualified family relationships are set out in schedule 4 to the Bill.

then they would sign the form outlined in schedule 2. This should be recorded in the patient's medical records.

The patient may identify the first doctor but not the second. The second doctor should be chosen by the first. The Policy Memorandum explains that this is to safeguard against patients choosing doctors they believe will support their request (i.e. 'doctor shopping'). The first doctor does not need to be the patient's own General Practitioner (GP).

Stage 3 - Second request

No sooner than 14 days after the first request, the person may make a second request for assistance. Again, this would require the endorsement of two doctors. These could be the same doctors from the first request or two completely different doctors. The doctors would then be asked to endorse the same factors set out in the first request i.e. that the person has capacity, has a qualifying illness or condition etc.

The Bill allows the individual to cancel any part of the process and any cancellation would be recorded in their medical records. Cancellation of one part of the process would not require them to go back to the start should they change their mind.

Once the second request has been granted the Bill would permit the person to be given assistance to commit suicide. The Bill specifies that someone whose request has been granted must make use of that assistance within 14 days. After this time, the protections offered in the Bill would no longer apply and any medication dispensed for the purposes of committing suicide must be removed by the licensed facilitator (see [Licensed Facilitators](#) below). The Policy Memorandum explains that this time period is to minimise the likelihood of the person's capacity diminishing.

Signature by Proxy

The Bill makes specific provision for people who are blind, cannot read or cannot sign their name. These people would still be able to make a preliminary declaration or a first or second request by using a proxy to sign on their behalf. In order to act as a proxy, a person must be:

- a practising solicitor
- a member of the Faculty of Advocates
- a Justice of the Peace in Scotland

If the proxy is outwith Scotland then they should be a notary public or whatever the equivalent is in that place.

Key Issues – The approval process

Assessment of capacity

In the written evidence there was widespread concern about the lack of provision for psychiatric assessment, with the feeling that this significantly undermines safeguarding in the Bill. Some respondents (e.g. Care for Scotland, Free Church of Scotland) expressed the fear that people with mental illnesses such as depression may not be picked up on as the assessment of capacity would be left to non-specialist doctors.

The current Bill differs from the End of Life Assistance (Scotland) Bill which contained a provision that would have required a psychiatric assessment at the first and second request for assistance. The psychiatrist would have been responsible for assessing that the person had the capacity to make the request and that they were doing so voluntarily and without undue

influence. The explanatory notes to the Bill explain that assessment of capacity does not require psychiatric expertise and a medical practitioner would have the option of seeking specialist input (Scottish Parliament, 2013c, para 28). This view is supported by the submission from the Royal College of Psychiatrists which states that psychiatrists would not expect to be routinely involved in determining whether people are able to make decisions about assisted suicide.

Timescales

Respondents to the call for evidence raised concerns with some of the timescales set out in the three stage process. Among those in favour of the Bill, there were some opposing views on the appropriateness of the timescales. Some felt they allowed adequate cooling off periods (e.g. Friends at the End) while others were concerned that they could be too long for those in pain and the three stage process could be too demanding for some (e.g. Dignitas).

Among those opposing the Bill, the general feeling seemed to be that the timescales are too short. This was raised in relation to the seven day period between the preliminary declaration and the first request, with some feeling that this is too short for the declaration to act as an adequate safeguard (e.g. Living and Dying Well). Others pointed out that the overall timescale from preliminary declaration to suicide could be as short as 24 days. Some linked the importance of timescales with fluctuations in capacity (for example, via episodic confusion). They felt this highlighted the importance of adequate assessment of capacity and given that the Bill does not require a psychiatric assessment, the timescales were felt to undermine the safeguards.

There were also mixed views on the 14 day time limit once approval had been granted. Some thought it too short and that it had the potential to place pressure on people to end their lives when they are not quite ready. Many of these submissions pointed to Oregon and the fact that many drugs obtained for suicide are never used (see [figure 1](#)). Some respondents (e.g. Mason Institute) thought that possessing the means to end life provided comfort and reassurance to some individuals, while others viewed having such drugs in the community as poor practice.

The role of doctors

While many were content with the role of doctors there was some concern with regards to the appropriateness of their skills and their role in the assessment process.

A significant number of submissions felt that, in the absence of any requirement for a doctor to examine or even know the patient, the role of the doctor would be largely administrative or constitute a 'rubber stamping' of what the patient wants (e.g. Muslim Council of Scotland). Others also expressed concern that doctors were being asked to verify the subjective experiences of the patient.

Similarly, others argued that non-specialist GPs are not appropriately trained to assess someone's suitability for assisted suicide. The Royal College of Physicians felt the pressure of the decision meant that many would not be willing to undertake the role. It was also highlighted by a large number of submissions that the Bill has no conscience clause for professionals (either health or legal) that may be involved. This was felt to be a significant omission and inconsistent with other legislation such as the Abortion Act 1967.

Some submissions also expressed concern that there was nothing to prevent patients from 'shopping around' for agreeable doctors. One submission pointed to the experiences of Oregon, where they claimed that 61% of prescriptions for lethal drugs are written by just 20 doctors (Society for the Protection of the Unborn Child). The latest annual report from the Oregon public health department does not go down to this level of detail, but the latest report indicates that 62

physicians wrote the 122 prescriptions provided under the Death With Dignity Act 1994. The median length of the patient-doctor relationship was 13 weeks (range 1-719) (Oregon Health Authority, 2014).

THE ACT OF ASSISTED SUICIDE

Means of death

The Bill does not specify any particular method for assisted suicide. The Policy Memorandum explains that it is envisaged the person's GP will prescribe a drug that will enable them to end their life painlessly, pointing to the availability of barbiturates²³ that may fulfil that purpose. What the Policy Memorandum envisages would likely fall within the definition of 'physician assisted suicide'. However, the Policy Memorandum also states that the Bill is deliberately drafted widely enough to allow other drugs or means to be used.

Licensed facilitators

The Bill would create the role of 'licensed facilitator'. The purpose of the licensed facilitator would be to provide such practical assistance as the person reasonably requests and to provide comfort and reassurance. They could also be present with the person at the time they committed suicide and they would be responsible for recovering any unused drugs, substances or other means after the 14 day expiry period. The Bill states that the licensed facilitators should use 'best endeavours' to fulfil these functions.

It would also be the role of the licensed facilitator to report the suicide to the police. They would also have to do this if the person had attempted suicide but had not died.

Licensed facilitators would need to be at least 16 and could not be a close family member, someone who would benefit financially from the death or a doctor or nurse with involvement in the person's care and treatment.

The Bill would require Ministers to appoint an organisation responsible for the licensing of facilitators. It would also give Ministers the power to regulate matters such as the procedure for granting licences as well as the training and supervision required.

Assistance

The Bill specifies that nobody can perform any action which in itself would bring about another person's death. The Bill specifically states that the cause of the individual's death must be as a result of the person's own deliberate act. Any assistance given to the individual could not infringe on this requirement otherwise it would constitute euthanasia. The Policy Memorandum explains that the assistance function of licensed facilitators is described in broad terms, in recognition of the fact that the nature and extent of the assistance required will vary greatly between individuals (Scottish Parliament, 2013b, Para 48).

Assistance may be given by the licensed facilitator or anyone else present.

²³ Barbiturates are a sedative drug which can be used for mild sedation or complete anaesthesia. They can be used in the treatment of conditions such as anxiety, insomnia and epilepsy.

Key issues – Act of assisted suicide

Scope of assistance – assisted suicide vs euthanasia

Those in support of the Bill were largely satisfied with the scope of assistance that could be given, welcoming the explicit prohibition of euthanasia. However, some did call for the expansion of this to encompass voluntary euthanasia, for example, to the terminally ill. However, as previously mentioned above, a significant number of submissions expressed concern about the potential for a 'slippery slope'.

Means of death

Some submissions noted that the Bill does not specify the means by which a person can commit suicide. While the Policy Memorandum envisages the person being prescribed a drug, it does not exclude other means. These submissions called for greater clarity on other methods and whether the protections offered in the Bill would apply (e.g. Faculty of Advocates).

Presence of others

Some submissions raised the concern that no doctor would be required to be with the patient when they attempt to end their life. This predominantly stemmed from concern that something may go wrong and medical assistance may be required. Others also questioned whether or not the Bill would require the licensed facilitator to be present at the time of death.

What does it mean to assist?

A significant number of submissions raised questions about the type of assistance that could be offered to individuals wishing to end their life. The Bill does not define what is meant by 'assistance' although it is clear that the person must bring about their own death. Some submissions viewed the need for clarity as essential for ensuring people were protected within the clear boundaries of the law. A clear definition was also viewed as essential for ensuring that unlawful actions are picked up on. These respondents argue that without precise definitions of terms there is scope for uncertainty and therefore potential that people will not be adequately protected by the legislation (e.g. Faculty of Advocates, Law Society).

Role of the licensed facilitators

Many responses welcomed the role of licensed facilitator and felt it added another safeguard to the process. However, many others called for greater clarification on aspects of the facilitator's role. Often these calls referred to clearer definitions of what assistance could be offered and what it means to provide 'reassurance'. Such clarity was deemed essential to protect the facilitator from prosecution for euthanasia.

Various practical issues were also raised, including the role of the facilitator in the event of a failed attempt, how the facilitator would recover unused drugs and where would they be returned to.

Some submissions felt that 16 is too young to undertake the role of facilitator believing it to be a role that would require emotional maturity.

CIVIL AND CRIMINAL LIABILITY

Preclusion of civil and criminal liability

The Bill removes any civil or criminal liability for any person involved in providing assistance to a person who commits suicide using the Bill's provisions, so long as the processes in the Bill are followed.

When a suicide or attempted suicide is reported to the police, if the police believe the processes have not been followed then they could investigate and refer the matter to the procurator fiscal to decide whether prosecution is appropriate.

Savings clause

The savings clause of the Bill provides for the protection of people who, acting in good faith and not carelessly, make an incorrect statement or other action inconsistent with the Bill.

Key Issues – Civil and criminal liability

Preclusion of liability

The preclusion of civil and criminal liability is central to the Bill's purpose and this was recognised by both supporters and opponents of the Bill. However, those opposed to the Bill raised other concerns with the provision. Over and above their general opposition to the Bill, these concerns centred on the lack of provision for addressing breaches of the legislation. In addition, some felt that - alongside the savings clause and the difficulty in proving undue pressure or coercion - it would render a successful prosecution almost impossible. Others also pointed out that the Bill does not prescribe any penalties for abuses of the legislation.

Savings clause

It was felt by many respondents that the savings clause lacks definition and is broadly phrased. Particularly contentious phrases include 'acting in good faith'. Others also called for clarity on the extent and nature of the clause (e.g. Dignity in Dying).

Role of the Police

Generally speaking, respondents in support of the Bill were satisfied with the role of the police as described in the provisions. However, a large number of submissions opposing the Bill, argued that the role of the police is insufficient because their involvement is dependent on what might only be a verbal report from the licensed facilitator.

There was further concern that a police investigation would be unlikely to achieve a successful prosecution in the case of wrongdoing due to the broad nature of the "savings clause" and the difficulty of proving coercion or undue pressure.

FINANCIAL MEMORANDUM

Estimated number of cases

Using data from Oregon, the Financial Memorandum to the Bill estimates that approximately 120 people per annum will get as far as making a second request (Scottish Parliament, 2013c).

Estimated Costs

The Memorandum expects that the main costs associated with the Bill will be in the following areas:

- Costs to Scottish Ministers of appointing licensing authority, preparing subordinate legislation and other material
- Costs to licensing authorities/licensed facilitators related to training, licensing and acting as a facilitator
- Costs to registered medical practitioners of assessing diagnosis and capacity
- Costs to the General Medical Council and the General Pharmaceutical Council of revising professional codes of practice
- Costs to the Police and the Crown Office and Procurator Fiscal Service of investigation into suspected wrongdoing
- Costs to individuals, potentially from appointing a licensed facilitator.

For most of these areas, the Financial Memorandum envisages that the additional costs will be minimal and will be subsumed within existing budgets. It does detail some indicative potential costs though, for example:

- Approximately £850 for the appointment of a licensing authority
- Around £500 per person for the training of a licensed facilitator
- Around £135-£350 cost to the individual for the appointment of a licensed facilitator

Estimated Savings

The Financial Memorandum expects some savings to the individual, for example, for those who would otherwise have travelled to places like Dignitas in Switzerland. The memorandum also recognises that assisted suicide may have some cost savings to the NHS although it strongly states that this is not the aim of the Bill (Scottish Parliament, 2013c).

Appendix 1 - Assisted Dying in Other Countries

Other countries and jurisdictions are often referenced in the debate on assisted suicide. The following table provides a brief summary on the forms of assisted dying available in the places most commonly referred to in the debate and the submissions received by the Health and Sport Committee

Table 5: Forms of Assisted Dying and Safeguards in other Jurisdictions (replicated from Lewis & Black (2012) [The Effectiveness of Legal Safeguards in Jurisdictions that Allow Assisted Dying](#))

	Netherlands	Belgium	Oregon
Type of Assisted Dying	Both euthanasia (understood as termination of life on request) and assisted suicide are legally permitted, if performed by physicians in accordance with the statutory criteria. This is set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.	In Belgium, the Euthanasia Act 2002 allows physicians to perform euthanasia (understood as termination of life on request). Assisted suicide is not explicitly covered, although Belgium's oversight body (Federal Control and Evaluation Commission), has accepted that cases of assisted suicide fall under the law.	In Oregon, the Death with Dignity Act 1994 permits physician assisted suicide in one form: the provision of a prescription for lethal medication, to be self-administered by the patient. Neither euthanasia, nor any other form of physician assisted suicide is permitted.
Eligible conditions/experience of suffering	The attending physician must be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement'. The patient's suffering need not be related to terminal illness, and it is not limited to physical suffering such as pain. A related criterion is that there must be 'no reasonable alternative in light of the patient's situation' and the patient must be suffering unbearable pain, their illness must be incurable, and the demand must be made in "full consciousness" by the patient.	In Belgium, the 'patient [must be] in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident'. Like the Netherlands, there is no requirement that the patient has a terminal illness. Additional procedural requirements are imposed if the patient is 'clearly not expected to die in the near future'.	In Oregon, the patient must be suffering from a terminal disease, defined as 'an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months'. There is no additional requirement relating to the patient's experience of the disease or any minimum level of suffering.

	Netherlands	Belgium	Oregon
Making the request	In the Netherlands, the patient's request must be 'voluntary and carefully considered'. The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent. The request must also be well informed. The statute does not require the request to be in writing. The statute does allow termination of life on advance request, if a competent person becomes incompetent after having made a written declaration of his request.	In Belgium, the patient must be 'legally competent' and the request must be 'completely voluntary' and 'not the result of any external pressure'. The physician must inform the patient about 'his health condition and life expectancy' and 'the possible therapeutic and palliative courses of action and their consequence'. The patient's request must be in writing and a request may be made in advance. However, since the triggering condition is unconsciousness, advance requests will not be applicable to many scenarios of future incompetence including dementia.	In Oregon, the competence, voluntariness and information requirements are set out in some detail. The request must be in writing and two witnesses must attest that the patient is acting voluntarily and is not being coerced. The patient must make an 'informed decision... that is based on an appreciation of the relevant facts' (which are described in detail in the act).
Eligible age	Over 18. A patient between the ages of 16 and 18 who is 'capable of making a reasonable appraisal of his own interests' may request euthanasia or assisted suicide. The parent or guardian must be consulted but does not have a veto. Patients between 12 and 16 must also pass the same capacity test, and in addition the parent or guardian's consent is required.	In Belgium, euthanasia is legal for patients over the age of 18 and for minors over 15 who have been 'legally emancipated'. However, recently the law was extended to all ages, although children would require the approval of their parents and counselling by doctors and a psychologist/psychiatrist.	The Oregon law applies only to patients over the age of 18.

	Netherlands	Belgium	Oregon
Consultation and referral requirements	In the Netherlands, an independent physician must see the patient and give a written opinion on whether the due care criteria are met. The consultation requirements are more stringent if the patient's suffering is the result of a psychiatric disorder. Most reported euthanasia cases involve a consultant from the state-funded programme Support and Consultation on Euthanasia in the Netherlands (SCEN).	In Belgium, the consulting physician must examine the patient and the medical record and ensure that the suffering requirement has been met. If the patient 'is clearly not expected to die in the near future', there is a mandatory additional consultation with either a psychiatrist or relevant specialist, and a waiting period of at least one month. The Life End Information Forum (LEIF) service, which is similar to the SCEN programme, has been developed in Flanders to provide advice to doctors. A consultation with a palliative care expert is not legally required, but many Catholic hospitals in Flanders impose such a palliative filter in addition to the statutory criteria. The law requires the patient's request for euthanasia to be discussed with the nursing team involved in caring for the patient	In Oregon, the attending physician must refer the individual requesting assisted suicide to a physician who is qualified to make a professional diagnosis and prognosis of the patient's disease. The physician must also determine that the patient is capable and acting voluntarily. A counselling referral must be made if the attending or consulting physician suspects the patient may have a mental disorder or depression impairing their judgement, and the request may proceed only if the counsellor determines that such a condition does not exist. There is no requirement in the act that individuals experience palliative care before receiving a prescription.
Identity of the person assisting	In the Netherlands, only physicians may lawfully provide euthanasia. The courts originally required that the person providing euthanasia was the patient's treating physician. However, the current requirement is that the physician must know the patient sufficiently well to assess whether the due care criteria are met.	The Belgian act requires that the physician has 'several conversations with the patient spread out over a reasonable period of time' to be certain of the persistence of the patient's suffering and the enduring character of his or her request. The legislative history makes clear that the patient should be able to bypass his or her attending physician if so desired.	In Oregon, the attending physician is defined as 'the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease'.

	Netherlands	Belgium	Oregon
Medical Care	In the Netherlands, one of the due care criteria requires the physician to have terminated the patient's life or assisted suicide with due medical care and attention. The Royal Dutch Pharmacological Association provides a list of appropriate medications. The criterion of due medical care and attention also normally requires the physician's continuous presence during the euthanasia or assisted suicide in case further medical intervention is required. This requirement also ensures that the medication to be used remains under the control of the physician.	The Belgian law does not include a provision requiring that a physician exercise due medical care when carrying out euthanasia but all medical procedures must be carried out with due care. The Commission Fédérale de Contrôle et Évaluation (CFCE) has been reluctant to develop rules on the physical presence of the physician in euthanasia cases or the medication that must be used.	The Oregon act permits only the provision of a prescription for lethal medication to be self-administered by the patient. No due care criterion is included although the physician must fulfil certain medical record documentation requirements.
Reporting and scrutiny of cases	In the Netherlands for a physician to be protected by the legal defence provided by the 2001 act, he or she must report the case to the municipal pathologist, who then passes the file to the relevant regional review committee. If this committee finds that the physician did not act in accordance with the due care criteria, the case is referred to the Public Prosecution Service.	In Belgium, compliance with the Euthanasia Act 2002 is monitored by the CFCE, to which all cases of euthanasia must be reported.	In Oregon, the physician must report each prescription written under the act to the Oregon Department of Human Services (ODHS), and report each death that results from the ingestion of the prescribed medication.

SOURCES

Anquinet, L et al. (2012) The practice of continuous deep sedation until death in Flanders (Belgium), the Netherlands and the UK: a comparative study. *Journal of Pain and Symptom Management*. Vol 44(1): 33-43.

Chalmers, J. (2010) Assisted Suicide: Jurisdiction and Discretion. *Edinburgh Law Review* 14 2010, pp 295–300.

Clements, B. (2014) Religion and attitude to euthanasia in Britain: Evidence from opinion polls and social surveys. [Online] Available at: <http://www.brin.ac.uk/news/2014/religion-and-attitudes-towards-euthanasia-in-britain-evidence-from-opinion-polls-and-social-surveys/>

Commission on Assisted Dying. (2012) The current legal status of assisted dying is inadequate and incoherent. Demos, London. [Online] Available at: http://www.demos.co.uk/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363

Comres (2014) ITV Tonight Assisted Dying Poll. [Online] Available at: http://comres.co.uk/polls/ITV_Tonight_Assisted_Dying_Poll_July_2014.pdf

Comres (2014b) Care – Assisted Suicide Poll. [Online] Available at: [http://comres.co.uk/polls/Care_Assisted_Suicide_Poll_July_2014_\(with_summary_table\).pdf](http://comres.co.uk/polls/Care_Assisted_Suicide_Poll_July_2014_(with_summary_table).pdf)

Crown Prosecution Service. Decision on Prosecution – the Death by Suicide of Daniel James [Online]. Available at: http://www.cps.gov.uk/news/articles/death_by_suicide_of_daniel_james/index.html

Crown Office and Procurator Fiscal Service [Online]. Available at: <http://www.crownoffice.gov.uk/>

Crown Office and Procurator Fiscal Service. (2001) The Prosecution Code. Edinburgh: Crown Office and Procurator Fiscal Service. Available at: http://www.copfs.gov.uk/images/Documents/Prosecution_Policy_Guidance/Prosecution20Code_20_Final20180412_1.pdf

The Crown Prosecution Service. Director of Public Prosecutions [Online]. Available at: <http://www.cps.gov.uk/about/dpp.html>

The Crown Prosecution Service. (2014) Director of Public Prosecutions responds to Supreme Court on assisted suicide policy. News release 16 October 2014. Available at: http://www.cps.gov.uk/news/latest_news/director_of_public_prosecutions_responds_to_supreme_court_on_assisted_suicide_policy/

Demos. (2010) The Commission on assisted dying briefing paper: key research themes. Demos, London. [Online] Available at: <http://commissiononassisteddying.co.uk/wp-content/uploads/2010/11/Demos-Briefing-Paper-The-Commission-on-Assisted-Dying-Key-Research-Themes.pdf>

Dignitas. (2014) Accompanied suicides per year and residence. [Online] Available at: <http://dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2013.pdf>

Director of Public Prosecutions. (2014) Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide [Online]. Available at:

http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

Earle, M and Whitty, N R. (2006) Stair Memorial Encyclopaedia. "Medical Law" Edinburgh: Butterworths.

European Court of Human Rights [Online]. Available at:

<http://www.echr.coe.int/Pages/home.aspx?p=home>

Ferguson, P. (1998) Killing "without getting into trouble"? Assisted Suicide and Scots Criminal Law. *Edinburgh Law Review* 2(3) 1998, pp 288–314.

Godlee, F. (2014) Choice in matters of life death. *BMJ*, Vol 349: g4384.

Gordon, G H and Christie, M G A. (2000–2001) *Criminal Law*. 3rd edn. Edinburgh: W Green & Son Ltd.

Jones, T H & Christie, M G A. (2012) *Criminal Law*. 5th edn. Edinburgh: W Green.

Kerr, D. (2011) Preserving Life: Scots Law and Assisted Suicide. *Juridical Review* 2011, pp 33–44.

Lipscombe, S and Barber, S. (2014) Assisted Suicide. Standard Note SN/HA/4857. London: House of Commons Library. Available at:

<http://www.parliament.uk/business/publications/research/briefing-papers/SN04857/assisted-suicide>

Mason, J K and Laurie, G T. (2013) *Law and Medical Ethics*. 9th edn. Oxford: Oxford University Press.

MacQueen, H and Wortley, S. (2010) Scots Law News. *Edinburgh Law Review* 14(1) 2010, pp 1–12.

McCall Smith, R A A and Sheldon, D. (1997) *Scots Criminal Law*. 2nd edn. Edinburgh: Butterworths.

McLean, S et al. (2009) Purdy in Scotland: We Hear, But Should We Listen? *Juridical Review* 2009, pp 265–284.

NatCen Social Research. (2015) Personal Communication with NatCen.

Oregon Health Authority (2013) Oregon vital statistics 2013. [Online] Available at:

<http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/13v2/Pages/index.aspx>

Oregon Health Authority. (2014) Death with Dignity Act Annual Report 2013. [Online] Available at:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>

Patel, K. (2004) Euthanasia and Physician Assisted Suicide Policy in the Netherlands and Oregon: A comparative Analysis. *Journal of Social Policy*, Vol 19(1).

Park, A & Clery, E. (2008) Assisted dying and decision making at the end of life. National Centre for Social Research. [Online] Available at: <http://www.natcen.ac.uk/media/3046/assisted-dying-and-decision-making.pdf>

Park et al. (2007) Quickening death in British Social Attitudes Survey: 23rd Report. NatCen Social Research, Sage Publications. Available at: <http://www.commissiononassisteddying.co.uk/wp-content/uploads/2011/10/Evidence-from-the-British-Social-Attitudes-23rd-report-Quickening-death-the-euthanasia-debate.pdf>

Price, C. (2013) More than two thirds of GPs think RCGP should change stance on assisted dying. Pulse, 20 November 2013. Available online at: <http://www.pulsetoday.co.uk/clinical/elderly-care/more-than-two-thirds-of-gps-think-rcgp-should-change-stance-on-assisted-dying/20005114.article#.VJdJQuqYA> [last accessed: 22 December 2014]

Public Prosecution Service for Northern Ireland. (2010) *Policy on Prosecuting the Offence of Assisted Suicide*. Belfast: Public Prosecution Service for Northern Ireland. Available at: <http://www.ppsni.gov.uk/SiteDocuments/PPS%20Press%20Office/Policy%20on%20Prosecuting%20the%20Offence%20of%20Assisted%20Suicide.pdf> [last accessed 9 January 2015]

Rostant-Bell, M. (2014) Analysis of submissions of evidence on the Assisted Suicide (Scotland) Bill – SP Paper 587. Edinburgh, the Scottish Parliament. [Online] Available at: http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/HS_Assisted_Suicide_Report.pdf

Royal College of Physicians. (2013) Prolonged Disorders of Consciousness – National Clinical Guidelines. London: Royal College of Physicians. Available at: https://www.rcplondon.ac.uk/sites/default/files/pdoc_web_final_navigable_2014.pdf

Royal College of Physicians (2014). RCP reaffirms position against assisted dying. Press release: 27 November 2014. [Online] Available at: <https://www.rcplondon.ac.uk/press-releases/rcp-reaffirms-position-against-assisted-dying>

SCOPE. (2014) Majority of people fear change to assisted suicide law. [Online] Available at: <http://www.scope.org.uk/media/press-releases/july-2014/assisted-suicide-law>

Scottish Government. (2010) Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] Integrated Adult Policy: Decision Making and Communication. Edinburgh: Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2010/05/24095633/0>

Scottish Human Rights Commission [Online]. Available at: <http://www.scottishhumanrights.com/>

Scottish Parliament (2013a) Assisted Suicide (Scotland) Bill – as introduced. Edinburgh, Scottish Parliament. Available at: http://www.scottish.parliament.uk/S4_Bills/Assisted%20Suicide/b40s4-introd.pdf

Scottish Parliament (2013b) Assisted Suicide (Scotland) Bill – Policy Memorandum. Edinburgh, Scottish Parliament. Available at: http://www.scottish.parliament.uk/S4_Bills/Assisted%20Suicide/b40s4-introd-pm.pdf

Scottish Parliament (2013c) Assisted Suicide (Scotland) Bill – Explanatory Notes. Edinburgh, Scottish Parliament. Available at: http://www.scottish.parliament.uk/S4_Bills/Assisted%20Suicide/b40s4-introd-en.pdf

Scottish Parliament Justice Committee. (2014) Official Report 26th meeting 2014, Session 4, 28 October 2014. Edinburgh: Scottish Parliament. Available at:

<http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9588>

Seale, C. (2009a) Hastening death in end-of-life care: a survey of doctors. *Social Science and Medicine*, Vol 69(11): 1659-1666.

Seale, C. (2009b) End-of-life decisions in the UK involving medical practitioner. *Palliative Medicine*, Vol 23(3): 198-204.

YouGov. (2013) Dignity in Dying survey results. [Online] Available at:

http://cdn.yougov.com/cumulus_uploads/document/e7h1082zyc/YG-Archive-Dignity-in-Dying-results-180413-assisted-dying.pdf

Ward, B and Tate, P. (1994) Attitudes among NHS Doctors to Requests for Euthanasia. *BMJ* 308: 6940, 1332 -1334. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2540258/>



SPICe

The Information Centre

RELATED BRIEFINGS

[SB 10-51 End of Life Assistance \(Scotland\) Bill](#)

Scottish Parliament Information Centre (SPICe) Briefings are compiled for the benefit of the Members of the Parliament and their personal staff. Authors are available to discuss the contents of these papers with MSPs and their staff who should contact Kathleen Robson on extension 85371 or email Kathleen.robson@scottish.parliament.uk or Sarah Harvie-Clark on extension 85373 or email Sarah.Harvie-Clark@scottish.parliament.uk. Members of the public or external organisations may comment on this briefing by emailing us at SPICe@scottish.parliament.uk. However, researchers are unable to enter into personal discussion in relation to SPICe Briefing Papers. If you have any general questions about the work of the Parliament you can email the Parliament's Public Information Service at sp.info@scottish.parliament.uk.

Every effort is made to ensure that the information contained in SPICe briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

Published by the Scottish Parliament Information Centre (SPICe), The Scottish Parliament, Edinburgh, EH99 1SP

www.scottish.parliament.uk