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Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 3 Proceedings

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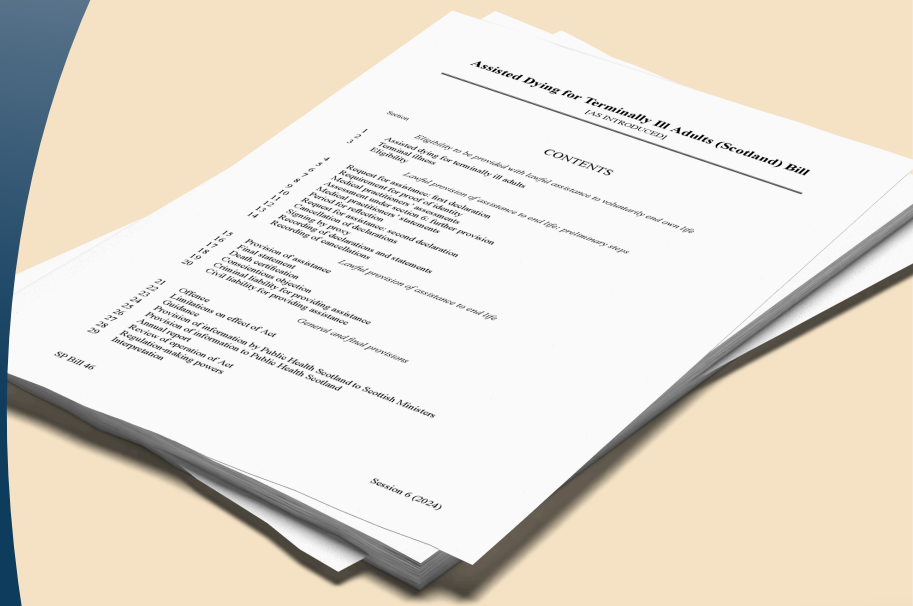
This briefing summarises the Assisted Dying for Terminally Ill Adults (Scotland) Bill (as amended at stage 2) before discussing the main changes made at stage 3 and key amendments not agreed to.



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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 Bill's key documents can be found on the Scottish Parliament Bill page.

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.

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.

The Committee also considered the Scotland Act 1998 (Modification of Schedule 5) Order 2026 [draft] which would give the Scottish Parliament limited competence to legislate in relation to the identification and regulation of substances and devices for use in assisted dying. The Committee reported on the order on 2 February 2026 and recommended the draft order be approved.

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

Stage 3 Proceedings

Stage 3 amendments to the Bill were considered by the Scottish Parliament over four sittings on 10-13 March 2026:

- 10 March 2026 Official Report
- 11 March 2026 Official Report
- 12 March 2026 Official Report
- 13 March 20206 Official Report

The following briefing:

- summarises the Bill's provisions as amended at stage 2,
- details the main changes agreed to at stage 3,
- summarises the main amendments that were not agreed to at stage 3.

For more detail on stages 1 and 2 of the Bill, please see the following SPICe briefings:

- Assisted Dying for Terminally Ill Adults (Scotland) Bill - the Bill as introduced
- Assisted Dying for Terminally Ill Adults (Scotland) Bill: A summary of stage 2 proceedings

Other SPICe briefings on the Bill include:

- 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

A SPICe blog explaining section 30 and section 104 orders under the Scotland Act 1998 was also produced:

- Explainer: Orders made under section 30 and section 104 of the Scotland Act 1998

The marshalled list of amendments for stage 3 is available on the Scottish Parliament website, alongside the groupings for debate:

- Marshalled list of amendments for stage 3
- Groupings of amendments for stage 3

The final version of the Bill is available on the Scottish Parliament website:

- Assisted Dying for Terminally Ill Adults (Scotland) Bill - As amended at stage 3

Eligibility

The Bill as amended at stage 2

To qualify for assisted dying under the Bill (as amended at stage 2), a person must be:

- an adult aged 18 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.

Having a disability and/or a mental health condition does not, by itself, count as being terminally ill.

Main amendments agreed to at stage 3

The Bill was amended at stage 3 to add a 6-month prognostic timescale to the eligibility criteria (amendment 2).

In order to be eligible for assistance under the Bill now, the terminally ill adult must also 'reasonably be expected to die within 6 months'.

Main amendments not agreed to at stage 3

Other amendments to eligibility which were not agreed to included:

- Excluding pregnant women from being eligible for assisted dying (amendment 137).
- Requiring the person to have been offered and have access to a fully costed palliative care plan (amendment 138).
- Requiring people seeking an assisted death to have been offered and have access to psychological support, and excluding those who had previously been screened or treated for suicidal thoughts or self harm (amendment 139).
- Requiring people with learning disabilities seeking an assisted death to have specialist input around the meaning of an assisted death, including the irreversible nature of it, other means of support available and how an assisted death might impact on other people (amendment 140).
- Excluding people from having an assisted death where their decision is influenced by factors such as financial hardship, social isolation and loneliness, feelings of being a burden, relationship breakdown, domestic abuse, inadequate housing, bereavement/ grief, untreated mental illness, discrimination, intellectual disabilities, Down Syndrome and Autistic Spectrum Disorder (amendment 141).

Coercion

The Bill as amended at stage 2

In order to be eligible for assistance under the Bill (as amended at stage 2), the assessing doctors must be satisfied that the person has made the decision voluntarily and free from undue influence.

An assessment of possible coercion should form a part of the assessments of both the coordinating doctor and the independent doctor. They then must make a statement that they are satisfied the person has made the decision voluntarily and has not been coerced or pressured by any other person before they can be deemed eligible for assistance.

An assessment of coercion must also take place by the doctor(s) in attendance at the time the approved substance is provided.

The Bill makes it an offence to coerce or pressure a terminally ill adult into making a first or second declaration, or to coerce or pressure them into taking an approved substance.

A person convicted of such an offence is liable:

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

Main amendments agreed to at stage 3

Several amendments at stage 3 removed references to coercion or pressure 'by any other person', thereby recognising pressures not tied to a specific individual but rather any form of pressure, including those that may be indirect or internal (amendments 24, 25, 35, 36, 41, 76, 77 and 80).

A series of amendments also expanded on what doctors must do when confirming that a request is voluntary and free from coercion:

- A requirement for doctors to enquire about and discuss indirect pressures affecting the person's ability to decide freely (amendment 27).
- A requirement for doctors to discuss potential coercion or pressure, including feelings of being a burden or financial pressures (amendment 158).
- A requirement for doctors to consider professional guidance on decision-making, including the impact of indirect pressures and other pressures affecting free choice (amendment 33).
- The introduction of a structured assessment of voluntariness at the second declaration stage, requiring an assessment to be conducted in private and to take any steps to address any factors which affect the person's ability to express themself freely. The doctor must explore direct, indirect, and internal forms of coercion, explore and mitigate any concerns identified and confirm that the person's wish is settled, enduring, and autonomous (amendment 93).

- The statements from both doctors must now say that the person is seeking an assisted death as a result of their terminal illness and not for any other reason (amendment 177 and 180).

An amendment was also agreed to which defined 'indirect pressures' as including self‑perception, societal expectations, or an absence of adequate health/care services to meet the person's needs (amendment 160).

Main amendments not agreed to at stage 3

Amendments not agreed to included:

- Provisions specifying a broader range of potential pressures and influence, including dependency, family or caring relationships, financial circumstances, care arrangements, feelings of being a burden and unmet palliative or social care needs (amendments 151, 152, 172, 175 and 178).
- Changes to the assessment process, including additional enquiries or consultation with safeguarding or coercive-control specialists (amendment 172).
- A requirement that both doctors should seek advice from a panel of experts appointed by Ministers. The panel would have included a palliative care doctor, a psychiatrist or expert in assessing capacity, and a social worker with experience in adult care and social support (amendment 181).
- The establishment of independent assessors for assessing coercion (amendment 174).
- An attempt to reduce the prison term on summary conviction for coercion from 2 years to 12 months (amendment 50).

Capacity

The Bill as amended at stage 2

To be eligible for assisted dying, the person must have the capacity to make the request for an assisted death. The Bill (as amended at stage 2) 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 the Bill in accordance with the Mental Health (Care and Treatment)(Scotland) Act 2003. This is set out in s328 of the 2003 Act as:

> “ **328 Meaning of “mental disorder”** (1) Subject to subsection (2) below, in this Act “mental disorder” means any— (a) mental illness; (b) personality disorder; or (c) learning disability, however caused or manifested; and cognate expressions shall be construed accordingly. (2) A person is not mentally disordered by reason only of any of the following— (a) sexual orientation; (b) sexual deviancy; (c) transsexualism; (d) transvestism; (e) dependence on, or use of, alcohol or drugs; (f) behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; (g) acting as no prudent person would act.”

The person is required to have capacity at each step of the process, including at the point where assistance is given.

The Bill requires that if the assessing doctors have any doubts about the person's capacity, then they must refer the person to a psychiatrist or someone who specialises in assessing capacity.

The assessing doctors, where they consider it appropriate, can also make enquiries or seek input from health, social care or social work professionals on the assessment of any relevant matter.

Nurses acting as authorised health professionals under the Bill, no longer have to assess the person's capacity at the time the approved substance is provided. This would now only be carried out by registered medical practitioners.

Main amendments agreed to at stage 3

The Bill now requires an assessing doctor to obtain a statement from the relevant local authority as to whether the person is being supported under:

- the Social Work (Scotland) Act 1968,
- the Adult Support and Protection (Scotland) Act 2007,
- the Adults with Incapacity (Scotland) Act 2000, or
- the Mental Health (Care and Treatment) (Scotland) Act 2003.

Where the statement indicates that the person is deemed unable to protect their own interests, or where the assessment indicates undue influence, the practitioner would be required to refer the person for assessment by a registered social worker (amendment 171).

In addition, the assessing doctors must now produce an accompanying statement setting out the nature of their relationship with the person seeking assisted dying and their assessment of the person's eligibility and capacity, including the steps they have taken to establish capacity (amendment 183).

Main amendments not agreed to at stage 3

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

- Requiring referral to a psychiatrists as a matter of course as opposed to only when there are doubts about capacity (amendment 163).
- Requiring assessing doctors to refer someone under the age of 25 to social work or

mental health services where there are concerns about capacity (amendment 170).

- The creation of a panel of experts to advise assessing doctors on assessing capacity, voluntariness, eligibility and absence of coercion (amendment 181 and 186).
- A requirement that immediately prior to the provision of the substance, the doctor present should carry out and document a structured, in-person assessment which establishes, on the balance of probabilities, that the adult has capacity. This would have replaced the original requirement that the practitioner be satisfied the person has capacity at that point(amendment 211).

The Process

The Bill as amended at stage 2

The process in the Bill (as amended at stage 2) includes the following steps:

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

The assessment process aims to ascertain the person seeking assistance is a terminally ill adult who meets the eligibility criteria, has been provided with or offered appropriate social care, made the declaration voluntarily and has not been coerced or pressured by any other person into making it.

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 the specialist's opinion.

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.

A doctor who is unwilling or unable to act as the coordinating doctor must direct the

terminally ill adult to another doctor or to relevant information (see also Participation and Protection for Staff). Health professionals would be prohibited from raising the topic of assisted dying with people under the age of 18.

Both doctors must enquire about - and discuss with the person - their reason for seeking an assisted death.

During the assessment, doctors must ascertain whether the person has been provided with or offered appropriate social care and, where they consider it appropriate, consider consulting health, social care, or social work professionals involved with the person. They may also consider seeking input from health, social care or social work professionals on any matter they have expertise in which is relevant to the person being assessed.

During the assessment, doctors must explain and discuss (as far as they consider it appropriate) the following matters with the person:

1. the person's diagnosis and prognosis,
2. any treatment available and the likely impact of it on the person's terminal illness,
3. any palliative, hospice or other care available, including symptom management and psychological support,
4. the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death),

They must also inform the person:

1. of the further steps that must be taken before assistance can be given to end their own life,
2. that they may decide at any time not to take those steps, including how to cancel the first declaration and any further steps,
3. that they may request to be referred for assessment by a registered social worker and the potential benefits of receiving such an assessment,
4. that they can be referred for a palliative care assessment to explore whether any additional support could be provided to them.

Main amendments agreed to at stage 3

The main amendments to the process made at stage 3 included:

- The introduction of an advance care directive option at the first declaration stage, allowing adults to outline wishes for future care, including: if they lose capacity before receiving assistance, lose capacity due to the effects of the approved substance or if they choose not to proceed (amendment 149). Doctors must inform people that they can make such a directive (amendment 159).
- Giving the terminally ill adult making a first declaration, the option to request a palliative care support plan. This should be provided in line with minimum regulatory requirements set by Ministers (amendment 150).
- Requiring the coordinating doctor to assess whether the person has been offered or

provided appropriate palliative care (amendment 23).

- Requiring both doctors to have met the adult in person and on more than one occasion (amendment 153).
- Requiring doctors to discuss palliative care options with the individual, ensuring understanding and recording the discussion (amendment 154).
- Removing the doctor's discretion to discuss with the person: their diagnosis, prognosis, available treatment and likely impact, palliative and end-of-life care options, and the nature of the substance that would be provided and how it would bring about death. All of these subjects must now be discussed with each individual (amendment 28).
- Making it mandatory, rather than discretionary, that the doctor advises the person seeking an assisted death to inform their medical practice and discuss the request with those close to them (amendment 32).
- Requiring doctors to involve social work and psychiatry where the person being assessed is under 25 and they have a condition that is of a fluctuating nature and with an unpredictable prognosis (amendment 164).
- Requiring referral to a palliative care specialist where appropriate palliative care has not been offered or provided (amendment 165) or where the person cites uncontrolled or feared uncontrolled symptoms as part of their reasons for seeking an assisted death (amendment 166). A person would be allowed to decline referral to a palliative care specialist without losing eligibility for assisted dying (amendment 167) but a doctor may take this refusal into account when deciding whether to make a statement (amendment 168).
- Requiring doctors to consider and advise (where they consider it appropriate) on the option of referral to social work or mental health services as part of the assessment process (amendment 169).
- Requiring doctors to request a local authority statement as to whether the person is supported under social work, incapacity, mental health or adult support and protection legislation (amendment 171).
- A requirement for detailed written records of all enquiries, discussions, explanations, referrals, information and advice given, and clinical reasoning or justifications for decisions, to be retained for 10 years and available to regulatory or oversight bodies (amendment 173).
- Requiring the coordinating doctor's statement to confirm that the person has been offered or provided with social care and palliative care relevant to their terminal illness (amendments 34A and 34).
- Requiring both doctors to prepare a report detailing assessment information and reasoning, signed and recorded in medical records (unless the declaration is cancelled) (amendment 37).
- Enquiries made of other professionals during an assessment must be included in the adult's medical records (amendment 95).

- All steps related to making a second declaration must be conducted in person, not remotely (amendment 188).
- Doctors must enquire into and record the adult's reasons for seeking an assisted death (amendments 79 and 81) and these reasons should be recorded (amendment 85).

Main amendments not agreed to at stage 3

The main amendments to the process not agreed to at stage 3 included:

- Preventing a doctor from acting as the independent doctor if they had discussed the case with, or seen assessment notes from, the coordinating doctor (other than administrative referral details) (amendment 155).
- Requiring the doctor to make enquiries of at least one health professional with qualifications and experience in the person's condition (amendment 157).
- Requiring doctors to inform the person that, if provided with an approved substance, it would be for them to decide if and when to use it (amendment 29).
- Requiring referral to a specialist experienced in the person's terminal illness in all cases, not just when there is diagnostic or prognostic uncertainty (amendment 161).
- Requiring routine referral to a psychiatrist, rather than only when there are doubts about capacity (amendment 163).
- Requiring doctors to refer adults under 25 to social work or mental health services where concerns existed about capacity, fluctuating or unpredictable diagnosis, safeguarding issues, communication needs, experience of multiple disadvantage or deprivation and limited support (amendment 170).
- Requiring a doctor who determined that a person was not eligible to issue a formal statement explaining their reasoning, share it with the person, and prevent any new assessments for 12 months (amendment 184).
- Requiring Scottish Ministers to establish an independent expert panel to advise doctors, with mandatory referral where there was uncertainty about capacity, concerns about coercion or mental disorder, or other circumstances set by regulations (amendment 186).
- Requiring the coordinating practitioner to notify the person's GP practice of declarations or statements, allowing other involved professionals to record disagreement and triggering a mandatory review by an independent panel before the process could continue (amendment 196).
- Requiring that failure to record a cancellation within seven days constitutes a professional breach, prompting regulatory review and a written apology to the person, with guidance from Ministers on handling such failures (amendment 197).

Signing by Proxy

The Bill as amended at stage 2

A person may have someone else ('a proxy') sign their first or second declaration if they cannot sign it themselves - for example, because of a physical impairment or difficulty reading - and if they authorise that person to sign on their behalf.

The proxy must sign in the person's presence and include their own name, address, the capacity that qualifies them to act as a proxy, and a statement confirming they are signing in that role. When these steps are followed, the declaration is legally treated as though the person signed it themselves.

To qualify as a proxy, the person must be an adult who has known the individual for at least two years or who falls into a category authorised by Scottish Ministers through regulations.

A proxy has to be satisfied that the person understands what the declaration means. Certain individuals are disqualified from acting as a proxy by Schedule 5 of the Bill or, in the case of a second declaration, if they acted as a witness for the first declaration. Disqualified individuals are:

- the person's spouse, civil partner or cohabitee,
- the person's parent or grandparent and any spouse, civil partner or cohabitee of that parent or grandparent,
- the parent of the person's spouse, civil partner or cohabitee and any spouse, civil partner or cohabitee of that parent,
- the person's child or grandchild and the spouse, civil partner or cohabitee of that child or grandchild,
- the person's brother, sister, nephew or niece and the spouse, civil partner or cohabitee of that brother, sister, nephew or niece,
- the person's aunt, uncle or cousin, the child of that cousin and any spouse, civil partner or cohabitee of that aunt, uncle, cousin or cousin's child,
- anyone who will gain financially in the event of the person's death whether directly or indirectly and whether in money or money's worth,
- any health professional who has provided treatment or care for the person in relation to that person's terminal illness.

Main amendments agreed to at stage 3

The main amendment to this part of the Bill was changing the requirement for a proxy to be satisfied the person understands its nature and effect, to requiring them to read the declaration aloud to the person (amendment 94).

This was changed on account of concerns from the Law Society of Scotland that the previous provision could imply the need for more extensive assessment and be open to legal challenge.

Main amendments not agreed to at stage 3

The main amendment not agreed to in relation to signing by proxy, was the requirement for the proxy to sign the declaration in the presence of a practising solicitor (amendment 192).

Advocacy

The Bill as amended at stage 2

Individuals who are considering requesting assistance to end their own life have a right to access independent advocacy if they need help to do so effectively and safely. Scottish Ministers must ensure that these advocacy services are available whenever required.

Advocacy support can include emotional, legal, and procedural guidance; helping safeguard the person's rights, autonomy, and well-being; preventing undue influence; and ensuring that all decisions are voluntary.

To count as independent, advocacy must be provided by someone who is not previously known to the individual or their family and is not involved in their care.

Providers of independent advocacy must meet advocacy service standards, which will be set through regulations by the Scottish Ministers. These standards may cover required training and experience, service quality, quality-assurance processes, and record-keeping.

Main amendments agreed to at stage 3

- Narrowing access to independent advocacy so that it applies to individuals who wish to be lawfully provided with assistance, rather than those merely considering it (amendment 199).
- Replacing 'require' with 'request' so that access to advocacy is based on an individual's request (amendment 200).
- Clarifying that advocacy supports individuals with the steps required before assistance can be lawfully provided (amendment 201).
- Revising the definition of 'advocacy services' to align it with the new wording focused on support with steps required prior to lawful assistance (amendment 203).
- Removing the illustrative list of what advocacy services may include (amendment 204). This has been replaced with a provision requiring guidance to be produced on advocacy services (amendment 259).
- Requirement that any agreement for advocacy services must include a term ensuring compliance with advocacy service standards (amendment 206).

Main amendments not agreed to at stage 3

The main amendment on advocacy not agreed to was the establishment of an Independent Advocacy Oversight Body responsible for accrediting all advocacy providers, monitoring and auditing services, and ensuring their independence (amendment 207).

Scottish Ministers would have been required to fully fund the Advocacy Oversight Body to carry out its functions effectively and any person providing advocacy services under the Act would need to have been accredited by the Advocacy Oversight Body.

The Advocacy Oversight Body would also have been require to create and maintain an accreditation scheme and keep records of monitoring and auditing activities, including aggregate data on service provision, compliance and interventions. The body would have been permitted to issue guidance to providers.

The Advocacy Oversight Body would also have been required to publish an annual report summarising findings, actions taken and compliance with accreditation standards.

Participation and Protection for Staff

The Bill as amended at stage 2

The Bill was amended at stage 2 to reframe section 18 on 'Conscientious Objection' to state that no individual is 'under any duty to participate'.

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 participation relates to 'direct' participation in the process and the requirement for the 'burden of proof' being on the individual member of staff was removed.

A doctor who is unwilling or unable to act as the coordinating doctor must direct the terminally ill adult to another doctor or to relevant information.

The Bill would also require that staff choosing not to take part in the process do not suffer any detriment. This would include ensuring no workplace discrimination, or adverse impact on employment, training or development.

The Bill also states 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.

Training and Guidance

The Bill (as amended at stage 2) requires 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. These regulations must be consulted on before being laid before the Scottish Parliament.

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

Main amendments agreed to at stage 3

The most significant amendments to this part of the Bill were the removal of the provisions

around conscientious objection (amendment 107) and the removal of the power for Ministers to regulate the training and qualifications of staff involved in assisted dying (amendments 86, 87, 88, 89, 120, 121, 123, 125).

These amendments were lodged by the Member in Charge of the Bill in collaboration with the Scottish Government. They aim to address concerns that such matters stray into areas reserved under the Scotland Act 1998, namely the regulation of health professions and employment protections (under Heads G2 and H1 of Schedule 5 of the 1998 Act).

This part of the Bill is now being pursued through a section 104 order under the Scotland Act 1998.

Section 104 orders allow the King or a UK Government Minister to make secondary legislation considered “necessary or expedient in consequence of any provision made by or under an Act of the Scottish Parliament” or through Scottish secondary legislation. Section 104 orders are considered by the UK Parliament and are usually brought into force after the enactment of a Scottish Parliament Bill, but before its commencement. [1]

The UK Under-Secretary of State for Scotland, Kirsty McNeil MP, wrote to the Scottish Affairs Committee of the House of Commons on 9 March 2026 to state that the UK Government agrees in principle with taking forward a section 104 order and - if the Bill passes - it will work with the Scottish Government on the legislation. [2]

The letter goes on to say:

> “ It is important to note the complexity of these matters and the detailed policy and legal work that would be required from both governments. This will require further consideration and analysis by respective officials. In view of that, and in recognising the final outcome of any Bill will need to be considered, the UK Government is not yet in a position to agree to the specific form of the Section 104 Order.”

Amendments were agreed to which would ensure that any commencement of the provisions of the Bill (if passed) could not take place until provision has been made under a section 104 order for specific purposes relating to the training, qualification and experience of health professionals, and protections relating to participation and no detriment (amendments 133 and 133A).

Main amendments not agreed to at stage 3

Other amendments on this part of the Bill which were not agreed to included:

- The creation of an 'opt-in register' of professionals willing to be trained and involved in assisted dying (amendment 142).
- The insertion of an institutional objection or 'no duty to participate' for care providers such as hospices, care services, independent healthcare services or any other institution specified by Ministers (amendments 117, 229, 232) or for wider establishments such as educational facilities and charities (amendment 231).
- The creation of a register of psychiatrists qualified and experienced in undertaking capacity assessments in the context of assisted dying (amendments 7, 8 and 20).
- The extension of the 'no duty to participate' provision to wider categories of staff such

as administration staff, receptionists, volunteers and delivery personnel (amendment 226).

- Clarification that the 'no duty to participate' includes referring, directing or signposting the person to another individual or organisation (amendment 227).
- The insertion of provisions that no individual or organisation should suffer any adverse consequences, coercion or pressure as a result of conscientious objection, and examples of what might constitute coercion and pressure (amendments 228 and 230).
- Amendments around raising assisted dying with a patient (amendments 18, 233, 234).

Some of these amendments may have been rejected due to concerns about legislative competence, rather than policy concerns.

Provision of Assistance

The Bill as amended at stage 2

Once a person has made two declarations, undergone all of the required assessments and has both doctors' statements in place, they could then request to 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' and must be supplied by a registered pharmacist. 'Authorised health professionals' would include a doctor or a registered nurse authorised by the coordinating doctor. Where the substance is provided by a registered nurse, they must also be accompanied by a doctor.

The substance would be specified by Scottish Ministers in regulations. Due to the reserved nature of medicines (under Head J4 of the Scotland Act 1998) the Scottish Government pursued the necessary powers via a section 30 order from the UK Government and this was approved by the Scottish Parliament.

The Scotland Act 1998 (Modification of Schedule 5) Order 2026 (SI 2026/276) was made on 10 March 2026 and came into force on 11 March 2026.

At the time the substance is provided, the doctor(s) present 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 substance must be self-administered by the person and no-one can administer the substance to another person.

While the substance must be self-administered, the coordinating doctor may:

> “ (a) prepare that substance for use by the adult, (b) prepare a medical device which will enable the adult to use the substance, (c) assist the adult to ingest or otherwise use the substance.”

The doctor and/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 be required to stay in

the same room after the substance has been taken.

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

Where a nurse stays with the person until they have taken the substance, or they have to remove the substance, the nurse must be accompanied by another health professional.

The Bill also gives Ministers 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.

Main amendments agreed to at stage 3

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

- Allowing Scottish Ministers to set requirements, via regulations, on when only an approved device may be used in connection with assisted death (amendment 97).
- The insertion of a new section empowering Scottish Ministers to identify 'approved substances' and 'approved devices' via regulations, with consultation and Secretary of State approval required (amendment 110).
- The insertion of a new section enabling the Secretary of State to make regulations concerning the supply, storage, record-keeping, manufacture, monitoring and enforcement relating to approved substances and devices, subject to affirmative procedure in both Houses of Parliament (amendment 111)
- Removing the requirement that an approved substance must only be supplied by a registered pharmacist (amendment 98). This reflects the availability of other supply routes.
- Adding that an authorised health professional, as well as the coordinating doctor, may provide an approved substance (amendment 42).
- Adding the provision of information or instructions about the use of the approved substance or device to what the coordinating doctor is allowed to do (amendment 216).
- Removing the requirement that, where nurses are acting as authorised health professionals, they must be accompanied by another health professional (amendment 10). This is replaced with a requirement that they must be accompanied by the coordinating doctor or another authorised health professional who is a doctor (amendment 11).
- Requiring the coordinating doctor or authorised health professional to remain physically present in the room from the point the substance is used until the person dies, or until it is clear the substance has not been fully taken and there is no risk from partial ingestion. They must also monitor the person and respond to signs of distress or complications (amendment 220).
- Clarification that complications, adverse reactions or unintended effects must be recorded in the adult's medical records (amendments 13 and 14).
- Removal of the requirement for an anonymised report of complications or adverse

reactions to be submitted to Public Health Scotland (amendment 15).

- Requiring the coordinating practitioner to include detailed information about the substance used in the final statement, including name, manufacturer, batch number, quantity, and method/date of administration (amendment 224).

Main amendments not agreed to at stage 3

The main amendments on the provision of assistance not agreed to at stage 3 were:

- Requiring the assessing doctor to ensure the person is fully informed, both orally and in writing and in a manner suited to their circumstances, about potential side-effects, risks, possible complications, the chance of prolonged or failed dying, unpredictability of responses, and limits of current evidence, and to be satisfied that the person has understood this information before proceeding (amendment 90).

- Requiring the doctor to record in the medical records that the specific risks and side-effects have been discussed, any questions asked by the person, and the reasons for concluding the person understood the information (amendment 96).

- Changing the requirement that the doctor or authorised health professional provides the approved substance, to a requirement that they must be present for the provision of the substance but might not necessarily provide it (amendment 210).

- Requiring the coordinating doctor to carry out and document an in-person, structured assessment immediately prior to provision of the substance, establishing on the balance of probabilities that the person has capacity and is acting voluntarily (amendment 211).

- Requiring voluntariness and absence of coercion to be confirmed by a third doctor who was not involved in the earlier assessments and who must attest to this in writing (amendment 212).

- A 'for the avoidance of doubt' provision, clarifying that nothing authorises any practitioner to physically assist a person to ingest or use the substance (amendment 213).

- Prohibiting the coordinating doctor from touching, activating, positioning, or physically manipulating the substance or device at the point of ingestion or use (amendment 217).

- Expanding requirements for removing an unused substance so it must be immediately secured and taken away, ensuring it is not left unattended, arranging for its return or destruction, and recording these actions (amendment 99).

- Adding registered pharmacists to the definition of “authorised health professional” for the purposes of providing assistance under the Bill (amendment 221).

- Requiring Scottish Ministers to make regulations on the management of cases where a person has taken the substance but not died within the expected time-frame (amendment 44).

- Creating a new duty for the coordinating doctor to report complications, adverse reactions or unintended effects to Public Health Scotland within time-frames set in

regulations, with Public Health Scotland using the data for monitoring and annual reporting (amendment 106).

Provision of Assisted Dying Services

The Bill as amended at stage 2

The Bill does not set out a specific service model for assisted dying and there has been discussion and debate throughout the Bill's passage around the best way to provide assisted dying services.

Some commentators have argued for a stand-alone service, while others would rather see assisted dying services integrated into the NHS.

Main amendments agreed to at stage 3

The Bill was amended at stage 3 to insert new provisions giving Scottish Ministers powers to organise and integrate assisted‑dying services within existing NHS structures (amendment 74).

This allows Ministers to make arrangements for the delivery of an assisted‑dying service and to modify existing health‑service legislation where necessary so that lawful assisted‑dying processes can operate alongside current NHS systems.

Other amendments agreed to included requiring regulations on the provision of assistance outwith the NHS to specify the settings or services where assistance must not be provided (amendment 240).

Main amendments not agreed to at stage 3

Amendment 250 sought to require NHS boards to set up a specialist assisted dying service for the area covered by the board. This amendment was not moved.

Amendment 293 also sought to establish an Assisted Dying Review panel to review each case where an adult was provided with assistance and assess whether or not the provisions of the legislation were complied with. This amendment was not agreed to.

Death Certification

The Bill as amended at stage 2

Where someone had undergone an assisted death, the Bill would require the underlying terminal illness to be recorded as the cause of death on the death certificate. The approved substance would also have to be recorded under the 'other relevant medical information' part of the certificate.

Main amendments agreed to at stage 3

The Bill was amended to remove the provisions requiring the substance to be recorded on the Medical Certificate of Cause of Death (MCCD) as 'other relevant medical information'.

This was replaced by a provision requiring the MCCD to refer to both the terminal illness and the use of an approved substance under causes of death (amendments 45, 46 and 47).

Main amendments not agreed to at stage 3

Amendment 225 sought to remove the provision that requires the use of the approved substance to be recorded on the MCCD as 'other relevant medical information' and replace it with a requirement to include a statement on the death certificate recording that the death resulted from assistance in ending the adult's life, including the use of the approved substance. This amendment was pre-empted by amendment 47 which was agreed to.

Civil and Criminal Liability

The Bill as amended at stage 2

The Bill (as amended at stage 2) would exempt anyone providing lawful assistance under the Act from criminal and civil liability.

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.

The Bill also makes it an offence to publish, distribute or display any advertisement, notice or material which promotes, encourages or solicits the provision of assisted dying to a terminally ill adult.

A person guilty of such an offence is liable:

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

Main amendments agreed to at stage 3

The main amendment agreed to in relation to civil and criminal liability was replacing the existing offence on the advertising of assisted dying, with a new regulation making power for Scottish Ministers to detail the offences, exceptions, defences and penalties relating to this offence (amendment 52).

Main amendments not agreed to at stage 3

The main amendments not agreed to included:

- Avoidance of doubt provisions to make clear that the protections from civil and criminal liability do not apply to any assistance provided after an approved substance has been provided and the person has not died as a result of using that substance i.e. they do not extend to any acts of assistance once it is clear the substance has not resulted in the person's death (amendments 108 and 109).
- An amendment seeking to set out the limits of what counts as lawful assistance under the Bill and that nothing in the Bill permits any person to carry out an act which in itself brings about death. Any person who performs such an act should be treated under criminal law as having caused the death, regardless of whether consent was given (amendment 236).
- Clarification as to what counts as 'lawful assistance' for the purposes of protection from civil liability. That is, protection from civil liability only applies if the professional has followed every legal and procedural requirement in the Bill, including all declarations, assessments, records, reports and ministerial guidance (amendment 237).
- Changes to the penalties on summary conviction for coercion. Namely, changing 2 years imprisonment with 12 months (amendment 50).

Reporting, Monitoring and Review

The Bill as amended at stage 2

The Bill (as amended at stage 2) places 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.

Scottish Ministers must also carry out an assessment of the impact of the Act on hospices and palliative/end of life care providers and publish a report. Following the publication of this report, Ministers must prepare and publish a code of practice about the interaction between assisted dying and palliative/end-of-life care services.

The coordinating doctor must record in the adult's medical records, any complications or adverse events resulting from taking the approved substance and an anonymised report must be submitted to PHS in the event of complications or an adverse event.

Main amendments agreed to at stage 3

The main amendments agreed to at stage 3 in relation to reporting, monitoring and review were:

- Requiring the impact assessment on palliative and end-of-life care services to be carried out on an ongoing basis, with reports produced after the first year and every three years thereafter (amendments 251, 253, 254).
- Requiring Ministers, when assessing impact, to consider charitable and non-statutory funding streams for palliative and end-of-life care (amendment 252).
- Requiring publication of the impact assessment within six months of each assessment being completed (amendment 253).
- Expanding the statutory review of the Act to report on how fully practitioners have taken required assessment steps, whether documentation requirements have been met, the availability of required information, and the operation of safeguards (amendment 117).
- Requiring the statutory review to report on how the code of practice has supported hospices and palliative-care providers, and whether further action is needed (amendment 118).
- Requiring the statutory review to include Ministers' assessment of the availability, quality and distribution of palliative-care services, access to information about such services, and the Act's implications for palliative-care provision (amendment 299).
- Requiring periodic detailed reviews of a representative sample of assisted-dying cases to inform annual and three-yearly reviews (amendment 278).
- Requiring PHS to report the number of assessments carried out, including how many

found a person eligible or ineligible (amendment 57).

- Requiring PHS to report the number of people aged 18 or under who requested assistance (amendment 280).
- Requiring reporting of the reasons practitioners gave for not making a statement (amendment 60).
- Requiring reporting of how many people were assessed as having been offered or provided with appropriate social care relevant to their terminal illness (amendment 61).
- Requiring reporting of complications, adverse reactions and unintended effects arising from the provision of assistance (amendment 62).
- Requiring reporting of the number of statements made by each coordinating and independent practitioner each year (amendment 281).
- Requiring reporting of how often the reflection period was less than 14 days (amendment 282).
- Requiring reporting of the time between the medical-practitioner statements and the person's death (amendment 283).
- Requiring detailed assessment of a sample of cases to be included in PHS' annual report (amendment 285).
- Requiring reporting on how many people were assessed as having been offered or provided appropriate palliative care relevant to their terminal illness (amendment 286).
- Requiring PHS to include an analysis of trends, safety risks, safeguarding concerns, inequalities and unintended consequences, and to identify significant risks with recommended actions (amendment 287).
- Requiring reporting on the availability, quality and distribution of health and social care services for those who made a first declaration, including symptom management and psychological support (amendment 288).
- Requiring PHS to take reasonable steps to obtain, verify and assess all required data, and to explain any missing information and efforts made to obtain it (amendment 290).

Main amendments not agreed to at stage 3

The main amendments not agreed to at stage 3 in relation to reporting, monitoring and review were:

- Requiring Scottish Ministers to arrange a referendum on the Act as soon as practicable after Royal Assent, to be held no later than 7 November 2028 (amendment 112).
- Requiring an independent review of the financial implications of implementing and operating the Act, with the findings laid before Parliament and accompanied by a ministerial response (amendment 255).
- Expanding the statutory review of the Act to include the safety, effectiveness and

reliability of medications and methods used, evidence of coercion or undue influence, accuracy of assessments, differential impacts, instances of non-compliance, and any other emerging risks or unintended consequences (amendment 119).

- Requiring the statutory review to assess the Act's impact on suicide prevention and wider mental-health outcomes, including effects on suicide rates, missed opportunities for intervention, and unintended consequences for mental-health services, with recommendations to strengthen prevention (amendment 297).

- Requiring the statutory review to assess the adequacy, sustainability and protection of funding for palliative, end-of-life and supportive-care services, including impacts on statutory and charitable funding, staffing, training and regional equity, and requiring Ministers to commit to funding any shortfalls (amendment 298).

- Requiring information provided by Scottish Ministers to be comprehensive, accurate and balanced, including guidance on independent advice, safeguards, alternatives such as palliative and psychological support, and suicide-prevention resources (amendment 275) and fully cover the legal, medical, social and ethical aspects of assisted dying (amendment 276).

- Requiring PHS to report on complications, side-effects or adverse reactions, including frequency and include professional recommendations on steps to prevent recurrence (amendment 115).

- Requiring Scottish Ministers to act within six months on recommendations relating to complications and adverse effects reported and to publish a statement of the actions taken (amendment 116).

- Requiring PHS to report on the number and nature of safeguarding concerns, referrals to protection services and the outcomes of safeguarding investigations (amendment 284).

- Requiring Scottish Ministers to publish PHS' annual report as soon as practicable and lay it before Parliament with a statement on any significant trends, risks or inequalities and the actions taken or planned in response (amendment 289).

- Requiring Scottish Ministers to, within six months of receiving PHS' report, publish a statement on actions taken or planned in response, explaining reasons where no action is taken, and to lay this before Parliament (amendment 291).

- Requiring the annual report to include a review of the Act's impact on suicide-prevention services, including funding, staffing, training, capacity, and measures Ministers will take to address any shortfalls (amendment 295).

- Requiring the annual report to include an assessment of the Act's impact on palliative and end-of-life care, covering funding, staffing, training, resource adequacy and steps Ministers will take to address shortfalls (amendment 296).

Guidance and Codes of Practice

The Bill as amended at stage 2

Scottish Ministers may issue guidance covering any aspect of how the Bill is to be carried out. Practitioners would be required to have regard to this guidance when performing their functions under the Bill, and compliance with it forms part of what constitutes 'lawful assistance'.

Scottish Ministers must also publish a Code of Practice setting out how assisted dying should interact with palliative and end-of-life care services. The Code of Practice must also:

- Provide guidance, training and support to all health and social care staff delivering hospice, palliative and end-of-life care, including non-statutory providers.
- Take steps to mitigate any negative impacts on existing palliative and end-of-life care services, including those delivered by non-statutory providers.
- Ensure statutory funding for palliative and end-of-life care is clearly distinguished so that assistance under the Act is not funded at the expense of existing services.
- Clarify how the Act aligns with current regulation and oversight of palliative and end-of-life care.

The statutory review must include an assessment of how effective this code of practice has been in supporting those services.

Main amendments agreed to at stage 3

The main amendments agreed to in relation to guidance and the code of practice were:

- Requiring guidance to cover how to identify and take account of indirect pressures that may influence a person's decision-making (amendment 54).
- Requiring guidance to include support and representation provided through advocacy services, including emotional support, practical advice and prioritisation of the adult's rights and well-being (amendment 259).
- Requiring guidance to set clear parameters distinguishing lawful assistance from the administration of a substance (amendment 260).
- Requiring guidance to include processes for raising and handling concerns before and after an assisted death (amendment 55).
- Requiring guidance on how to interpret and apply the 6-month eligibility requirement in practice (amendment 262).
- Requiring guidance on how health boards should arrange the provision of assistance, including developing patient pathways (amendment 263).
- Requiring that guidance must not describe assisted dying as part of palliative, end-of-life or dying-related care (amendment 267).
- Requiring draft guidance to be laid before the Scottish Parliament for approval before coming into force (amendments 268 and 269).
- Requiring anyone involved in the assisted-dying process to have regard to relevant guidance issued by Ministers (amendments 270 and 271).

- Requiring Ministers to keep guidance under ongoing review, with a formal review within three years and at least every five years thereafter (amendment 272). This review requirement should apply equally to any revised guidance (amendment 273).

- Requiring the Chief Medical Officer to publish guidance on assessments for people under 25 with fluctuating, unpredictable conditions, with power to revise it (amendment 274).

- Requiring public authorities (to be specified in regulations) to have due regard to the code of practice on the interaction with palliative and end-of-life care services (amendment 258).

Main amendments not agreed to at stage 3

The main amendments not agreed to in relation to guidance and the code of practice were:

- Replacing the reference to 'training and quality assurance' with a requirement for mandatory training, accreditation and ongoing competence requirements (amendment 261).

- Requiring guidance on eligibility, assessment standards, coercion safeguards, practitioner training and competence, and oversight arrangements to be laid before the Scottish Parliament for scrutiny and approval (amendment 266).

- Replacing the former funding-stream requirement in the code of practice with a duty to set out how statutory and charitable palliative-care funding must be clearly separated, monitored and audited to prevent diversion to assisted-dying services, and creating a reporting duty on Ministers (amendment 256).

- Requiring the code of practice to include provisions giving effect to organisational conscientious objection, ensuring no hospice or care provider is required to participate, facilitate or provide assistance contrary to their ethical or religious beliefs, protecting such organisations from penalties or loss of funding, and establishing procedures that maintain patient access to eligible services (amendment 257).

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