# ASSISTED SUICIDE (SCOTLAND) BILL

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## POLICY MEMORANDUM

### INTRODUCTION

1. This document relates to the Assisted Suicide (Scotland) Bill introduced in the Scottish Parliament on 13 November 2013. It has been prepared by Non-Government Bills Unit on behalf of Margo MacDonald MSP, the member in charge of the Bill, to satisfy Rule 9.3.3A of the Parliament's Standing Orders. The contents are entirely the responsibility of the member and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 40–EN.

### POLICY OBJECTIVES OF THE BILL

2. The Bill provides 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.

3. In this way, the Bill allows people who actively wish to retain control of their lives to secure a dignified death at a time of their own choosing, instead of having to endure a poor and declining quality of life until such time as they die as a result of their illness or condition.

4. The fear of a protracted, painful and undignified death is very real for many people, whether or not they have themselves been diagnosed with a terminal illness or condition. Despite all the advances in medical technology in recent years, and the high-quality palliative care that is available in many places, not everyone can be assured of a "good death" in which pain is kept at bay and a reasonable quality of life is maintained until the end. For some, their final months or years are dominated by pain or discomfort and the inability to experience or enjoy those things that previously gave their life meaning and which most of us take for granted. They may be paralysed or have limited mobility, they may need help with feeding and washing, everything they do may be painful, slow and frustrating.

5. The Bill is not just aimed at the small number of people whose quality of life is already so low that they would prefer not to go on living. It is also aimed at those whose diagnosis has allowed them to see such a situation in prospect, and even those who are currently healthy but fear for an uncertain future. For them, just knowing that there is a way out should they ever need it could be of great comfort and reassurance.

6. For the medical profession – which has always had to wrestle with the ethical dilemmas involved in end-of-life treatment – the Bill offers transparency and consistency. While it has long been accepted that the levels of medication necessary to manage pain effectively during the final stages of a terminal illness can have the effect of shortening life, some doctors have been prepared to go further, prescribing or administering deliberately higher doses than needed for pain-management in order to bring the patient's suffering to an earlier end. However, as this was necessarily a covert and unregulated process, there was no consistency in where and how it was done. It was also unfair on doctors to expect them to jeopardise their reputations and even risk imprisonment in order to do what they saw as being in the best interests of their patients. In any case, in the aftermath of the Harold Shipman scandal (in which a rogue GP was convicted in 2000 of murdering 15 of his elderly patients), it is now much more difficult for any GP, whatever their motivation, to exercise such discretion.

7. In recent years, much attention has focused on the availability of assistance with suicide through clinics overseas – the best-known example being Dignitas. Over 200 Britons have so far travelled to Switzerland to end their lives with the assistance of this organisation.[1] But this is an expensive option, in practice only available to the better-off. Even for those who can afford it, there are disadvantages – many prefer to die at home rather than in an unfamiliar place, and the friends or relatives who accompany them face the possibility of prosecution or other legal action on their return. Also, the demands of travelling to Switzerland sometimes make it necessary to go at an earlier stage in their illness than they might otherwise wish, to ensure they are strong enough to complete the process – thus denying them precious time with their families.

## BACKGROUND

### Legal context

8. Suicide and attempted suicide are not themselves illegal in Scotland, or in other parts of the UK. However, it is likely to be against the law to encourage or assist a suicide or an attempted suicide.

9. In England and Wales, assisting a suicide is a statutory offence (under section 2 of the Suicide Act 1961), with decisions on prosecution taken by the Director of Public Prosecutions (DPP). The law relating to the DPP's role has been clarified by two high-profile cases. In the case of Diane Pretty, the House of Lords upheld the DPP's refusal to give an advance undertaking not to prosecute Ms Pretty's husband should he assist her in ending her own life. (The European Court of Human Rights subsequently held that Ms Pretty's right to respect for her private life under Article 8 of ECHR had been interfered with, but it upheld the UK's right to continue to prohibit assisted suicide on the grounds of protecting the vulnerable.) In the case of Debbie Purdy, the House of Lords ruled that the DPP's refusal to issue guidance on whether Ms Purdy's husband would face prosecution for helping her travel to Switzerland to die contravened the European Convention on Human Rights (ECHR). Following this judgement, the DPP issued guidelines aimed at clarifying the approach to cases of encouraging or assisting a suicide.[2]

[1] Source: Dignitas response to consultation on the draft Assisted Dying Bill published by the All-Party Parliamentary Group on Choice at the End of Life, available at: http://www.dignitas.ch/index.php?option=com_content&view=article&id=60&Itemid=104&lang=en

[2] Available from: http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html

However, these guidelines do not have the force of law, and in any case have no direct bearing in Scottish cases.[3]

10. In Scotland, the decision whether to prosecute is one for the Crown Office and Procurator Fiscal Service (COPFS), taking account of all the circumstances of the case, including whether prosecution would be in the public interest. It is possible that a person who assists someone else to commit suicide would be prosecuted for homicide (i.e. murder or culpable homicide), or for some lesser offence (such as assault or culpable and reckless injury/behaviour), although the lack of relevant case-law makes it difficult to establish how likely this is to happen in any particular case.

**The End of Life Assistance (Scotland) Bill**

11. Margo MacDonald first attempted to persuade the Parliament to provide a statutory mechanism to enable people to secure assistance to end their lives in Session 3. She lodged a draft proposal in December 2008 and a final proposal in April 2009.[4] The End of Life Assistance (Scotland) Bill was then introduced in January 2010 and referred to an ad hoc committee. After extensive evidence-taking, the committee published its Stage 1 Report in November 2010, with a majority of its members recommending rejection of the Bill.[5] The Stage 1 debate took place in December 2010, on a free vote, and the Bill was defeated by votes to 85 votes to 16 (with 2 abstentions).

12. While the current Bill builds on the work done in relation to the previous one, the policy has also been substantially developed.

13. In particular, the current Bill limits eligibility to those with an illness that is, for them, terminal or life-shortening or a condition that is, for them, progressive and either terminal or life-shortening – but does not also include those who are permanently physically incapacitated, thus addressing concerns (disputed at the time by the member) that the previous Bill inappropriately targeted disabled people.

14. In addition, the current Bill is clear that the assistance it authorises does not include any form of euthanasia – thus addressing a specific concern that the previous Bill would have authorised some forms of voluntary euthanasia in addition to assisted suicide.

15. The process that a person must go through has also been amended, removing some overly-complex aspects, while at the same time enhancing overall the set of safeguards it provides. The main changes are the requirement for a preliminary declaration to be made before a first request, and provision for the training and licensing of facilitators, able to provide some of the practical assistance likely to be required.

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[3] Source: Law Society of Scotland: http://www.journalonline.co.uk/News/1007039.aspx
[4] The proposal may be viewed at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/17939.aspx
[5] End of Life Assistance (Scotland) Bill Committee, 1st Report, 2010, available at: http://www.scottish.parliament.uk/parliamentarybusiness/PreviousCommittees/19514.aspx.

16. In introducing this new Bill, despite the failure of her earlier attempt, the member is responding to a high level of support and encouragement she has received and continues to receive. She also believes that opinion among politicians, the medical profession and the public continues to move in the direction of assisted suicide – and she is confident that this new Bill will receive a higher degree of support than its predecessor, both from within the Parliament and across Scotland. She believes that it remains unacceptable to leave the law as it stands, given the impact this has on those people it condemns to an unnecessarily protracted and unpleasant death, and on the relatives and friends who have to watch them suffer.

## DETAIL OF THE BILL

17. The Bill sets out a process that a person seeking an assisted suicide is to follow. This consists of three stages – a preliminary declaration, a first request and a second request. There are eligibility criteria at each stage, and disinterested third parties have a role in ensuring that these are met and that the steps in the process are correctly followed. Each stage in the process must be recorded, and there are minimum time-limits between the stages to provide a "cooling off" period, plus a maximum time-limit at the end as a further safeguard against the deterioration of capacity.

18. The aim is to provide a process that is practical, robust and clear – that is, one that provides a practical route towards an assisted suicide that is not unduly time-consuming or onerous, but at the same time has the checks and balances necessary to provide public confidence and to protect vulnerable people against abuse.

19. Where this process is correctly followed, the Bill provides legal protection to those involved in providing assistance to the person who commits suicide. The protection is both against criminal and civil liability (under sections 1 and 2 respectively), in each case subject to the "essential safeguards" set out in section 3 being complied with.

### Preliminary declaration

20. A person cannot make a first request until certain conditions are satisfied – as explained below. In particular, the person must already have been diagnosed with a relevant illness or condition, and have concluded that their quality of life is unacceptable. However, the policy is not to allow anyone to go straight to a first request without having already indicated (by means of a preliminary declaration) a willingness to consider an assisted suicide. This is one of the safeguards that together should ensure that no-one opts for an assisted suicide without careful consideration over an appropriate period.

21. There is no limit on how far ahead of a first request a preliminary declaration can be made, and it is envisaged that some people who support the idea of assisted suicide as a valid end-of-life choice will make such a declaration when they are relatively young and in good health, simply to ensure that if they are later diagnosed with a relevant illness or condition, the first pre-condition of seeking an assisted suicide is already in place. At the same time, the Bill recognises that requiring the preliminary declaration to be made a long way in advance is not realistic – many people will not wish to face up to the reality of end-of-life choices until they are older or have been diagnosed with a relevant illness or condition. However, there must be a

minimum period of 7 days between the signing of the preliminary declaration and the first request – to provide a "cooling off period".

22. To make a preliminary declaration, the person must be at least 16 and registered with a medical practice in Scotland (see section 4). For the reason already explained, there is no requirement at this stage to have any particular diagnosis or to view one's quality of life as unacceptable. Nor is having capacity (defined in section 12) a pre-condition of making a preliminary declaration, in order to ensure it is a simple and non-burdensome process. (Capacity is, however, a key criterion at the first and second request stages.)

23. The preliminary declaration (set out in schedule 1) is worded in an open-ended way – that is, signing it in no way commits the person to taking the process any further – and the declaration includes an express recognition that there is a right to cancel it at any time. At the same time, anyone who is opposed in principle to the idea of assisted suicide can take reassurance from the fact that simply by never making a preliminary declaration they can disqualify themselves entirely from the process.

24. A further safeguard is provided by the requirement for the preliminary declaration to be signed in the presence of a witness, and then checked by a registered medical practitioner. The witness must be over 16 and may not be a close relative, someone who stands to gain financially from the person's death, or someone involved in their medical care (in relation to the relevant illness or condition); but they must have some prior acquaintance with the person. The aim is to ensure that the witness can make an informed but detached judgement as to whether the person is making the declaration voluntarily (recognising that a stranger would be less likely to notice if someone was acting out of character or was under inappropriate pressure). The registered medical practitioner's role is not, at this stage, to carry out any professional assessment, but simply to check that the terms of the declaration itself and the witness statement comply with the legislation and that nothing stated in either is (so far as the practitioner is aware) false.

25. After a preliminary declaration is completed, the fact it has been made must be recorded in the person's medical records (section 5), so that there is an objective basis for checking later that this step in the process has been carried out (and not subsequently cancelled under section 7).

**First and second requests**

26. Following a preliminary declaration, a person seeking an assisted suicide must make two requests for assistance, separated by a minimum period of 14 days. Each is in near-identical terms, and each requires to be endorsed by two registered medical practitioners (see sections 8 to 11).

27. As pre-conditions for each request, the person must be at least 16 and registered with a medical practice in Scotland. In addition, the person must have concluded that their quality of life is unacceptable – having reflected on the illness or condition that they have, and concluded that there is no prospect of any improvement in their quality of life. The illness or condition itself must also satisfy certain conditions – if it is an illness, it must be, for that person, either terminal or life-shortening; and if it is a condition, it must also be, for that person, progressive.

28. 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.

29. As a result of how qualifying illnesses and conditions are defined, it is not enough just to have a condition that involves physical constraints (however severe) and to have concluded on that basis that your quality of life is unacceptable. There was a perception among some critics of the previous Bill that certain people with disabilities would have been eligible for end-of-life assistance simply by virtue of being disabled, and that this stigmatised such people as having lives not worth living. The member strongly disputed that interpretation of the previous Bill, but has altered the policy for this Bill in order to ensure that no such perception is even inadvertently created.

30. Another difference from the previous Bill is that no time-limit is included as part of the definition of "terminal". The idea is that an illness or condition can qualify so long as it is recognised that the eventual outcome will be death, however far in advance of that outcome the diagnosis is made. This recognises that setting any particular time-limit (such as death being expected within six months) is arbitrary and may be inappropriate (quite apart from the practical difficulties of reliable prognosis). Not only do different patients with the same illness or condition decline in health at different rates, they may also have very different attitudes to how much of the time still left to them they wish to forego.

31. Key safeguards at both request stages are that two registered medical practitioners must separately confirm the person's diagnosis and satisfy themselves that the person has capacity to make the request. In addition, both practitioners must take a view on how consistent the person's conclusion about the unacceptability of their quality of life is with the medical facts known to the practitioner. The aim here is not to substitute the person's judgement about the quality of their own life with a medical opinion (i.e. the test is not whether the person's quality of life would be acceptable to the practitioner, or even whether the person's view of their quality of life is reasonable), but it does entitle each doctor to withhold their endorsement of the request if they feel that the person's own assessment of their quality of life is clearly at odds with the evidence.

32. The second medical practitioner must be identified by the first, rather than by the patient. This is a further safeguard to address any concern that a person whose eligibility is doubtful would be able to keep asking different doctors in the hope of finding two prepared to support their request.

33. The 14-day minimum interval between first request and second provides a further "cooling-off period". There is deliberately no upper time limit between the two requests. Just as the aim is to allow people to make a preliminary declaration well in advance of being eligible to make a first request, should they wish, so they may make a first request as soon as they become

eligible to do so, without then feeling under pressure to move to a second request until they are ready.

34. Each request must be in the form set out in the relevant schedule (2 or 3). These forms involve the person signing up to a sequence of clear statements, by which they make declarations about aspects of their eligibility and their understanding of the implications. Similarly, the form of the statements made by the two registered medical practitioners provides a checklist of the matters on which each must be satisfied. The forms have been designed to promote consistency and minimise the chance of any challenge to the process on procedural grounds (as might be the case if, for example, the Bill did not prescribe a form of words, and a judgement was therefore required as to whether the form of words used in a particular case matched the statutory requirements).

35. The making of each request must be recorded in the person's medical records (section 13) – so that there is certainty later that all the necessary steps have been taken (and not cancelled). Accordingly, while either request may be cancelled at any time, cancellation must also be recorded in the medical records (section 15). Cancelling either request does not itself cancel any earlier step in the process. This allows a person who has had second thoughts to go back a stage, without necessarily having to start the whole process anew. (A person whose second thoughts are more fundamental has, of course, the ability to cancel every step thus far taken, should they wish to do so.)

36. Section 14 provides for the three elements required at each request stage – the person's own request, and the statements by the two registered medical practitioners – to be contained in a single document (as set out in schedules 2 and 3). These documents must exist in hard-copy form. As a practical safeguard, a person may arrange for a certified copy to be made, so the copy can be used in the event of the accidental loss or destruction of the original.

**Signature by proxy**

37. Section 16 makes provision for a preliminary declaration, a first or second request or a cancellation to be signed by a proxy where the person is blind, unable to read, or unable to sign. Such provision is important in the context of this Bill, where the people eligible to request assistance are much more likely than would normally be expected to be unable to complete forms unaided. However, given the significance of what is involved in the declarations made at each stage of the process, section 16 includes important safeguards in relation to signature by proxy – the proxy must be a solicitor, advocate or justice of the peace (or, in other jurisdictions, a notary public or the equivalent) who does not have a disqualifying relationship with the person, and must be satisfied that the person understands the effect of the document being signed on their behalf.

**The act of suicide**

38. It is envisaged that, following completion of a second request, the person's GP will prescribe for them drugs suitable to enable them to end their life painlessly. The member understands that there are forms of barbiturates that are already included in the list of drugs that GPs are entitled to prescribe that will serve this purpose if an appropriate dose is taken. Pharmacists presented with such a prescription would be expected to dispense the medicine.

39. It is anticipated that the relevant professional organisations (the General Medical Council for GPs and the Royal Pharmaceutical Society for pharmacists) would amend their guidelines and codes of practice to reflect any change in the law. (Current guidelines would prevent their members from prescribing or dispensing drugs for the purpose of causing death.) Any such revised guidelines or codes might include recognition that some GPs and pharmacists will have ethical or faith-based objection to any involvement in assisted suicide, but it is anticipated that the large majority of GPs and pharmacists would not exercise any such opt-out, and that in most cases where they did, it would simply be a case of finding another local GP or pharmacy prepared to assist.

40. Although it is envisaged that prescribed drugs will be the normal method used, the Bill is drafted widely enough to allow for the use of other substances or means, should those be preferred or become available.

41. Section 17 requires the act of suicide (e.g. the taking of any drug) to take place within 14 days of the second request being recorded in the person's medical records. The purpose of this time-limit is to minimise the chances of the person's capacity deteriorating significantly in the interval between the second request (which is the last point when capacity is professionally assessed) and the act of suicide itself. As noted above, there is no upper time-limit on the interval between the first and second requests, thus allowing a person to move to second request stage only when they are nearly ready to bring their life to an end.

42. Section 18 makes explicit that it must be the person's own deliberate act that is the cause of death (or would have been, in the case of an attempt). In this way, the Bill ensures that the legal protection it affords to those involved in assisting a suicide does not extend to any instance of euthanasia – that is, any instance of killing a person, with or without his or her consent, to end their suffering (sometimes called "mercy killing").

**Licensed facilitators**

43. The Bill provides for a category of people who are trained and licensed to provide assistance to persons seeking to end their lives. Such "licensed facilitators" provide an additional safeguard against misuse through the direct attendance of someone with an informed and detached perspective. Facilitators must be over 16, and cannot provide assistance to anyone with whom they have a close family relationship, a financial relationship or a medical or nursing relationship (as defined in schedule 4). The attendance of a facilitator does not preclude the attendance of others, such as close family members, and there is also nothing to prevent such other persons from also providing assistance.

**Licensing authorities and the role of Ministers**

44. Facilitators must be licensed by an authority which has been appointed, by order, by the Scottish Ministers (under section 22). Any such order is subject to the affirmative procedure (that is, it would require approval by the Parliament). More than one licensing authority may be appointed (for example, if no candidate organisation operates throughout Scotland).

45. Ministers will no doubt wish to satisfy themselves that any organisation is appropriately qualified and resourced to take on the licensing role. They can also be expected to set out a general framework within which any authority is to work. In particular, Ministers may set out in regulations (subject to the negative procedure – that is, they could be annulled by resolution of the Parliament) how applicants for licences are to be checked and trained, how those who have been licensed are to have their training kept up-to-date and how they are to be supervised and inspected. Regulations may also include provision on a range of procedural matters (including the grounds on which a facilitator's licence may be suspended or revoked, and the facilitator's right of appeal against such a suspension or revocation).

46. Ministers may also issue directions to licensed facilitators – and licensing authorities must do what they can to ensure the facilitators they have licensed comply with any such directions. Ministers may also issue guidance to licensing authorities (something for which no provision in the Bill is needed), and those authorities must have regard to any such guidance. Any such directions or guidance must be published, in the interests of transparency, and to ensure easy access to them for those whom they affect.

47. In this way, the Bill gives Ministers high-level oversight of the licensing regime, thus providing a degree of political accountability, but without adding any significant new administrative burden at government level. That burden will instead be borne mainly by licensing authorities themselves, whose role is to check the suitability of applicants (for example, via Disclosure checks on previous convictions) and to train them in their role and responsibilities. It is envisaged that organisations generally supportive of assisted suicide (such as the Humanist Society Scotland) may be willing to take on this role.

**The role of facilitators**

48. The general functions of licensed facilitators are listed in section 19. All four are functions that a facilitator is "to use best endeavours" to carry out – recognising that a facilitator, however well-trained and conscientious, may not always be in a position to do all of them in full. In addition, the first two functions are described in very broad terms, recognising that the nature and extent of the assistance that each person will need or want will vary greatly according to their illness or condition (for example, whether they are physically capable of lifting a cup to their lips unaided), and their particular circumstances (for example, whether they also have family members supporting them at the end). The fourth general function, which is to remove, as soon as practicable after the 14-day time-limit expires, any drug (or other substance or means) dispensed or supplied for the person's suicide, should help to ensure that the time-limit is observed.

49. As well as these general functions, facilitators are obliged (under section 20) to report the person's death to the police as soon as practicable. Should the person attempt suicide but not die, that must also be reported. It would then be for the police to make any investigation they consider necessary. Should there be any reason for believing that the process set out in the Bill was not properly followed, the police would have the option to refer the matter to the procurator fiscal, to consider whether any prosecution is appropriate. In doing so, the procurator fiscal would take into account section 24, which is intended to ensure that errors and omissions made in good faith by people endeavouring to act in accordance with the Bill do not undermine the legal protection that it otherwise affords.

**Commencement**

50. Section 25 provides for certain provisions to come into force immediately, so that certain powers conferred by the Bill (such as Ministers' power to appoint licensing authorities) can be exercised in advance of anyone gaining the right to begin the process of making a preliminary declaration and then a first and second request. The rest of the Bill comes into force 6 months later. Such an interval will be necessary for the training and licensing of an initial tranche of facilitators, and to allow medical governing bodies (such as the General Medical Council) to consider the implications of the legislation and make any necessary changes to their guidance and codes of practice.

## ALTERNATIVE APPROACHES

51. Given that the aim is to secure a substantial change in the law, it was considered that there was no credible alternative to primary legislation. Some greater clarity may come from case-law in due course, but no decision by the courts is likely to change the law substantially in such a sensitive area, as the courts quite properly see that as a matter for parliament to decide on.

52. The option of re-introducing the previous End of Life Assistance (Scotland) Bill was also considered, but quickly discounted. While disappointed with its rejection, the member recognised that the scrutiny process had demonstrated some problems with that Bill, and that a fresh approach was required. The current Bill therefore aims to learn lessons from the previous one, and also to reflect the member's on-going discussions with many people and organisations campaigning for change.

53. A number of specific issues arose during the development of the Bill, where policy choices were required.

54. For example, it was decided to limit the Bill to assisted suicide (where the person's death is the result of their own deliberate act, albeit with assistance), thus excluding any type of euthanasia; and to apply a relatively tight definition of the qualifying illnesses and conditions, thus excluding some conditions, however severe their impact on quality of life. Both decisions were taken in order to counter lines of objection to the previous Bill which, however much the member disputed their merits, undoubtedly contributed to its defeat. As a result, it is recognised that the form of assisted suicide the Bill authorises will not be available to all those that the member would ideally wish to include. While this is a matter of regret to the member, she considers this a price worth paying if it allows the Bill to secure majority support in the Parliament. She would be confident that, 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.

55. Another policy decision was to require anyone seeking an assisted suicide to be registered with a medical practice in Scotland. This was considered a necessary condition to address any concerns that the Bill might lead to a cross-border traffic in people resident elsewhere travelling to Scotland to seek an assisted suicide (so-called "suicide tourism"), particularly if the law prevailing in the rest of the UK remains unchanged. However, unlike in the previous Bill, it is no longer considered necessary or appropriate to require a person to have been so registered for a continuous period of 18 months – as this would also deny access to the Bill's procedures to

people who have only recently taken up residence in Scotland for other reasons (and who may only be diagnosed with a relevant illness or condition after their arrival). In practice, GP practices require evidence of address before they will register new patients, and this makes it unlikely that anyone would succeed in registering in Scotland without relocating on a medium or long-term basis. There may be a small number of people who would be able to satisfy the test of being registered with a Scottish practice without actually being resident in Scotland by virtue of living just over the border in a location closer to the Scottish practice than the nearest one in England. (Even for such people, of course, the Bill only makes assisted suicide available in Scotland, and does not change the legal position in the rest of the UK.)

56. Various choices were needed in the framing of the various safeguards built into the process. In particular, the member was very conscious of the need to provide assurances to those who fear that the availability of assisted suicide will put vulnerable people at risk from inappropriate pressure (for example, from relatives seeking to relieve themselves of an onerous burden of care). She is confident that the Bill strikes an effective balance, with a range of robust safeguards included, but a process that can still deliver relatively quickly when required, and without unnecessary bureaucracy.

57. A key safeguard built into the process is the professional assessment of a person's capacity, to ensure that no-one can obtain an assisted suicide if there are doubts about their ability to understand the implications of that choice. In developing the Bill, consideration was given to whether a test of capacity needed to be included at or immediately before the act of suicide. However, the view was taken that this could be intrusive and that it would be more appropriate to assess capacity at each of the two request stages, as part of the endorsement role of the two registered medical practitioners. In addition, the Bill sets a 14-day time limit between the second request and the act of suicide (while setting no upper time-limit between first and second requests). This is to address concerns that a person might otherwise be able to go through the request process and obtain a prescription at a relatively early stage, when they still have capacity, and then hold off using the medication for an extended period, by which time their capacity to make informed decisions may have deteriorated substantially.

## CONSULTATION

58. Margo MacDonald lodged the draft proposal for this Bill on 23 January 2012, accompanied by a consultation document. The consultation period ended on 30 April 2012, and a summary of the responses was then prepared by the Non-Government Bills Unit and published (with the member's commentary) on 30 September 2012, alongside the final proposal.[6]

59. The consultation document was sent to 149 organisations and individuals, and was widely publicised in the media. Responses were received from 55 organisations and 793 individuals. Nearly two-thirds (64%) of respondents opposed the proposal, while a third (33%) supported it and 3% were undecided or expressed no clear view. However, the responses included a large number of individual responses which either gave no reasons or merely endorsed the views of others. Among those respondents (organisations and individuals) who gave their own reasons in

[6] The proposal, consultation document and summary are available at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/46127.aspx

support of their view, the balance of opinion was very different – 59% in favour, 35% opposed and 6% neutral or undecided.

60. Margo MacDonald, in her commentary on the responses, noted that the level of opposition among consultation respondents was out of step with wider public attitudes as indicated by opinion-poll data. She has taken careful account of the information provided and arguments advanced by respondents in further developing the Bill.

61. Account has also been taken of the results of her 2008 proposal, and of the evidence taken by the End of Life Assistance (Scotland) Bill Committee on the previous Bill that resulted from that earlier proposal.

62. Margo MacDonald and her staff have continued to liaise closely with relevant organisations and individuals as the current Bill has been developed. This has included seeking comments on a draft version of schedules 1 to 3 from someone with direct experience of helping people facing up to end-of-life choices, and from a practising GP. Their thoughtful feedback has been reflected, where appropriate, in the final versions of these schedules.

## EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

### Equal opportunities

63. A right to an assisted suicide is likely to be used disproportionately by older people, as the people most likely to be diagnosed with a qualifying illness or condition. However, the Bill makes access to assisted suicide equally available to adults (over-16s) of any age.

64. Evidence from Oregon suggests that similar numbers of men and women obtain lethal medication, and use it to end their lives, under the Death With Dignity Act.

65. People from some ethnic groups or national origins, and people with certain religious faiths, are less likely to seek an assisted suicide on the grounds of incompatibility with their traditions or beliefs; but there is nothing in the Bill that would make it any more difficult for such a person to follow the process it lays down for any other reason. The Bill also respects the fact that some people may have faith-based or ethical objections to assisting another person's suicide – for example, if a person's own GP has such an objection, the Bill does not oblige them to act against their conscience, and any form of assistance that they might provide can equally well be provided by another GP in the same practice, or by a doctor from outside the practice. (The most that the person's own GP is obliged to do is to record certain factual information in the person's medical records – something that does not itself constitute assisting in the person's suicide.)

66. By providing a mechanism for assisted suicide in Scotland, at minimal cost to the individual, the Bill will particularly benefit those on lower incomes, given that the only current practical equivalent (travel to a clinic such as Dignitas in Switzerland) is relatively expensive and so affordable only to the better-off.

**Human rights**

67. The member is pursuing this Bill in the belief that the current law does not fully respect people's rights to control the timing and manner of their own deaths, and their right to a dignified death. To that extent, the Bill enhances human rights, in the member's view.

68. The Bill clearly has implications for human rights under ECHR – particularly Article 2 (right to life) and Article 8 (right to respect for private and family life). However, the member is confident that it is consistent with ECHR case-law, which suggests that states have some "margin of appreciation" in deciding whether and how to legislate for assisted suicide (as, indeed, a number of ECHR-signatory states have already done). Such legislation might be considered incompatible with ECHR if, for example, it failed to provide adequate safeguards against coercion, failed to exclude particularly vulnerable groups such as children or adults with incapacity, or required anyone to assist a suicide against their conscience. However, the member is confident that the robust safeguards in this Bill make a successful challenge on human rights grounds very unlikely.

**Island communities**

69. While the Bill applies in the same way throughout Scotland, an assisted suicide may in practice be harder to obtain for people living in small and remote communities, including island communities – particularly as travelling is likely to be particularly difficult for people who have the sort of illness or condition outlined in the Bill. The process requires the direct involvement of a number of other people to carry out certain functions, for example as a witness to a preliminary declaration. It may be harder for a person living in a small and remote community to identify someone who meets the various qualifying criteria and is able to attend at the relevant time and place to witness their declaration. It may also be more difficult for someone living in such a location to gain access to an alternative doctor if the only local GP declines to assist on grounds of conscience.

70. The member acknowledges these difficulties but considers them unavoidable. It would not be appropriate to weaken the safeguards provided in the Bill, and it would be impractical and unrealistic to differentiate in the way the process operates by reference to geography.

**Local government**

71. The Bill confers no powers or obligations on local authorities, and has no other direct impact on local government. There are implications for the NHS through the role conferred on registered medical practitioners, but it is not expected that the Bill will have any direct impact on Health Boards.

**Sustainable development**

72. The Bill has no direct environmental impact (for example, in terms of resource or energy use). There is no reason to suppose that the changes it makes could not be sustained indefinitely.

*This document relates to the Assisted Suicide (Scotland) Bill (SP Bill 40) as introduced in the Scottish Parliament on 13 November 2013*

# ASSISTED SUICIDE (SCOTLAND) BILL

## POLICY MEMORANDUM



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