

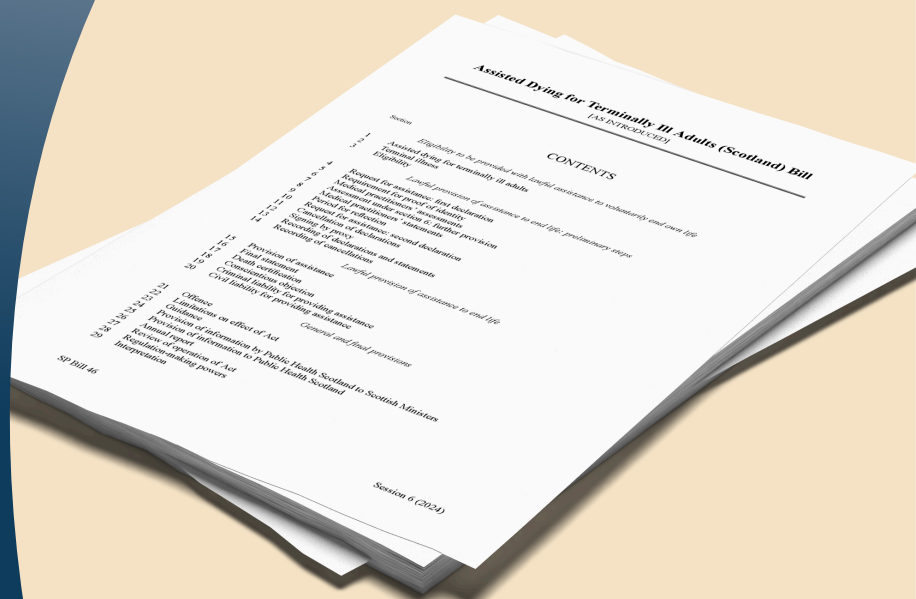


SPICe Briefing
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Assisted Dying for Terminally Ill Adults (Scotland) Bill: A summary of stage 2 proceedings

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The Assisted Dying for Terminally Ill Adults (Scotland) Bill completed stage 2 on 25 November 2025. This briefing provides an overview of the main changes to the Bill, as well as a summary of key amendments not agreed to.



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Summary

This briefing:

- outlines the Bill's key provisions at introduction,
- summarises the main comments and recommendations made by the Health, Sport and Social Care Committee in its stage 1 report,
- details the main changes to the Bill at stage 2, and
- summarises the main amendments that were not agreed to at stage 2.

A total of 298 amendments were lodged and considered at stage 2 and 74 were agreed to.

Eligibility

Under the Bill (as introduced), eligibility for assisted dying requires a person to be at least 16 years old, diagnosed with a terminal illness, ordinarily resident in Scotland for 12 months, registered with a Scottish GP and have the capacity to make decisions.

Stage 1 evidence debated whether a prognostic timescale should be added to the definition of terminal illness but the Health, Social Care and Sport Committee ('the Committee') accepted the view that clinical judgement should prevail over fixed timelines. Concerns were also raised about setting the age at 16, as this is at odds with the UN Convention on the Rights of the Child (Scotland) Act 2024 which defines adulthood at 18.

Key amendments made were increasing the minimum age of eligibility from 16 to 18 and clarifying that disability or mental health conditions alone do not constitute terminal illness.

Amendments not agreed to included; adding a 3- or 6-month prognostic timescale, raising the age to 25, requiring detailed palliative care or anticipatory care plans, mandating access to social care, and excluding those on social care waiting lists.

Process

The Bill (as introduced) sets out a process for assisted dying, beginning with a first declaration, followed by assessments and statements from both a coordinating doctor and an independent doctor. After a second declaration, a formal request for assistance can be made. The process is designed to ensure the person is a terminally ill adult who meets eligibility requirements, acts voluntarily, and is free from coercion. A 14-day reflection period is required between declarations, though this can be shortened to 2–13 days if death is imminent. The person may withdraw from the process at any stage.

The Committee raised several issues about the process in its stage 1 report. It highlighted the need for legal clarity on whether medical practitioners are obliged to raise assisted dying, as well as acknowledging concerns about 'doctor shopping'. Calls for tailored psychological support for patients and professionals were noted, as well as debate over the 14-day reflection period. Practical concerns were also raised about allowing proxy signatures and the Committee stressed the importance of ensuring appropriate training and qualifications for those involved.

At stage 2, several amendments were made to strengthen safeguards and support. These

included requiring doctors unwilling to act as coordinators to direct patients elsewhere, prohibiting professionals from raising assisted dying with under-18s and obliging both assessing doctors to discuss the patient's reasons for seeking an assisted death. Doctors must also ensure appropriate social care has been offered, explain palliative and hospice options, and inform patients of their right to social work or palliative care assessments. Additional safeguards were introduced around proxy arrangements and a right to independent advocacy was added. Scottish Ministers must now also set regulations on training, qualifications and the experience required of the doctors and authorised health professionals involved in assisted dying.

The Bill was also amended to make it mandatory, rather than optional, for Scottish Ministers to produce guidance on the operation of the Act (if passed), including training and quality assurance. They must also consult trade unions and professional bodies when developing guidance.

Amendments to the process not agreed to included creating an Assisted Dying Review Panel to determine eligibility, prohibiting doctors from initiating discussions about assisted dying, and establishing a new administrative body. Other rejected proposals included extending the reflection period to 28 days, mandating referrals to social workers or psychiatrists, requiring independent assessments of coercion, and the creation of a register of practitioners willing to participate. An amendment to establish an Assisted Dying Training Authority was also rejected. This body would have overseen training standards, accreditation of practitioners and ongoing education, with a focus on equality, palliative alternatives and rights under the UN Convention on the Rights of Persons with Disabilities.

Capacity

The Bill requires that anyone seeking assisted dying must have the capacity to make the request. Capacity is defined as being able to understand, decide, communicate, comprehend, and remember the decision and not being affected by a mental disorder as defined under the Mental Health (Care and Treatment) (Scotland) Act 2003. Capacity must be confirmed by assessing doctors, with referral to a specialist if needed.

At stage 1, concerns were raised that defining capacity in the Bill could become outdated if the law evolved, though it was noted capacity is well understood in medical practice and could be supported through training. There was also debate as to whether assessments should be carried out solely by doctors or involve specialists, with recognition that complex cases may require psychiatric or social work input. References to 'mental disorder' also raised fears of discrimination and potential breaches of UN disability rights, prompting calls for non-discriminatory safeguards. The Committee also highlighted challenges in assessing fluctuating capacity but rejected the inclusion of advance directives.

Stage 2 amendments agreed to included requiring referral to a psychiatrist if capacity is in doubt, mandating input from health and social care professionals where assessing doctors think appropriate, and removing the need for nurses acting as authorised health professionals to assess capacity at the time assistance is provided.

Amendments not agreed to included a presumption of incapacity unless proved otherwise, mandatory training for doctors in assessing capacity, and requiring advance care directives alongside the first declaration.

Provision of Assistance

After successfully completing the required process, the Bill (as introduced) allows a person

to be provided with an approved substance to end their life. The coordinating doctor or an authorised health professional (doctor or nurse) may supply the substance, which must be specified in regulations. At the point of provision, the professional must confirm the person has capacity, is acting voluntarily, and is free from coercion. They must remain with the individual until the substance is either taken or removed, though not necessarily in the same room.

Stage 1 consideration highlighted concerns about discrimination risks for people with disabilities in requiring the substance to be self-administered, a lack of clarity around what self-administration means, uncertainty about what would constitute permissible assistance, and what to do in the event of complications. The Committee stressed the need for clearer guidance and consistency in drafting, particularly regarding the presence of healthcare professionals during administration.

At stage 2, key amendments agreed to included; allowing doctors to prepare devices for self-administration, allowing the doctor to assist the person to ingest or otherwise use the substance, requiring that the substance must be supplied by a registered pharmacist, that nurses acting as the authorised health professional must be accompanied by a doctor or another health professional, clarifying that professionals must remain in the same room until the substance is taken, and a doctor must be present at the point of assistance. Additional amendments clarified that no one may administer the substance to another person and gave Ministers powers to regulate assisted dying provided outside the NHS, including specifying which settings must not be used for assisted dying.

Proposals not agreed to included requiring doctors to intervene if the substance failed, and mandating Scottish Ministers to issue guidance on complications.

Death Certification

Under the Bill (as introduced), the death certificate of someone who has an assisted death would list the underlying terminal illness as the cause of death, with the approved substance noted separately. The Committee concluded both should appear on the certificate, requiring further clarification if the Bill progresses.

At stage 2, it was agreed the approved substance should be recorded on the death certificate under other medical information. Proposals to list the illness as an underlying condition or the substance as the direct cause of death were not accepted.

Conscientious Objection

The Bill (as introduced) allows health professionals to refuse participation in assisted dying on grounds of conscience, with the burden of proof resting on the individual objecting.

Stage 1 consideration highlighted concerns about the extent of this provision, its clarity and whether it could create a barrier to access. The Committee discussed whether objecting practitioners should have a duty to refer patients onwards, whether there should be protections against workplace discrimination (a 'no detriment' clause), and the merits of opt-in versus opt-out participation models. It also noted mixed views on institutional objection.

At stage 2, references to 'conscientious objection' were replaced with 'no duty to participate' and clarified it applies to direct involvement only. The burden of proof requirement was also removed. Amendments also ensured staff who opt out should face no detriment and clarified that doctors are not obliged to raise assisted dying but may do

so at their discretion.

Proposals not agreed to included adding an institutional objection, broader definitions of participation, and the creation of registers of doctors or psychiatrists willing to take part.

Civil and Criminal Liability

The Bill (as introduced) exempts healthcare professionals from liability when assisting eligible adults in line with its provisions, while maintaining that directly ending a life or assisting outside the process remains a criminal offence. It also criminalises coercing or pressuring a terminally ill adult to make a declaration, with penalties of up to 2 years' imprisonment on summary conviction or up to 14 years on indictment.

At stage 1, concerns were raised about defining and assessing coercion, the ability of professionals to identify it, and enforcement of the offence.

Stage 2 amendments added offences for coercing someone into taking the approved substance and for promoting or soliciting assisted dying through advertisements. A proposal to require training for professionals in identifying coercion was not agreed to.

Reporting, Monitoring and Review

The Bill (as introduced) requires Public Health Scotland (PHS) to report annually to Ministers on assisted dying, including numbers of declarations, eligibility decisions, provision and use of approved substances, place of death, reasons given for seeking an assisted death, and anonymised demographic data. Ministers may regulate reporting requirements, impose penalties for breaches, and must review the legislation within five years.

Stakeholders at stage 1 welcomed these provisions but called for clarity on data categories, collection processes, and review timing. The Committee stressed that any additional data must have a clear purpose and noted proposals for a sunset clause, though without comment on its merits.

At stage 2, amendments added requirements for doctors to record complications, submit anonymised reports to PHS, and for Ministers to assess the impact on hospices and palliative care, followed by the creation of a code of practice outlining how the services should interact.

Proposals not agreed to included assessing social services capacity, holding a referendum on assisted dying, commissioning independent financial reviews, creating oversight bodies, introducing sunset clauses, and various proposals for expanding data collection.

Background

The Assisted Dying for Terminally Ill Adults (Scotland) Bill was introduced in the Scottish Parliament on 27 March 2024 by Liam McArthur MSP.

The Health, Social Care and Sport Committee ('the Committee') was designated as lead committee for Stage 1 consideration of the Bill on 16 April 2024 and produced its stage 1 report on 30 April 2025.

The stage 1 debate was held on 13 May 2025 and the general principles of the Bill were agreed to, with 70 votes for, 56 against and 1 abstention.

All of the Bill's key documents can be found on the Scottish Parliament [Bill page](#), including:

- [Assisted Dying for Terminally Ill Adults \(Scotland\) Bill \(as introduced\)](#)
- [The Health, Social Care and Sport Committee Stage 1 Report](#)
- [The Marshalled List of Amendments at stage 2](#)
- [The Groupings of Amendments at stage 2](#), and
- [The Assisted Dying for Terminally Ill Adults \(Scotland \) Bill \(as amended at stage 2\)](#).

There are also other SPICe briefings available on the Bill:

- [Stage 1 briefing on the Assisted Dying for Terminally Ill Adults \(Scotland\) Bill](#)
- [Assisted Dying for Terminally Ill Adults \(Scotland\) Bill and the European Convention on Human Rights](#)
- [Palliative Care and Assisted Dying](#)
- [Definitions of Terminal Illness in Assisted Dying Legislation](#)

Stage 2 Proceedings

Stage 2 amendments to the Assisted Dying for Terminally Ill Adults (Scotland) Bill were considered by the Committee over the course of 4 meetings between 4 November and 25 November 2025.

Prior to Stage 2 proceedings, [a Financial Resolution](#) for the Bill was also agreed by Parliament (on 30 October 2025). This was to allow for certain amendments with cost implications to be agreed.

This briefing:

- outlines the Bill's key provisions at introduction,
- summarises the main comments and recommendations made by the Health, Sport and Social Care Committee in its stage 1 report,
- details the main changes to the Bill at stage 2, and
- summarises the main amendments that were not agreed to at stage 2.

A total of 298 amendments were lodged and considered at stage 2 and 74 were agreed to.

The remaining amendments were either not agreed to, not moved or withdrawn.

Eligibility

The Bill (as introduced)

To qualify for assisted dying under the Bill (as introduced), a person must be:

- an adult aged 16 or over,
- ordinarily resident in Scotland for at least 12 months,
- registered with a Scottish GP, and
- capable of understanding and making decisions about their situation.

They must also be terminally ill, meaning they have an advanced and progressive disease, illness, or condition from which they cannot recover and which is reasonably expected to cause their premature death.

Stage 1 consideration

Issues raised in relation to eligibility at stage 1 were largely focused on the definition of terminal illness and age.

In relation to the definition of terminal illness, the most common suggestion to change the definition was to add a 'prognostic timescale'. This refers to a length of time in which the terminally ill person is expected to die and is a common feature in assisted dying legislation internationally.

The Committee acknowledged the difficulty of accurately predicting life expectancy for terminally ill patients, while also acknowledging the risk that excluding a prognostic timescale could broaden eligibility to those not near death. However, it accepted Liam McArthur's rationale for omitting a timescale and agreed that determining eligibility should rest on clinical judgement rather than a fixed timescale.

In relation to age, the Committee acknowledged Liam McArthur's intention to set the age at 16 to align with Scots law. However, it also noted stakeholder concerns about a conflict with the UN Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024, which defines adulthood at 18, and warned this discrepancy could create challenges for legal enforcement.

Main amendments agreed to at stage 2

Several amendments were lodged at stage 2 aiming to amend the eligibility criteria for accessing assisted dying. The main changes to the eligibility criteria agreed to were:

- An increase in the age of eligibility from 16 to 18 years (amendments 1,2 and 3),
- An amendment to make it clear that having a disability and/or a mental health condition does not, by itself, count as being "terminally ill" (amendment 24).

Main amendments not agreed to at stage 2

One of the most commonly suggested amendments to the the eligibility criteria was to add a prognostic timescale to the definition of terminal illness. Consequently, amendments were lodged to add a timescale of 3 months (amendment 143) and 6 months (amendments 4, 83, 97, 119 and 144) but these were not agreed to.

Other amendments to the eligibility criteria not agreed to were:

- increasing the age of eligibility to 25 years (amendments 152 and 168),
- requiring the person to have a fully costed palliative care support plan that meets minimum standards set by Ministers in regulations (amendment 145),
- requiring the person to have an anticipatory care plan in place which includes a plan for palliative care (amendment 25),
- requiring that the person has accessed social care relevant to their terminal illness (amendment 219),
- declaring someone ineligible if they have been unable to access appropriate social care and have been on a waiting list for care for a continuous period of 6 weeks or more prior to make the request for assisted dying (amendment 221),
- declaring a person as not having capacity to consent (and therefore ineligible for assisted dying) if they have one of a prescribed list of conditions such as an eating disorder, mood disorder or intellectual disability (amendment 147),
- excluding people whose illness is the result of voluntarily stopping eating or drinking (amendment 144).

Process

Bill as introduced

The process in the Bill (as introduced) includes the following steps:

1. First declaration
2. Coordinating doctor assessment
3. Coordinating doctor statement
4. Referral to independent doctor
5. Independent doctor assessment
6. Independent doctor statement
7. Second declaration
8. Request for assistance
9. Provision of assistance

The process aims to ascertain the person who made the declaration(s) is a terminally ill adult who meets the eligibility criteria, made the declaration voluntarily and has not been coerced or pressured by any other person into making it.

There would be a 14-day reflection period in between making the first and second declarations. This can be shortened to between 2-13 days if both doctors agree death is likely to occur in less than 14 days. The person can withdraw from the process at any point.

Stage 1 consideration

The stage 1 report on the Bill commented on several aspects of the process. This included:

- **Duty to raise assisted dying**

The Committee suggested that, if the Bill progresses, its wording may need amendment to provide clear legal protections for medical practitioners in relation to whether they choose to raise assisted dying or not. It also noted this issue touches on the limits of the Scottish Parliament's legislative competence and suggests that, if the Bill becomes law, guidance could offer additional clarity.

- **Doctor Shopping**

The Committee noted concerns about the risk of 'doctor shopping' if a patient's initial request for assisted dying is declined, but accepted Liam McArthur's view that existing safeguards should prevent this. However, if the Bill progresses, the Committee suggested considering additional safeguards through amendments, such as a central register of psychiatrists or an independent body or ethics committee to oversee and review practitioners' decisions.

- **Psychological support**

The Committee noted calls for the Bill to provide tailored psychological support for individuals requesting assisted dying and the healthcare professionals involved. It highlighted this as an issue for the Scottish Government and professional bodies to address if the Bill becomes law.

- **Period of reflection**

The Committee noted mixed views on the Bill's 14-day reflection period, with many considering it too long. However, it also acknowledged the provision that this could be reduced to 48 hours if the person is expected to live less than 14 days. It felt that whether the default 14-day period should be revised would be an important area for debate and possible amendment.

- **Signing by proxy**

The Committee drew attention to a range of practical concerns that were raised regarding the provisions that enable documents to be signed by a proxy. It encouraged these concerns to be addressed via amendment, based on further advice and input from the legal profession.

- **Other safeguards**

Other more general points on the practical application and inherent safeguards in the process were also raised by the Committee in its report. This included around the training, qualifications and experience of those involved in the process.

Main amendments agreed to at Stage 2

The main amendments agreed to in relation to the process in the Bill included:

- A doctor who is unwilling or unable to act as coordinating doctor must direct the terminally ill adult to another doctor or to relevant information (amendment 27).
- Prohibiting health professionals from raising the topic of assisted dying with under 18s (amendment 53)
- Both the coordinating and independent doctor must enquire about and discuss the person's reasons for seeking an assisted death (amendment 90).
- Coordinating doctors must ascertain whether the person has been provided with or offered appropriate social care relevant to their illness (amendment 228).
- Where they consider it appropriate, assessing doctors must consider consulting health, social care, or social work professionals involved with the person, or seeking their input on any other matter they are qualified in or have experience of (amendment 69).
- Both the coordinating and independent doctor must explain and discuss not only palliative care but also hospice care, symptom management, and psychological support (amendment 29).
- Doctors must inform the person they may request an assessment by a registered social worker, including potential benefits of receiving such an assessment

(amendment 92) and they must inform the person they can be referred for a palliative care assessment to explore further support (amendment 93).

- Where an assessing doctor has any doubts about whether the person has a terminal illness or the capacity to make the decision, they must refer them to a suitable specialist and consider their opinion (amendments 95, 96, 98 and 99).
- A proxy is now defined as someone who has known the person for at least 2 years or as specified in regulations (amendment 32). The disqualifications set out in Schedule 5 of the Bill (as introduced) still apply.
- A right of access to independent advocacy and a duty for Ministers to ensure it is made available to those who need it (amendment 242).
- A requirement for Scottish Ministers to regulate for advocacy service standards, with which service providers must comply with (amendment 243).

Alongside amendments to the process itself, there were also several amendments related to the required training, qualifications and experience of those involved in the process. This included a requirement for Scottish Ministers to make regulations detailing the training that doctors and authorised health professionals must undertake in order to be involved in the assisted dying process. This is in addition to regulations detailing the qualifications and experience they must have (amendments 65, 67, 230, 224, 34, 34A, 34B, 35A and 35B). These regulations must be consulted on before being laid before the Scottish Parliament (amendment 35).

The Bill was also amended to make it mandatory, rather than optional, for Scottish Ministers to produce guidance on the operation of the Bill (amendments 261 and 262). This guidance must include provisions on training and quality assurance to support effective implementation (amendment 263). In addition, when developing the guidance, Ministers must now consult with trade unions and professional bodies representing those who will carry out functions under the Act (amendment 265).

Main amendments not agreed to at stage 2

The main amendments lodged in relation to the process that were not agreed included:

- Creation of an Assisted Dying Review Panel which would determine eligibility (amendments 239 and 240).
- Prohibiting doctors and health professionals from initiating a discussion about assisted dying (amendment 220).
- Provisions requiring that at various parts of the process, it is stated the person is acting entirely of their own initiative and without the encouragement, suggestion or influence of others (amendments 223, 237 and 238).
- The creation of a body responsible for the administrative functions of the Act (amendment 148).
- Requiring the coordinating doctor to ask the person about their reasons for seeking an assisted death and, if it becomes apparent it is for reasons not related to their terminal illness or falls outwith the provisions of the Act, then the process must be stopped (amendment 229).

- Encouraging an assessing doctor to refer the person to disability organisations for advice about support for living with their terminal illness (amendment 234) or to their local authority for further assessment of support to enable them to live independently (amendment 235).
- Requiring an assessing doctor to refer the person to a social worker and a psychiatrist for assessment and take account of their opinion (amendment 157).
- Requiring an independent assessment of whether the person has been coerced (amendment 161).
- Extending the period of reflection from 14 to 28 days (amendments 7,8 and 9).
- Requirement to refer the person for a palliative care assessment (amendment 116).
- Requesting information on whether the adult is vulnerable or at risk (amendment 100).
- A requirement to enquire what advice and support the adult has received to enable them to live independently in line with article 19 of the UN Convention of the Rights of Persons with Disabilities (amendment 231).
- Enhanced assessment of under 25s seeking assisted dying (51).
- Preventing someone seeking a further assessment for assisted dying earlier than 6 months since their last assessment (117A).
- The creation of a register of people willing to carry out functions under the Act (amendments 66 and 151).

An amendment in relation to training and equalities was also not agreed to (amendment 270). This would have created an independent body known as the Assisted Dying Training Authority.

The Assisted Dying Training Authority would have been responsible for setting and updating training standards for medical practitioners involved in assisted dying, accrediting providers and practitioners annually, and ensuring ongoing education reflects best practice, ethics, and societal attitudes.

Training would have included knowledge of palliative care alternatives, respect for equality and non-discrimination principles, and awareness of the rights and experiences of people with disabilities, terminal illness, or socio-economic disadvantage. It would also have had to cover independent living rights in line with Article 19 of the UN Convention on the Rights of Persons with Disabilities, alongside recognition of coercion or undue influence.

Capacity

The Bill (as introduced)

To be eligible for assisted dying, the person must have the capacity to make the request for an assisted death. The Bill (as introduced) describes a person as having capacity if they are not suffering from a mental disorder which might affect the making of the request, and they are capable of the following:

- understanding information and advice about making the request;
- making a decision to make the request;
- communicating the decision;
- understanding the decision; and
- retaining the memory of the decision.

‘Mental disorder’ is defined in accordance with the Mental Health (Care and Treatment)(Scotland) Act 2003.

The Bill (as introduced) requires that capacity be confirmed by the assessing registered medical practitioners, and contains an option to refer to a specialist if this is considered necessary to be able to determine capacity.

Stage 1 consideration

The Committee heard concerns that putting a definition of capacity on the face of the Bill could become outdated as legal definitions evolve. However, it also heard evidence that changes are unlikely soon and that capacity is well understood within medical practice and could be addressed by additional training and guidance to ensure practitioners are suitably equipped to test for capacity.

Views differed on whether capacity assessments should be carried out solely by the assessing doctors or involve specialists. It was noted that most medical bodies consider this a core skill for medical practitioners, but assessments can be complex, time-consuming and may require input from psychiatry or other professionals. The Committee noted calls for clearer wording on the role of such external input and highlighted the potential need for specialist expertise, including contributions from social workers and mental health officers.

The Committee also heard concerns about references to “mental disorder” in the Bill, fearing it could lead to automatic exclusion of individuals with such conditions, potentially breaching UN disability rights. Some suggested removing the term entirely. The Committee concluded that further work is needed to ensure fair, non-discriminatory assessment while protecting vulnerable individuals.

The Committee also called for clarity on assessing those with fluctuating capacity and noted debate over allowing advance directives. While some argued for their inclusion, evidence and the Bill’s drafting intention suggest they would be legally and practically problematic.

Main stage 2 amendments agreed to

The main amendments agreed to in relation to capacity were:

- Making it mandatory for assessing doctors to refer a person to a psychiatrist or someone who specialises in assessing capacity when there are any doubts about their capacity (amendment 95).
- Requiring assessing doctors, where they consider it appropriate, to make enquiries or seek input from health, social care or social work professionals on the assessment of any relevant matter (amendment 69).

- Removing the requirement for nurses acting as authorised health professionals to assess the person's capacity at the time the approved substance is provided to them (amendment 77).

Main stage 2 amendments not agreed to

The main amendments not agreed to in relation to capacity were:

- People seeking assistance to die are presumed not to have capacity unless it is established by evidence beyond a reasonable doubt that they do have capacity (146).
- A presumption that people do not have capacity if their primary motivation for seeking an assisted death is one of a list of prescribed conditions. These conditions included eating disorders, intellectual disabilities and mood disorders (147).
- Training for doctors in the assessment of capacity (255).
- The inclusion of a requirement for people making a first declaration to also make an advanced care directive about their care wishes in the event they lose capacity before they are provided with the approved substance, become incapacitated due to the effects of the substance or choose not to use the substance (amendments 153, 156, 163 and 209).

Provision of Assistance

The Bill (as introduced)

Under the Bill (as introduced), once a person has made two declarations, undergone all of the required assessments and has both doctors' statements in place, they could be provided with an 'approved substance' to end their own life.

The substance could be provided by the coordinating doctor or an 'authorised health professional'. Authorised health professionals would include a doctor or registered nurse authorised by the coordinating doctor. The substance would be specified in regulations.

At the time the substance is provided, the doctor or nurse must be satisfied that the individual has the capacity to make the request and that they are doing so voluntarily and free from coercion or pressure from others.

The doctor or nurse providing the substance may be accompanied by any other health professional they think necessary. The Bill defines a health professional as a doctor, registered nurse or a registered pharmacist.

The doctor or nurse must remain with the individual until they decide to take the substance and, if they do, until the person has died. They would not need to stay in the same room.

If the person decides not to use the substance to end their own life, the doctor or nurse must remove it from the premises.

Stage 1 consideration

The Committee acknowledged Liam McArthur's emphasis on self-administration as central

to the Bill but highlighted concerns that, without clearer definitions, individuals with certain conditions or disabilities may face discrimination in accessing assisted dying.

The Committee also highlighted issues about the lack of clarity around what constitutes self-administration and the extent of permissible assistance from health professionals. Overall, the Committee stated the need for detailed guidance on self-administration and assistance to ensure clarity, safety, and protection for all involved in the assisted dying process.

The Committee noted the conflicting evidence around the potential for complications resulting from the approved substances and stressed the importance of ensuring any substances are properly authorised and licensed.

The Committee also noted perceived inconsistencies in the Bill regarding the presence of healthcare professionals in the room once the person has taken the approved substance. It was believed this could have implications for law enforcement and the Committee welcomed Liam McArthur's commitment to revisit this drafting.

Main stage 2 amendments agreed to

The main amendments agreed to in relation to the provision of assistance were:

- Allowing the doctor to prepare a medical device to let the person administer the substance themselves or allow the doctor to assist the person to ingest or otherwise use the substance. The provisions would not allow the doctor to administer the substance (amendment 10).
- A requirement that the coordinating doctor or authorised health professional will stay in the same room as the person until they have taken the substance (amendment 33).
- A requirement that the approved substance can only be supplied to the doctor or authorised health professional by a registered pharmacist (amendment 173).
- A requirement that where the approved substance is provided by a registered nurse, they must be accompanied by the coordinating doctor or another doctor acting as an authorised health professional (amendment 76).
- A requirement for nurses acting as an authorised health professional to be accompanied by another health professional if they stay with the person once they have taken the substance, or if the person decides not to take the substance and the nurse has to remove it (amendment 79).
- An avoidance of doubt provision to confirm that a person cannot administer the substance to another person (amendment 244).
- The addition of a regulation-making power in relation to assistance provided outwith the NHS, including the power to specify 'any settings or services where assistance must not be provided' (amendment 62).

Main stage 2 amendments not agreed to

The main amendments not agreed to in relation to the provision of assistance were:

- Requiring a doctor to intervene and take all reasonable steps to preserve life in situations where the substance has not had the intended effect (181).

- Requiring Scottish Ministers to prepare and publish guidance for doctors and health professionals on the provision of assistance, including what to do in the event of complications (268).

Death Certification

The Bill (as introduced)

Under the Bill (as introduced), if a person underwent an assisted death, their underlying terminal illness would be recorded as the cause of death on their death certificate, rather than the substance they took to end their life.

The Explanatory Notes to the Bill also state:

“ It is expected that the use of the approved substance will also be recorded on the death certificate.”

Stage 1 consideration

The Committee heard differing views on what should be recorded as the cause of death for assisted deaths, noting these views aligned with positions for or against the Bill.

It concluded that both the underlying illness and the approved substance should appear on the death certificate and, if the Bill progresses, further work would be needed - through amendments or guidance - to determine how best to achieve this.

Main stage 2 amendments agreed to

The only change made to this part of the Bill was to ensure that the approved substance is recorded as other relevant medical information on the death certificate (amendments 36, 37 and 38).

Main stage 2 amendments not agreed to

The only other amendments lodged in relation to this part of the Bill were to record the terminal illness as an underlying condition on the death certificate (amendment 246) and record the approved substance as the direct cause of death instead (amendment 247). These amendments were not agreed to.

Conscientious Objection

The Bill (as introduced)

The Bill (as introduced) sets out that no one is under any duty to participate in anything authorised under the Bill if they have a conscientious objection.

The Bill (as introduced) does not prescribe who the conscientious objection would apply to but the Policy Memorandum indicates that it would apply to doctors and other health professionals involved in the process.

The Policy Memorandum also describes conscientious objection in the following way:

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

The Bill (as introduced) goes on to say that in any legal proceedings, 'the burden of proof of conscientious objection is to rest on the person claiming to rely on it'.

Stage 1 consideration

The Committee heard significant amounts of evidence in relation to this part of the Bill and it was addressed in the stage 1 report under the following headings:

- **Scope of the conscientious objection clause**

The Committee heard differing views on the scope of the conscientious objection clause and stressed the need to balance protecting healthcare professionals with avoiding unnecessary barriers to assisted dying. Concerns were raised that the current wording lacks clarity, and legal stakeholders emphasised the importance of defining the clause clearly in the Bill rather than relying on secondary legislation. Correspondence highlighted potential challenges if senior officials, such as the responsible Minister or Chief Medical Officer, exercised conscientious objection. The Committee concluded that, if the Bill progresses, this part of the Bill must be revisited to ensure legal clarity and certainty for all parties.

- **Duty to refer/'No duty' clause**

The Committee considered suggestions by some stakeholders for the addition of a 'no duty' clause, which would allow practitioners who object to assisted dying to avoid referring patients to another practitioner. While some supported this, others warned it could create unreasonable barriers to access. Evidence from Victoria, Australia, suggests such clauses can make access more difficult compared to jurisdictions without them.

The Committee concluded that requiring objecting practitioners to either refer patients or provide additional information would strike a fair balance between practitioners' rights and patients' ability to access assisted dying.

- **'No detriment'**

The Committee noted evidence in support of a 'no detriment' clause within the Bill. Such a clause would protect healthcare staff from potential workplace discrimination as a result of not being involved in the assisted dying process. The Committee called on Liam McArthur to give the matter further consideration ahead of stage 2.

- **'Opt-in' versus 'opt-out'**

The Committee noted stakeholder support for an 'opt-in' model for healthcare staff participating in assisted dying and noted Liam McArthur's willingness to explore it further. However, it sought clarity on how it would work and assurance it would not create barriers to access. The Committee concluded that the concept merited further consideration at Stage 2.

- **Institutional objection**

The Committee heard mixed views on including a right to 'institutional objection' in the Bill. It agreed that, should the Bill progress, it needs clearer provisions on how institutions can reasonably act under its implementation.

Main stage 2 amendments agreed to

The main change to this part of the Bill was the removal of references to 'conscientious objection' and re-framing the Bill to refer to 'no duty to participate' (amendment 40). This means that staff would be able to choose not to participate on any grounds, not just as a matter of conscience. It was also clarified that the duty to not participate relates to 'direct' participation in the process (amendment 39) and reference to the 'burden of proof' being on the individual member of staff was also removed (amendment 41).

In addition, there were also amendments agreed to which would ensure that staff choosing not to take part in the process do not suffer any detriment (amendments 11 and 248). This would include ensuring no workplace discrimination, or adverse impact on employment, training or development (amendment 192).

Finally, the Bill was also amended to clarify that no doctor is under any duty to raise the topic of assisted dying with a person, but they can use their own professional judgement to decide if and when to discuss it (amendment 195).

Main stage 2 amendments not agreed to

The main amendments not agreed to in relation to conscientious objection were:

- The inclusion of an 'institutional objection' for care homes, hospices and other settings, alongside an accompanying 'no detriment' clause (amendments 16, 20, 52, 193, 249).
- Greater clarification on what 'participation' entails for the purposes of conscientious objection and the inclusion within this of any activities which would facilitate assisted dying (amendment 190).
- The creation of a register of doctors willing to participate in assisted dying (amendment 151).
- The creation of a register of psychiatrists eligible to undertake further psychiatric assessments (amendment 80).

Civil and Criminal Liability

The Bill (as introduced)

The Bill (as introduced) would exempt healthcare professionals from criminal and civil liability when they provide an eligible adult with assistance to end their own life, so long as the assistance complies with the Bill's provisions.

It would continue to be a criminal offence to end someone's life directly. There is also no change in the law for any action to assist dying outside of the process provided for in the

Bill.

The Bill would also make it an offence to coerce or pressure a terminally ill adult to make a first or second declaration.

A person found guilty of committing such an offence would be liable:

- On summary conviction to imprisonment of up to 2 years, or a fine not exceeding level 5 on the standard scale or both
- On conviction on indictment to imprisonment for up to 14 years or a fine, or both.

Stage 1 consideration

At stage 1, the Committee heard evidence of a range of concerns on the provisions of the Bill related to coercion, including:

- the definition of coercion,
- the process for assessing coercion,
- the capacity and capability of healthcare professionals to be able to assess coercion, and
- enforcement of the offence of coercion as set out in the Bill.

Main stage 2 amendments agreed to

The main changes agreed to on this part of the Bill included the addition of an offence of coercing or pressuring a terminally ill adult into taking an approved substance (amendment 42).

The Bill was also amended to make it an offence to publish, distribute or display any advertisement, notice or material which would promote, encourage or solicit the provision of assisted dying to a terminally ill adult (amendment 252).

Main stage 2 amendments not agreed to

The only amendment on this part of the Bill that was not agreed to was a provision requiring regulations to specify training in identifying coercion, pressure or undue influence (amendment 225).

Reporting, monitoring and review

The Bill (as introduced)

The Bill (as introduced) would place a duty on Public Health Scotland (PHS) to submit a report to Scottish Ministers on the provision of assisted dying in Scotland.

This report would need to include the number of:

- people who made a first declaration

- people who made a second declaration
- people who made a second declaration but decided not to be provided with an approved substance
- people who were provided with an approved substance and died as a result
- statements made by registered medical practitioners which concluded the person was eligible to be provided with assistance
- statements made by registered medical practitioners which concluded the person was not eligible to be provided with assistance
- people who made a first declaration but did not go on to make a second declaration
- people who made a second declaration but did not go on to be provided with an approved substance
- people who were provided with an approved substance but did not go on to use it.

For those who use the approved substance, PHS must also report the substance provided, place of death (e.g., home, hospital, care home), and the person's reasons for ending their life. PHS must also collect anonymised demographic data and publish annual reports to the Scottish Government, which will be laid before Parliament.

The Bill empowers Scottish Ministers to set regulations on what information is provided, by whom, and when, including prohibitions on disclosure and penalties for breaches (up to £5,000).

The Scottish Government must also review the legislation within five years and report to the Scottish Parliament on its effectiveness and any concerns, taking account of PHS annual reports.

Stage 1 consideration

The Bill's provisions on reporting and monitoring were generally welcomed by stakeholders during stage 1 and recognised as being important. However, several areas of improvement were suggested in the following areas:

- Categories of data being collected.
- Processes for collecting information.
- Time-frame for review.

The Committee heard calls for collecting additional information during the review process but stressed in its stage 1 report that any extra data must have a clear purpose and be directly relevant. It also highlighted the importance of allowing enough time to gather meaningful data before reviewing the legislation, noting that while the Bill sets a five-year review period, an earlier review could be initiated if necessary.

Finally, the Committee acknowledged proposals for a sunset clause, which would require Parliament to vote for the Bill's continuation after a set period, but made no comment on the merits of such a clause.

Main stage 2 amendments agreed to

The main amendments agreed to on this part of the Bill include:

- A requirement that the coordinating doctor must record in the adult's medical records, any complications or adverse events resulting from taking the approved substance (amendment 183).
- A requirement that an anonymised report must be submitted to Public Health Scotland in the event of complications or an adverse event (amendments 183 and 184).
- Scottish Ministers must carry out an assessment of the impact of the Act on hospices and palliative/end of life care providers and publish a report (amendment 54).
- Following the publication of the report assessing the impact of the Act on hospices and palliative/end of life care, Ministers must prepare and publish a code of practice about the interaction between assisted dying and these services (amendment 55).

Main stage 2 amendments not agreed to

The main amendment not agreed to in relation to the reporting, monitoring and review of the provisions were:

- A requirement for Scottish Ministers to assess the capacity of social services once the Bill receives Royal Assent and prepare and publish a report to be laid before the Scottish Parliament (amendment 258).
- A requirement to hold a referendum on the Act's provisions after it receives Royal Assent (amendment 259).
- A requirement for Scottish Ministers to commission an independent review of the financial implications and operation of the Act (amendment 260).
- The creation of a Scottish Commission on Assisted Dying to keep the operation of the Act under review and report to the Scottish Parliament (amendment 18). A similar amendment on the creation of an Assisted Dying and Oversight Body was also not agreed to (amendment 199).
- The inclusion of 3 year, 5 year, 10 year and 15 year sunset clauses (amendments 218, 14, 272 and 272).
- Various amendments with suggestions for data to be collected or reviewed (e.g. amendments 21, 22, 202, 203).

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