AN OVERVIEW CONCERNED WITH A HISTORY OF LEGAL RULINGS, LEGISLATION AND SOCIAL CHANGE IN SCOTLAND RELATING TO ASSISTED DYING AND THEIR POTENTIAL INFLUENCE ON THE CURRENT ATTEMPT TO INTRODUCE ASSISTED DYING LEGISLATION VIA THE McARTHUR BILL

Keywords: Scotland; Scottish; assisted dying; euthanasia; legislation; law.

Abstract

An examination of legal precedents that have operated in concert with demographic and political developments in Scotland to lead to the Assisted Dying For Terminally Ill Adults (Scotland) Bill (2024). In understanding why legislative change now appears possible in Scotland, we will examine legal changes globally and closer to home, the persistence of public support, and changes in the view of a majority of medical representative institutions. Whilst not an exhaustive trawl of literature, it is hoped that this may be beneficial as an introduction to the subject.

Introduction.

Assisted Dying, as of December 2025 is practiced legally in Belgium, Canada, Austria, Luxembourg, Netherlands, Oregon, Washington, New Jersey, New Mexico, Hawaii, Montana, Maine, Colorado, California, District of Colombia, Maine, Vermont and Switzerland. Spain, Portugal, Colombia, Ecuador, New Zealand, all six Australian states plus the Australian Capital Territory[1]. The Isle of Man have legalised Assisted Dying, and legal support is also available in Colombia. Recently Jersey has voted to introduce Assisted Dying, as has New York and Delaware. The French government introduced a bill on Assisted Dying which has now passed its first stage. Iceland has introduced a bill on Assisted Dying, as has Cuba, Kentucky, Maryland, Massachusetts, and Tennessee. Legislation supporting death with dignity has advanced this year in Indiana, Missouri, New Hampshire, Maryland, Florida, Kentucky, Tennessee and Nevada. Over the summer of 2025 Slovenia approximately Slovenians passed a law allowing terminally ill people to access voluntary assisted deaths, and in December the Illinois End of Life Options for Terminally Ill Patients Act (SB1950) was signed into law.

In Switzerland and Germany there is an extensive practice of assisting those who wish to die without explicit legislation. In Switzerland assisting dying has been legal since 1942 if the motive is compassionate. Spain, the Netherlands, Belgium and Luxembourg have laws that allow not only people who are terminally ill but also those who are incurably and intractably suffering but not terminal to request and receive assistance to die. In Canada assisted dying is available to those whose death is

[1] Legislation in the Capital Territory allows both self-administration and administration by medical practitioners, and has no timeframe limitation, unlike other states where a six-month limit (or twelve in Victoria) exists.

reasonably foreseeable, and in the Australian Capital Territory it is available to those experiencing intolerable and intractable suffering, and with no specific timeframe[2] applied.

In countries such as the Netherlands and Canada where the courts have allowed significant change, the resulting assisted dying legislation has been more wide-ranging in terms of access. In countries where courts have proven reluctant to introduce changes to the law, the resulting legislation has tended towards the more conservative. In the Netherlands and in Canada, a range of court-based legal precedents operated in defining both the law and appropriate legal sanctions, subsequently enshrined in legislation. The key concept of justification of assisted dying in the Netherlands is based around the concepts of beneficence and necessity[3], while in Canada, the US and the UK, the core justifying concept leans more towards personal autonomy. In addition, compassion has been a key stated concept behind the current McArthur Bill[4] in Scotland. Other principles raised in debates in various global jurisdictions include a rights to freedom from torture and unreasonable suffering, the right to dignity, and the right for a person to end their own life.

At this point it is reasonable to posit that the campaigns and arguments rehearsed both internationally and also relating to assisted dying in the United Kingdom are no longer novel to the British public. The debate and arguments of those who support and those who oppose assisted dying have been vigorously tested in previous and current attempts to introduce legislation within the UK.

England/Wales and Assisted Dying

Assisted Dying Bills are working their way through both Holyrood and Westminster, both based on a 'terminal condition model' as already established recently in Australia, New Zealand and originally in Oregon, rather than an 'unbearable suffering model' as established in Belgium, Holland, Spain and Canada. Imminence of death rather than degree of suffering is prime within the Westminster (and Scottish) proposals. Attempts to seek clarification through judicial review in UK courts have tended to do so on the basis that the right to an assisted death was compatible with the right to a private life, bodily autonomy and self-determination guaranteed by Article 8 of the European Convention on Human Rights. It is worth briefly examining the Westminster path to the current proposals, as Scotland and England/Wales are part of the United Kingdom, legal developments in each country are often cross-referenced, and the courts in each jurisdiction have remained relatively unwilling to significantly change existing legislation whilst nonetheless providing relatively clear indications via prosecution outcomes and indeed decisions

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[2] In Victoria, death must be expected within a year, while in other territories the timeframe is six months.

[3] Lewis, P. "The Dutch Experience of Euthanasia." Journal of Law and Society, Volume25, Issue4 December 1998. https://doi.org/10.1111/1467-6478.00107

[4] Ward, AJ. From Criminality to Compassion Reforming Scots Law on Assisted Dying: A Fullerian, Compassion-Based Analysis. Strathclyde University 2022 10 at https://stax.strath.ac.uk/concern/theses/z890rt783

not to prosecute that existing law may be argued to be unclear and insufficient for contemporary needs.

In England, court-ruling precedents may have played a part in defining the current legislation before Westminster. Suicide was decriminalised in 1961 in England and Wales but encouraging or assisting a suicide, even where consent and request are evident, was specifically made illegal under the Suicide Act 1961. The ruling in the case of Pretty v. U.K[5], the European Court of Human Rights confirmed that more active and direct assistance in ending a life remained illegal. However, after the House of Lords ruling related to Purdy[6], the Crown Prosecution Service (under DPP Keir Starmer) in 2010 (updated in 2014 and again in 2023[7]), clarified a number of factors that may incline or disincline the DPP towards prosecution. For example it was now understood that anybody accompanying a person travelling to Dignitas should not be prosecuted[8]. Cases where individuals charged with murder by claiming to be compassionately ending the lives of intractable suffering provided some clarity in terms of likely prosecution outcome[9] - Dr David Moor had administered multiple lethal doses but was able to cite the doctrine of 'double-effect' and was acquitted, Meanwhile, members of the public who killed a loved one who was intractably suffering. claiming consent, were not imprisoned for murder - Bernard Heginbotham received a community rehabilitation order, Brian Blackburn received a suspended sentence, and David March received a suspended sentence and 50 hours of unpaid work.

Since the beginning of this new century there have been four attempts to introduce assisted dying legislation for England and Wales in Westminster. The first three attempts failed, while the fourth has recently passed it's first stage. Between 2002-6, Lord Joffe tabled a private member's bill - the Patient (Assisted Dying) Bill, based on the Oregon model, in four iterations/amendments, but was strongly opposed by religious groups, pressure groups and opposition from medical organisations, and the Bill was ultimately killed by peers voting 148 to 100 to delay it for six months. In 2014, and then in 2016 Lord Falconer's attempts lacked government support and ran out of time. In 2015, Rob Marris MP introduced a Private Member's Bill which was voted down by 330 votes to 118. In 2016/17 Lord Hayward introduced a private member's bill, which also ran out of time. Baroness Meacher introduced a bill in October 2021 which passed a second reading in the House of Lords but again ran out

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[5] Pretty v UK, European Court of Human Rights. Application no. 2346/02. Final Judgement at https://www.refworld.org/jurisprudence/caselaw/echr/2002/en/78916

[6] R (Purdy) v DPP [2009] UKHL 45

[7] An additional factor in support of prosecution in 2023 is "The suspect was acting in their capacity as a medical doctor, nurse, or other healthcare professional and the victim was in their care."

[8] https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide

[9] Kanellopoulou, Georgia. "Euthanasia in the UK and the need for a legislative change." https://www.academia.edu/25211206/Euthanasia_in_the_UK_and_the_need_for_a_legislative_change?email_work_card=view-paper

of time. In 2022 Lord Forsyth tabled an amendment to the 2022 Health and Care Act seeking to introduce an additional clause enabling an assisted dying bill to be presented, but the amendment was not moved. As of September 2025, the Terminally Ill Adults (End of Life) Bill sponsored by Kim Leadbeater and Lord Falconer on June 20th 2025 passed in the House of Commons by 314 to 291votes, and underwent a Second Reading in the House of Lords in September and went to committee stage, to be revisited on 24 October 2025 and 31 October 2025. There remains a possibility, as the Bill is a private member's Bill, that with over a thousand amendments raised by a small number of Lords opposing the Bill that it may fail due to lack of time.

While successful passage of a law in one UK jurisdiction in no way guarantees passage of a similar law in another, it would be fair to note a cumulative effect has occurred in terms of coverage of the issues and progress made by both legislative proposals.

Opposition to assisted dying

A range of well-organised and well-funded pressure groups continue to oppose assisted dying. Key UK opposition groups are Our Duty of Care, Care Not Killing, and Right To Life UK. Disability Rights UK, Disability Equality Scotland and the British Geriatrics Society also oppose Assisted Dying legislation. The Church of Scotland, the Catholic Church in Scotland, and the Scottish Association of Mosques also oppose Assisted Dying. The campaign against the Scottish legislation has also had contributions from opponents from other countries.[10] The Telegraph, The Times and The Mail have also been vociferous in their opposition, and give the impression that the level of support for both sides of the debate is much more even than polls indicate.

The strength of feeling, although consistently a minority view, amongst those who oppose assisted dying is undeniable. Key arguments against AD are noted by Materstvedt et al[11]:

> If euthanasia is legalized in any society, then the potential exists for:
> (i) pressure on vulnerable persons; (ii) the underdevelopment or devaluation of palliative care; (iii) conflict between legal requirements and the personal and professional values of physicians and other healthcare professionals; (iv) widening of the clinical criteria to include other groups in society; (v) an increase in the incidence of nonvoluntary and involuntary medicalized killing; (vi) killing to become accepted within society.

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[10] https://www.humanism.scot/2024/11/27/we-write-to-the-herald-over-inaccurate-assisted-dying-article/?fbclid=IwY2xjawHCXkRleHRuA2FlbQIxMQABHZCvWuIXj2YBk0teEYXAA4V6_dDhiZLRO_bfzwdJRyYQlRdoJmF_m_0cvg_aem_ha6bv6Jsu9SoFVAAj5OSNQ#AssistedDying

[11] Materstvedt et al. Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force. Palliative Medicine 2003; 17: 97-101. https://www.researchgate.net/publication/10798732_Euthanasia_and_Physician-Assisted_Suicide_A_View_from_an_EAPC_Ethics_Task_Force

As opposition to assisted dying for purely religious reasons has lost traction, that argument has been superceded by arguments that any system of assisted dying must inevitably be open to abuse by those with wicked intent. A common criticism persists that opposition is fundamentally religious at its core and that a dearth of reliable evidence has been provided to support claims made by opponents. Schuklenk argues that:

> Essentially, it is a propaganda war between a fairly small band of deeply religious and well-organized opponents of assisted dying and mostly secular proponents of a change in legislation. Opponents today hide behind a gaggle of secular names to hide their religious backgrounds. Their arguments have also switched from their traditional "God doesn't permit assisted dying" to various public reason-based arguments.

The most common arguments framed by those who oppose assisted dying are the 'slippery slope' and that the vulnerable will be at risk. One benefit to being behind other European and other English-speaking states in successfully introducing assisted dying legislation is that there are multiple case-studies to examine both for good practice and to examine concerns raised by opponents. This appears to have been to the detriment of opposition to assisted dying. Common claims by opponents involve the claim that any pro assisted dying legislation will put the vulnerable and disabled in danger of coercion be the beginning of a slippery slope to further and even more dangerous legislation. The slippery slope argument is predicated on the assumption that further dangerous expansion is inevitable, which has has not been the case for example where legislation has remained relatively unchanged since it passed in 1994. Sivers observes that where legislative change has occurred to expand the scope of access to assisted dying, the constitutional arrangements are fundamentally different in Scotland (compared, for example, to Canada where court rulings have led to substantive legal change). Sivers notes that

> even if a future Scottish Parliament were to consider changes, the 'legislative creep' that could effect change to eligibility criteria would have to go through the same robust parliamentary process as any other Bill. Gradual and increasing loosening of criteria specified in an Act is not a foregone conclusion, and the law can and does stand as a bulwark against sliding down the slippery slope.[12]

As Beauchamp & Childress note: "To date none of the abuses some predicted have materialized in Oregon.The Oregon statute's restrictions have been neither loosened nor broadened. There is no evidence that any patient has died other than in

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[12] Sivers, Sarah. Clarity, compassion and choice — what next for Assisted Dying for Terminally Ill Assisted dyingults (Scotland) Bill and why status quo is 'anything but safe'. Law Society of Scotland Journal. 15th May 2025. https://www.lawscot.org.uk/members/journal-hub/articles/clarity-compassion-and-choice-what-next-for-assisted-dying-for-terminally-ill-assisted dyingults-scotland-bill-and-why-status-quo-is-anything-but-safe/

accordance with his or her own wishes."[13] Pickett[14] notes that "[i]n both the Netherlands and Oregon, vulnerable groups are less likely to select euthanasia or assisted suicide. The mentally handicapped, psychiatric patients, and children are underrepresented among patients selecting euthanasia or assisted suicide in the Netherlands." Deliens[15], with reference to Wels and Hamarat[16], found that "[r]esearch evidence from Belgium does not support the repeatedly expressed concern that older people, disabled people, or people with psychiatric disorders would be under pressure to access euthanasia." Professor Emeritus Jocelyn Downie, in her review of the Supreme Court of Canada's ruling records that the Supreme Court confirmed that there is:

> no evidence from permissive regimes that people with disabilities are at heightened risk of accessing physician-assisted dying; no evidence of inordinate impact on socially vulnerable populations in permissive jurisdictions; in some cases palliative care actually improved post-legalisation; physicians were better able to provide overall end-of-life treatment once assisted death legalised; the trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide.[17]

As Justice Baudouin in Canada concluded after considering expert evidence: "Neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope or even heightened risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying."

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[13] Beauchamp, TL & Childress, JF. The Principles of Biomedical Ethics, 7th Ed. Oxford University 1 Press (2013): p181

[14] Pickett, J "Can Legalization Improve End of Life Care? An Empirical Analysis of the Results of the Legalization of Euthanasia and Physician-Assisted Suicide in the Netherlands and Oregon https://publish.illinois.edu/elderlawjournal/files/2015/02/Pickett.pdf

[15] Deliens L. Assisted Dying and the Slippery Slope Argument—No Empirical Evidence. *JAMA Netw Open.* 2025;8(4):e256849. doi:10.1001/jamanetworkopen.2025.6849 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833184

[16] Wels J, Hamarat N. Incidence and prevalence of reported euthanasia cases in Belgium, 2002 to 2023. *JAMA Netw Open*. 2025;8(4):e256841. doi:10.1001/jamanetworkopen.2025.6841 ArticleGoogle Scholar

[17] Downie, Joyce (2016) Permitting Voluntary Euthanasia and Assisted Suicide: Law Permitting *Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions Reform Pathways for Common Law Jurisdictions*. QUT Law Review Volume 16, Issue 1: 97 https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1906&context=scholarly_works

Commenting on the empirical evidence from the Netherlands and the US State of Oregon, Professor Raymond Tallis of the Royal College of Physicians, states that "[e]very single one of those assumptions is false."[18]

It is true however that recently in the State of Victoria the life expectancy rule was expanded from six to twelve months, and doctors are now allowed to raise the issue with terminally ill patients, but this required extensive debate and further legislation. Much more controversially, in Belgium, a change to legislation now provides for a child in a 'medically futile condition', and who is experiencing constant and unbearable suffering that cannot be alleviated to request, with parental, medical and psychiatric support, voluntary assisted dying. This change was possible only after extensive consultation and public and political debate and in this case a two-thirds majority in Parliament. No change would have occurred without public support and the assent of Parliament. Similarly, any substantive change to any existing assisted dying legislation in Scotland would require further legislation to be passed.

Scotland and Assisted Dying

The 2025 Church of Scotland Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying expounded on another common argument that:

> [t]hose eligible for Assisted Dying under the current proposals—those with an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death—are not choosing between life and death, but between two types of death.[19]

It may be accurate to state that views both of the public (see below) and within the Scottish Parliament have more closely aligned in recent years. The first attempt to introduce assisted dying legislation in 2010, introduced by Margo MacDonald MSP, was broader in terms of access and provision, and voted down at Stage 1 by 85 votes to 16 (with 2 abstentions). The MacDonald proposals were closer the the Benelux model, allowing for the administration as well as provision of a terminal dose, and could be accessed by anybody 16 years or older who " (a) has been diagnosed as terminally ill and finds life intolerable; or (b) is permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable".[20] The second attempt, included a more detailed process than the MacDonald Bill, was

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[18] Bernheim, JL & Raus, K (2016) *Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care.* Journal of Medical Ethics; 43:489-494. https://jme.bmj.com/content/43/8/489

[19] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. 12.9, 9.

[20] End of Life Assistance (Scotland) Bill 2010 [4]. https://webarchive.nrscotland.gov.uk/3/archive2021.parliament.scot/S3_Bills/End of Life Assistance (Scotland) Bill/b38s3-introd.pdf

introduced by Patrick Harvie MSP in 2015. Again, access was broader than the McArthur Bill, with anybody 16 years or older who suffers from a condition that is progressive and "either terminal or life-shortening"[21] and "sees no prospect of any improvement in the person's quality of life".[22] This time, any administration of a lethal dose by another party was excluded, with any fatal dose to be self-administered. The proposal lost by 82 votes to 36.

The Assisted Dying for Terminally Ill Adults (Scotland) Bill introduced by Liam McArthur MSP on 27 March 2024 to the Scottish Parliament has much in common in terms of process with the 2015 Bill, and pays cognisance not only of the Oregon system but also of the various laws successfully passed recently in Australia and New Zealand. As noted in the House of Commons Library, The Law on Assisted Suicide (July 2022)[23]:

> Assisting a suicide in Scotland is not a specific offence, however people who are suspected of doing so could potentially be prosecuted for more general offences including murder, assault or offences under the Misuse of Drugs Act 1971. Unlike in England and Wales, there is no published prosecution policy specifically relating to cases where there is suspicion of assisted suicide in Scotland….In September 2021 Liam McArthur MSP proposed the Assisted Dying for Terminally Ill Adults (Scotland) Bill, which sought to "enable competent adults who are terminally ill to be provided at their request with assistance to end their life….The consultation summary sets out that a "clear majority" of respondents (76%) were supportive of the proposal, with 2% partially supportive, 21% fully opposed and 0.4% partially opposed.

Fakonti & Papadopoulou state that "The introduction of the new Scottish Bill is a significant opportunity to clarify the Scottish criminal law on the issue of assisted suicide."[24]

The McArthur Bill can be viewed as a pragmatic response to both previous attempts at legislation that failed[25] (in terms of presenting a more limited scope) and to the existing case law precedents, such as they are, in Scotland. The original draft is

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[21] Assisted Suicide (Scotland) Bill 2015 [8]5. https://webarchive.nrscotland.gov.uk/3/archive2021.parliament.scot/S4_Bills/Assisted Suicide/b40s4-introd.pdf

[22] As above [8]4.

[23] Health and Social Care Committee. Assisted Dying/Assisted Suicide, Second Report of Session 2023–24 [53]

[24] Fakonti & Papadopoulou, as above.

[25] Both attempts occurred at a time where there was significantly greater active opposition from medical representative and religious organisations. Both failed at the first stage due to lack of sufficient support and over lack of specificity, and concerns over issues such as "slippery slope", coercion and potential disruption to existing medical services in Scotland.

available online.[26] The bill stays comfortably within existing Scottish legal parameters, as defined by precedent. The initial proposal presented to the Scottish Parliament limits and defines those eligible for assistance in dying, and with reference to the current Scottish Government definition[27], as those who are terminally ill:

> A person is terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death.[28]

This definition remains debated, with pressure at the time of the third stage to change to a six-month mortality limit (as per the model adopted in Oregon and a number of other states, including most Australian provinces). The final version of the Bill is likely to limit access to those who are terminally ill and likely to die within six months. A medical professional can supply but not administer a fatal dosage - it must be self-administered by the patient. No medical professional need participate if unwilling. The rationale behind the narrowing of access, in addition to the confirmed success in similarly narrowed legislation in the Antipodes also relates to issue of causality under existing Scots law (see later). In response to concerns over risks that may exist in relation to the vulnerable and disabled, the Bill also strengthens safeguards against potential coercion. As Fakonti & Papadopoulou note[29] "The Scottish Bill treats coercion as a distinctive wrong, further protecting autonomy." Anybody found guilty of coercion is liable to a sentence between 2 and 14 years and/or a fine.

Warlow's summary confirms:[30]

> the patient must administer any life ending substance themselves. They must be an adult, resident in Scotland, registered with a GP in Scotland, and mentally competent, as confirmed by two independent doctors. Important lessons from the last attempts to pass a bill on Assisted Dying in Holyrood have been incorporated into the new bill. For example, it does not allow an assisted death for anyone who is not "terminal" (meaning close to death, but within no specific time period) even if they have a debilitating, incurable, and progressive disease, and certainly not if they have a mental disorder that might affect their decision. The safeguards against coercion and exploiting a dying person have been strengthened, as have safeguards for disabled people who are not terminally ill and who have no wish to end their lives. The life ending

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[26] https://www.parliament.scot/-/media/files/legislation/bills/s6-bills/assisted-dying-for-terminally-ill-adults-scotland-bill/introduction/bill-as-introduced.pdf

[27] https://www.gov.scot/policies/social-security/terminal-illness/

[28] Assisted Dying for Terminally Ill Adults (Scotland) Bill SP Bill 46, Session 6,1. 2024.

[29] Fakonti & Papadopoulou, as above.

[30] Warlow, Charles. A new bill could legalise Assisted Dying in Scotland. BMJ 2024;385:q792. https://www.bmj.com/content/385/bmj.q792

> medication will never be in public circulation and a healthcare practitioner will be present at the person's death. The patient must have had palliative care and hospice options explained to them. Clinicians can opt out of any involvement, just as they can with termination of pregnancy. There will be a robust system to record data on every patient, publicly available annual reports from Public Health Scotland, and a review of the legislation after five years.

The first reading of the Bill in Holyrood took place on 13 May 2025[31]. Opponents focussed on the slippery slope argument, on direct and indirect coercion, the risks to vulnerable groups, and the financial and organisational challenges in providing appropriate training and providing equal provision across the country. A commitment to strengthening palliative care in general was discussed. On the general principles, the Bill was supported by seventy votes to fifty-six. The Bill has returned to committee, and at Stage 2 almost 300 amendments were advanced and explored. Further amendments will be explored in Stage 3 in February/March 2026.

Although the Bill limits access to those who are terminally ill, the McArthur Scottish consultation noted that:

> Many believed a wider group of people should be able to choose an assisted death than the intended definition would allow for, such as those with potentially longer-term degenerative conditions, such as various neurological conditions and forms of dementia. A significant number of respondents also raised concerns about the proposal that the life ending substance must be self-administered, noting that some people who would wish to choose an assisted death would not be able to take the medicine themselves. Many respondents believed this to be potentially discriminatory and called for a health care professional to be able to administer the drug in certain circumstances, or that there should at least be clarity on how life would be ended in such circumstances.[32]

The McArthur Bill however, allows for self-administration only, closer to the Oregon and Antipodean models. A significant majority of those intractably suffering would be enabled by the McArthur Bill to legally access an assisted death, although those with conditions not classed as terminal would not, and those incapable of self-administration may likely also be excluded. These exclusions are likely to remain controversial.

In view of the failure of two previous Bills, in opposition to consistent public sentiment, any expectation that the percentage of votes in Holyrood would mirror the consistent 75%+ support in the public in favour of assisted dying would be naive.

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[31] Session can be viewed at https://www.youtube.com/watch?v=9V_XeEOCFoU

[32] McArthur L. The Scottish Parliament. Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill: Summary of Consultation Responses 6 found at https://www.parliament.scot/-/media/files/legislation/proposed-members-bills/assisteddyingconsultationsummaryfinaldraft.pdf

Certainly it can be argued that reducing the scope the legislation in comparison to previous attempts has been a pragmatic compromise, as in previous attempts the perfect may well have proven to be the enemy of the good. Bache[33] notes in his research on voting patterns related to assisted dying in the past that politicians remained uncomfortable dealing with complex moral issues, were risk averse and "'routinely avoid responsibility' where possible for fear of offending a vocal minority of constituents with passionate views".[34] The closeness of the vote on the first stage, with only 55.1% of MSPs supporting the Bill, and a number of those voicing continuing reservations[35] would appear to justify the conservative nature of the Bill.

Changing Scottish demographics

According to the Scottish government:

> The Scottish population is ageing and in 2020, there were an estimated one million Scotland residents aged sixty-five years or older. By 2040, this will rise to an estimated 1.4 million, or 25% of our population….Currently in Scotland people aged over 70 years live with an average of three chronic health conditions.[36]

Living with numerous and often complex health problems is becoming the norm for older people and those from disadvantaged communities in Scotland.[37] People are also living longer[38], but many of these additional years are spent with health

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[33] Bache, Ian. How (and when) does party matter? Explaining MPs' positions on assisted dying/assisted suicide. Parliamentary Affairs (2025) XX, 1–21 Advance Access Publication 1 March 2025. https://www.academia.edu/128612404/How_and_when_does_party_matter_Explaining_MPs_positions_on_assisted_dying_assisted_suicide

[34] Bache, as above 4.

[35] Sim, Phil. What next for Scotland's assisted dying bill? BBC News 13 May 2025 https://www.bbc.co.uk/news/articles/c0k3v3gdjjmo

[36] Scottish Government (2022) Health and Social Care Strategy for Older People: Analysis of Consultation Responses https://www.gov.scot/publications/health-social-care-strategy-older-people-analysis-consultation-responses/

[37] Scottish Government (2022) Health and Social Care Strategy for Older People: Analysis of Consultation Responses https://www.gov.scot/publications/health-social-care-strategy-older-people-analysis-consultation-responses/

[38] Government Office for Science (2016) Future of an Ageing Population. https://assets.publishing.service.gov.uk/media/5d273adce5274a5862768ff9/future-of-an-ageing-population.pdf

problems, often multimorbidities[39] [40] [41]. In some cases palliative care is simply insufficient and/or unpalatable to chronic sufferers.[42] [43] The Scottish government has stated that:

> In 2016/17 there were about 57,000 deaths in Scotland, a figure set to rise slightly to just over 60,000 by 2037. Around 75% of these people will have needs arising from living with deteriorating health for the years, months or weeks before they die.[44]

Although the number of cases related to an assisted death remain sparse, at least in the reporting, there can be no doubt that the number of cases will increase, as will the amount of court time taken up, traumatising those involved, and most likely with consistent and repeated non-punitive outcomes. Increasing numbers of Scots have already encountered, and may in the future directly or indirectly encounter the limitations of existing legal end-of-life provision for the intractably suffering.

Medical institutional opinion

In terms of financing, the Westminster Impact Assessment for Assisted Dying[45] estimated that while introducing assisted dying would not save the NHS money, it would not necessarily add significantly to the overall health-care budget.

While palliative care organisations were historically opposed to assisted dying, and The Association for Palliative Medicine (of Great Britain and Ireland (APM) remains opposed, the Association of Palliative Care Social Workers in their November 2024

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[39] Gondek et al (2021) Prevalence and early-life determinants of mid-life multimorbidity: evidence from the 1970 British birth cohort. BMC Public Health volume 21, Article number:1319. https://doi.org/10.1186/s12889-021-11291-w

[40] Healthcare Improvement Scotland: More about multimorbidity and diabetes. https://rightdecisions.scot.nhs.uk/type-2-diabetes-mellitus-quality-prescribing-strategy-a-guide-for-improvement/polypharmacy-in-diabetes/more-about-multimorbidity-and-diabetes/

[41] Mercer, Stuart Prof. Multimorbidity. Advanced are Research Centre. https://edwebcontent.ed.ac.uk/sites/default/files/atoms/files/acrc_briefing_3_v.1.pdf

[42] Cookson et al. Unrelieved Pain in Palliative Care in England. National Institute for Health Research. 2019 https://www.ohe.org/publications/unrelieved-pain-palliative-care-england

[43] Dignity In Dying. The Inescapable Truth About Dying in Scotland. 2019 https://features.dignityindying.org.uk/inescapable-truth/

[44] Scottish Government (2018) Palliative and End-of-Life Care by Integration Authorities: advice note. https://www.gov.scot/publications/strategic-commissioning-palliative-end-life-care-integration-authorities/pages/5/

[45] Impact Assessment: Terminally Ill Adults (End of Life) Bill (as amended in the House of Commons Public Bill Committee) **IA No**: DHSCIA9682 May 2025 https://assets.publishing.service.gov.uk/media/68247bfdb9226dd8e81ab849/terminally-ill-adults-end-of-life-bill-impact-assessment-updated.pdf

Statement on Assisted Dying[46] take no position on assisted dying, Hospice UK present a neutral tone of "no collective view"[47], Marie Curie maintain a neutral position, and in response to the Proposals for an Assisted Dying for Terminally Ill Adults (Scotland) Bill, the Scottish Partnership for Palliative Care (SPPC) did not "adopt a position in principle either in support or in opposition to a change in the law"[48], although they expressed concerns.

Meanwhile, even back in 2001, throughout the BMA/RC/RCN guidance, there is an implicit concern with the concept of 'quality of life' and it is emphasised that life should not be prolonged at any cost:

> 'Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to its quality or the burdens of treatment on the patient.'[49]

Between 2009 and 2024, the General Medical Council, the Royal College of Nursing, the British Medical Association, the Royal College of Physicians, the Royal College of Radiologists' (RCR) Faculty of Clinical Oncology, the Royal College of Psychiatrists, the Royal College of General Practitioners, the Royal College of Surgeons, and the Royal College of Anaesthetists moved from clear opposition during the time of previous attempts to introduce assisted dying legislation to neutrality on the issue. A 2020 British Medical Association survey however found that 54% of surveyed members "would not be willing to actively participate in the process of administering life-ending drugs, should it be legalised. A quarter (26%) said they would, and one in five (20%) were undecided on the matter." 50% supported doctors being able to prescribe life-ending drugs.[50] The move overall of representative bodies from opposition to neutrality can be regarded as significant in shifting the debate.

Public opinion

UK-wide organisations such as My Death My Decision, Dignity in Dying, Humanists UK and Scottish-based organisations such as Friends at the End, Dignity in Dying Scotland and the Humanist Society Scotland have consistently and effectively lobbied politicians and operated public information campaigns. Support for Assisted Dying within the general public has been consistent for decades. Between 1983 and 2016,

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[46] Association of Palliative Care Social Workers. Statement on Assisted Dying, November 2024. https://apcsw.org.uk/wp-content/uploads/sp-client-document-manager/7/apcsw-full-statement-on-assisted-dying-november-20241.pdf

[47] https://www.hospiceuk.org/assisted-dying 22/04/25

[48] https://www.palliativecarescotland.org.uk/content/publications/SPPC-Response-to-Proposals-for-an-Assisted-Dying-Bill.pdf

[49] BMA/RC/RCN (2001) Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Journal of Medical Ethics, October 2001: 7. https://jme.bmj.com/content/27/5/310

[50] https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf

the British Social Attitudes Survey pegged UK public support for Assisted Dying consistently at 75% to 82%[51]. In the most recent British Social Attitudes Survey[52], 79% of the public supported Assisted Dying. In the previous year's survey, 78% supported Assisted Dying. While Dignity in Dying recorded in 2013 that only only 45% agree that those suffering incurably but non-fatally should be able to access an assisted death[53], the Autumn 2024 National Centre for Social Research British Social Attitudes survey found 25% expresses full support, and a further 33% believed that doctors probably should be allowed to end the life of those suffering intractably but not terminally, in total 58% in favour.[54] The National Centre for Social Research, in written evidence submitted to Westminster confirmed that:

> There has been broad support for Assisted Dying/suicide for 20 years, particularly in the case of people with painful and incurable terminal diseases; support has strengthened in the case of people with painful and incurable diseases that will not kill them.[55]

In the July 2024 survey 'Rethinking the UK's approach to dying'[56], it was the stated preference of 83% of respondents to prioritise their quality of life over living longer in the last years of their life. Of the 1,214 people in the sample whose last close friend or family member to die had died of a short or long-term illness, 26% said that a friend or family member received medical treatment they would not have wanted towards the end of their life. In September 2024, a YouGov survey took an in-depth look at attitudes in the UK towards Assisted Dying. It found that 73% of Britons believe that Assisted Dying should be legal in the UK, with only 13% opposed. A majority, seven out of ten of those supporting Assisted Dying also supported Assisted Dying for those suffering intractably but not terminally.[57]

41% of Scots have witnessed a dying family member or friend suffer unbearably towards the end of their life.[58] Only 6% of Scots think the current law in relation to Assisted Dying in Scotland is working well.[59]

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[51] BMA. Public and professional opinion on physician-Assisted Dying. 1.

[52] Humanists UK. Overwhelming public support for Assisted Dying – public mood unchangedciting British Social Attitudes Survey, available at https://humanists.uk/2025/03/18/overwhelming-public-support-for-assisted-dying-public-mood-unchanged/ 18 Match 2025

[53] https://www.dignityindying.org.uk/blog-post/assisted-dying-not-assisted-suicide/

[54] https://natcen.ac.uk/news/public-support-assisted-dying-remains-high-and-stable

[55] https://committees.parliament.uk/writtenevidence/116429/pdf#:~:text=The proportion of respondents saying Table 1, 1.

[56] Compassion in Dying. Rethinking the UK's Approach to Dying (2024) available at https://compassionindying.org.uk/resource/rethinking-uk-approach-dying/

[57] Smith, M. Three quarters support Assisted Dying law at https://yougov.co.uk/politics/articles/50989-three-quarters-support-assisted-dying-law

[58] Dignity in Dying. The Inescapable Truth of Dying in Scotland (2019) 8 available at https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[59] Dignity in Dying, as above. 8

There continues to be strong and consistent support amongst the public for assisted dying, and in a context of increasing instances of chronic suffering amongst the public. Medical organisations have by and large dropped their opposition to the legalisation of assisted dying. The arguments for and against are clearer than ever in the minds of the public and legislators, and the practicalities of introducing assisted dying have been studied in detail.

Scottish Legal Overview

The ASSISTED DYING FOR TERMINALLY ILL ADULTS (SCOTLAND) BILL, introduced by Liam McArthur MSP, is at this time of writing moving towards the third stage in Holyrood.

Suicide is not illegal in Scotland. However, Chalmers[60] [61] questions the supposition that this has always been the case, suggesting that the act of suicide may have been regarded in the past as illegal but unpunishable. Ward also notes the historical ambiguity that remains on this issue[62]. It is not unreasonable to speculate that suicide was regarded as taboo in the past, but the lack of evidence of prohibition or prosecution suggests that, certainly in the past century or so, suicide has not been treated or regarded as illegal. In the past, in certain circumstances, where an attempt in public had caused alarm, a charge of breach of the peace could be raised, but this appears unlikely now. Historically, forfeiture and confiscation of property to the crown could be applied, but forfeiture is not applicable now in cases where a person has died by their own hand. Assisting another person's death, in certain circumstances, is also not illegal in Scotland, although direct causation of a death remains a prosecutable offence, and forfeiture of the property that would have been inherited by a person who has assisted in a suicide in the knowledge and motivation of personal gain is possible. In Scotland, relevant court rulings remain sparse and there remains limited formal guidance from the The Crown Office and Procurator Fiscal Service (COPFS), unlike the guidance provided in England by the Crown Prosecution Service.[63] [64]

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[60] Chalmers, J. Assisted Suicide (Scotland) Bill: Response to Question Paper: The Position under Existing Scots Criminal Law. 2015 https://www.gla.ac.uk/media/Media_393071_smxx.pdf

[61] Chalmers, J. "Assisted suicide: jurisdiction and discretion." Edinburgh Law Review, 2010, 14 (2). 298. ISSN 1364-9809 (doi:10.3366/elr.2010.0007) https://eprints.gla.ac.uk/70278/1/70278.pdf

[62] Ward 2022 as above 63-67

[63] Ward, AJ. Who Decides? Balancing competing interests in the Assisted Suicide debate. LL.M(R) thesis 2015 26. http://theses.gla.ac.uk/6394/2015WardLLM.pdf

[64] Chalmers, 2010 as above

Whilst each assisted dying case in Scotland in the past 40 years has resulted in a verdict of culpable homicide and an admonition[65] (the individual although convicted, is free to go about their life), killing of another individual will usually be investigated as possible murder.

It would be useful to briefly examine the criteria of 'recklessness' and 'wickedness', along with the terms 'murder' and 'culpable homicide'.

Under Scots law, murder is the wilful and deliberate taking of a life, with wicked/depraved/reckless intent. Wicked intent is established where death of the victim was the outcome intended by the perpetrator. Reckless conduct is that which is carried out with insufficient thought as to outcome or consequences. Stark defines reckless as "unreasonable/unjustified risk-taking".[66] McDiarmid notes that in Scots law 'recklessness' is a "lack of caution, or rashness, or disregard for consequences"[67] in carrying out the act.

Wicked recklessness is established where wicked intent may not be proven, but the characteristics and severity of assault indicate a state of mind that is analogous in terms of wickedness and depravity to that of a deliberate killer. In the cases of assisted deaths in Scotland in recent decades, it is not unreasonable to speculate that the decisions made to assist in the death of a loved one were not rash, but considered at some length, and judging by the outcomes in trials relating to assisted deaths, may have been seen to be so by the court. Certainly the outcomes in recent decades suggest that the flexibility available to prosecutors allowed for compassionate rather than punitive outcomes. Recognising and protecting the sanctity of life, as McDiarmid notes, has been a central part of Scots Law historically but culpable homicide "navigates the broad range of behaviours which may be brought within its own ambit of lesser seriousness in killing"[68], i.e short of murder. As Ward notes, "the principle of actus non facit reum nisi mens sit rea is generally applied in Scots Law."[69] In effect, it is separately labelled (from murder) and understood as: "blameworthy killing which is not murder".[70]

A successful defence of provocation can negate the elements of wicked intent or wicked recklessness, reducing the charge from murder to culpable homicide. The

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[65] A formal judicial reprimand and warning to not reoffend.

[66] Stark, F. "The Reasonableness in Recklessness." Criminal Law and Philosophy 14, 9–29 (first page) 2020. https://doi.org/10.1007/s11572-019-09501-z. https://d-nb.info/1197826513/34

[67] McDiarmid 2023 as above: 16

[68] McDiarmid, C. Examining Culpable Homicide in Scots Law in Reed, A et al (eds) Killings Short of Murder: A Research Companion London Routledge 2018 2. Found at https://pure.strath.ac.uk/ws/portalfiles/portal/85074601/McDiarmid_2018_Killings_short_of_murder_culpable.pdf

[69] Ward 2022 as above 74

[70] Maher, as above 13

accused is seen to have acted from a type of weakness rather than wickedness that could be understandable in any "ordinary person'. McDiarmid notes that "provocation and diminished responsibility are the only formal mechanisms available in Scots law for the ""reduction" of murder to culpable homicide"[71]. McDiarmid suggests that if an intention to kill does not necessarily amount to wicked intent and therefore murder, then there would exist a further partial defence to murder of "lack of wickedness"."[72] Chalmers and Leverick note that Lord Justice-General (Rodger) stated that "just as the recklessness has to be wicked so also must the intention be wicked".[73] The existence of provocation would mean that the accused's action "though culpable, was not wicked".[74] As Maher notes "By contrast culpable homicide is an unlawful killing where the accused lacks intention to kill or such wicked recklessness."[75] While provocation and diminished responsibility may be accepted as mitigating factors in a killing, the killing is still regarded as unjustified under the law and can currently only lead to a lesser conviction of culpable homicide.

Assisted deaths may be neither accidental nor characterised by wicked intent to kill or action of wicked recklessness[76]. Judging by the outcomes in trials relating to assisted deaths in recent decades, the actions taken by those who assisted in a death were not perceived to be reckless or wicked in intent. Consideration may have been given to the emotional trauma experienced by a person who has agreed to assist a death, and the possibility of diminished responsibility. Ward notes that there can be an argument of diminished responsibility may play a part in rulings

> where the accused had strong emotional ties to the deceased person, a court may be persuaded that the accused was suffering from diminished responsibility and could avail themselves of this partial defence. Diminished responsibility is now a statutory defence in Scotland, which codified the common law.[77]

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[71] McDiarmid 2023 as above: 5

[72] McDiarmid 2023 as above: 5

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[75] Maher, G. "'The most heinous of all crimes': Reflections on the structure of homicide in Scots law." in J Chalmers & F Leverick (eds), Essays in Criminal Law in Honour of Sir Gerald Gordon. Edinburgh Studies in Law, Edinburgh University Press, Edinburgh 2010 3. Found at https://www.pure.ed.ac.uk/ws/portalfiles/portal/16518952/GHG_Book_chapter_09_Dec.pdf

[76] e-Jury Manual, 2024. Page 57.2 / 133. https://judiciary.scot/docs/librariesprovider3/judiciarydocuments/judicial-institute-publications/jury-manual-pdf-version-3-september-2024.pdf?sfvrsn=77191416_0

[77] Ward, 2022 as above 93

The public in general and when participating in juries have not regarded assistance to die as wicked in cases where suffering has been unbearable and intractable and clear consent was given. Outcomes in court in the past four decades have certainly been consistent with public support for assisted deaths, regarded as as compassionate acts in support of those intractably suffering in conditions of great trauma for both the sufferer and the person assisting. This certainly seems to be the case with Brady[78], Edge, Wilson and Gordon[79] (see later) as marked by a clear but not wicked intent. At the discretion of the Lord Advocate in Scotland such acts of compassion are, in the absence of legislation on assisted dying, still likely to lead to a court case, prosecution and sentencing that recognises "the inherent wrongfulness of killing"[80]. McDiarmid argues that cases such as Ross v Lord Advocate[81] leave "culpable homicide as rather an amorphous category, lacking even a clear definition of *actus reus* and *mens rea*."[82]

In Drury v HM Advocate[83] an appeal reduced the conviction of murder to culpable homicide. Chalmers and Leverick describe the Drury full bench decision of five judges as "the most controversial judicial decision on Scots criminal law of recent years".[84] [85] The basis of the reduction was that despite the degree of violence involved, the act could be mitigated via a plea of diminished capacity, and therefore insufficient 'wickedness', due to provocation. In this case, Stuart Drury had violently assaulted his ex-partner Marilyn McKenna with a hammer having discovered her with a new partner and she subsequently died. Drury was initially convicted of murder. The conviction was quashed on appeal, reduced to culpable homicide. The archaic notion of provocation due to a threat to male "ownership" of a partner in relation to perceived infidelity is problematic in itself, but as Lady Mcdiarmid has

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[78] Brady 1997 see later 18.

[79] Gordon 2018 see later 19.

[80] McDiarmid as above 5

[81] see later.

[82] McDiarmid as above 5

[83] https://www.casemine.com/judgement/uk/5a8ff7eb60d03e7f57eb2dc3

[84] Chalmers, J., and Leverick, F. (2007) *Murder through the looking glass: Gillon v HM Advocate.* Edinburgh Law Review, 11 (2). pp. 230-236. p230 ISSN 1364-9809 *http://eprints.gla.ac.uk/37740/*

[85] The plea of provocation, on the basis of infidelity was accepted (an outdated notion for many) despite the relationship having ended some time previously and McKenna having turned to both civil and criminal law to protect her from Drury's stalking of both her and her children.

noted, McKenna had ended the relationship[86] [87] and McKenna had sought legal protection from stalking by Drury[88]. At the time of her death, she was trying to be rehoused 'outwith the area in which [he] was operating'.[89] None of this appears to have been taken into account during the appeal.

McDiarmid notes that the subsequent cases of Elsherkisi[90] [91] and Meikle[92] clarified that an intention to kill "absent either provocation or diminished responsibility, will, generally, signify murder". While after Drury it may have been argued that the "wicked" part of 'wicked recklessness' may not apply, the judge in the original Elsherkis trial stated "intending to kill someone is obviously wicked". However, no new precedent was established as the appeal ruled that the judge's statement was made within the context of the absence of mitigation or justification that could allow for a verdict of culpable homicide. The appeal ruling also reiterated that it was for a jury to decide the accused's state of mind.

The Drury interpretation was also challenged in Gillon,[93] [94] and while some useful clarification was achieved, the mens rea analysis in the Drury case was accepted as valid. Chalmers and Leverick argue that:

> Because culpable homicide requires the accused to be aware of the risk which he is running – "reckless" in the proper sense of the term – "wicked" is, in this context, used to distinguish those reckless killings which should be treated as murderous from those which are instead culpable homicide.[95]

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[86] Lady McDiarmid. Drury v HM Advocate. 2001 SLT 1013 in Scottish Feminist Judgments: (Re)Creating Law from the Outside In, Eds Sharon Cowan, Chloë Kennedy and Vanessa E Munro, 117

[87] McDiarmid, Claire. Reflective Statement: Drury v HM Advocate. 126-130 in Scottish Feminist Judgments: (Re)Creating Law from the Outside InEds Sharon Cowan, Chloë Kennedy and Vanessa E Munro: 129

[88] Chalmers, J., and Leverick, F. (2007) *Murder through the looking glass: Gillon v HM Advocate.* Edinburgh Law Review, 11 (2). pp. 230-236. p230 ISSN 1364-9809 *http://eprints.gla.ac.uk/37740/*

[89] McDiarmid, Reflective Statement: 130

[90] Elsherkis v HM Adv 2011 SCCR 735.

[91] On 26 May Mustafa Elsherkis assaulted Mohammed Idris Mirza with a knife and killed him.

[92] Meikle….

[93] Gillon v HM Advocate [2006]ScotHC HCJAC_61 https://www.casemine.com/judgement/uk/5a8ff85060d03e7f57ebe2fb

[94] Gillon assaulted and killed Gary George Allan Johnstone on on 13 January 1998, striking him repeatedly with a spade. On appeal, the court reaffirmed the law's requirement that there existed a reasonable proportionality between the provocation and the responding actions.

[95] Chalmers and Leverick Murder Through 236

McDiarmid argues that the definition of culpable homicide remains broad and vague.[96] The ruling on Petto[97] was critical of such terms as wicked and depraved, describing them as limiting and anachronistic, meriting serious re-examination. As a result, a "Discussion Paper on the Mental Element in Homicide (Discussion Paper no 172)'[98] was published in 2021. However, assisted dying was excluded from the scope of the paper. McDiarmid questions whether "mercy killing can be appropriately accommodated within the general common law scheme for homicide and, if not, what should be done about it."[99]

When examining the outcome of mercy-killing cases in the past four decades in Scotland, the juries were either provided with evidence of diminished responsibility, or appeared to have taken as read that such deaths occurred without wickedness or recklessness. McDiarmid observes that "the insistence in Drury, a full-bench decision of the appeal court, on the need for the presence of sufficient 'wickedness' before murder can be established may still have resonance in relation, particularly, to so-called mercy killings."[100] Interpretation therefore remains somewhat amorphous, although the breadth of possible interpretation can allow the Lord Advocate a great deal of discretion in decisions to prosecute. As McDiarmid notes, "[t]he Crown's discretion can allow for a compassionate, morally grounded response"[101], quoting Douglas Husak[102]:

> Even when the state has a good reason to discourage a given type of behaviour, it may lack a good reason to subject those who engage in it to the hard treatment and reprobation inherent in punishment.[103]

Where assistance has been requested and consent has been given, and the taking of a life is recognised as an act of compassion, a charge of murder is unlikely although not impossible. Certainly, if the court does not accept arguments of consent and compassionate motivation, but instead concludes that '*mens rea'* (wicked intention to kill or wicked recklessness)" exists, a charge of murder is possible.

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97 Petto v HMA, 2011 SCCR 519

98 *https://www.scotlawcom.gov.uk/files/9716/2254/8710/Discussion_Paper_on_the_Mental_Element_in_Homicide_-_DP_No_172.pdf*

99 McDiarmid 2023 as above: 9

100 McDiarmid 2023 as above: 6

101 McDiarmid 2023 as above: 10

102 "The Criminal Law as Last Resort" (2004) 24 Oxford Journal of Legal Studies 207.

103 McDiarmid 2023 as above: 17

Opinions long-held by the public in relation to mercy killings have been reflected in jury deliberations and rulings on the matter. A charge of culpable homicide has proven to be the ultimate verdict (resulting in freedom with an admonishment) in those Scottish cases between 1982 and 2025 (except in one case resulting in a verdict of assault with probation) where a death has been assisted and consent and compassionate motivation were argued and accepted.[104]

The crux of the current debate, ongoing in the Scottish Parliament, in relation to legal sanction, is whether the act of assisting a death as a compassionate means to curtail the intractable suffering at the request of a consenting individual with a terminal condition should result in criminal prosecution at all. If an assisted death were to follow a legally sanctioned procedure, it would become a health management matter, not a criminal matter. An assisted dying system as proposed by McArthur, with checks in place and consent confirmed would in large part remove these cases from the need for prosecution. Any case within or outwith such a system, where potential malfeasance is identified, would still be subject to investigation and prosecution. Any case that lay within the accepted parameter prescribed by law would no longer further traumatise individuals who followed legal prescription nor take up court time and resources.

In the absence of such a legalised system of assisted dying, it is useful to examine the current state of affairs as the law stands.

[104] See later 18-19

Degrees of Causality: Assisting A Person To Die

In Scotland helping a person to die can lead to prosecution for murder, culpable homicide or reckless endangerment.[105] [106] However, a number of case outcomes have some bearing on the likely adjudication and sentencing in cases relating to any Scot who assists another in their death.

The provision and/or administration of a substance to an individual, where the substance could cause harm and could lead to a fatality.

The cases of Khaliq and Anor[107], and Ulhaq[108] involved the sale of solvent-abuse kits, in the knowledge that they would be abused and therefore posed a risk to users. Despite self-administration by the purchasers, the sale by the accused was adjudged to be a culpable and reckless act that could lead to a conviction of culpable homicide where death occurs as a result. These cases at the time indicated that voluntary ingestion by users may not break the causal link. While these cases did not involve culpable homicide (there were no deaths), the principle established was subsequently cited in *Lord Advocate's Reference (No 1 of 1994)* 1996 JC 76[109] [110], which reiterated that voluntary consumption by a victim did not break the causal link of supply. A subsequent decision in the Westminster House of Lords[111] reignited the debate on whether supply constitutes culpable and reckless behaviour (they did however distinguish between supply and administration). A bench of five judges in Scotland would subsequently consider the principle in McAngus & Kane[112].

In the case of McAngus & Kane, Kevin MacAngus had supplied ketamine to a group, one of whom, Andrew Turner, died from self-ingestion of a lethal amount. The defence was based around principles of causation and personal autonomy. The defence argued that there was no recklessness or intent to harm, and that "voluntary

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[105] Fakonti, C & Papadopoulou, N, '"Choice, autonomy, coercion in Scotland's Assisted Dying for Terminally Ill Adults Bill 2024". 2025, Edinburgh Law Review, vol. 29, no. 1, pp. 162-168. C(1) https://researchonline.gcu.ac.uk/ws/portalfiles/portal/99210555/99187574.pdf

[106] Warlow, Charles. A new bill could legalise Assisted Dying in Scotland. BMJ 2024;385:q792. para 2 https://www.bmj.com/content/385/bmj.q792

[107] Khaliq and Anor v HMA 1983 SCCR 483 (CCA); 1984 JC 23; 1984 SLT 137.

[108] Ulhaq v HMA 1991 SLT 614.

[109] https://www.casemine.com/judgement/uk/5a8ff8d660d03e7f57ece156

[110] Stoddart, Charles. Breaking the chain. The Journal, Law Society of Scotland. 20th April 2009. https://www.lawscot.org.uk/members/journal/issues/vol-54-issue-04/breaking-the-chain/

[111] R v Kennedy (No 2) [2008] 1 AC 269. https://publications.parliament.uk/pa/ld200607/ldjudgmt/jd071017/kenny-1.htm

[112] McAngus & Kane v HMA 2009 HCJAC 9 at https://www.casemine.com/judgement/uk/5a8ff85160d03e7f57ebe30c#:~:text=The

ingestion of a drug by a competent adult was a *novus actus interveniens*[113] which broke the causal link."[114] In parallel, Michael Alexander Kane had supplied and also injected a controlled and potentially lethal drug, diamorphine, to two people, one of whom, Sheila Marie MacMillan, died. His defence had been concerned that the additional phrase "culpable and reckless" was only included in Kane's charge, arguing that "There was no effective difference between supply and administration in the circumstances of these cases".[115]

In both cases the intent and expectations of the accused, despite any awareness of the dangers associated with the illegal drugs in question, was that a recreational and non-lethal experience would occur amongst friends. While there was also consent in the Kane case, the direct administration of the drug was regarded to more clearly resemble causation via culpable and reckless conduct. Emerging in the ruling was the notion that although 'culpably and recklessly' may be implied in all such cases, culpable homicide can apply in relation to supplying or administration of a controlled drug only if the prosecution offers to prove it was a reckless act. Citing Professor Glanville Williams, the ruling noted that a volitional act sets: "a new "chain of causation" going, irrespective of what has happened before"[116], and that outside of those who lack capacity, the exercise of free will is assumed in criminal law. The ruling states that

> generally speaking, informed adults of sound mind are treated as autonomous beings able to make their own decisions how they will act….Thus D is not to be treated as causing V to act in a certain way if V makes a voluntary and informed decision to act in that way rather than another.[117]

However, despite personal volition of Turner, the supply of a drug for immediate ingestion tied McAngus to involvement and could establish a causal link to the subsequent death and therefore culpability. The ruling noted

> [t]he law can with justification more readily treat the reckless, as against the merely unlawful, actor as responsible for the consequences of his actions, including consequences in the form of actings by those to whom he directs such recklessness….Subject always to questions of immediacy

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[113] Liability lies, through a new intervening act, with the person who chose to carry out that act.

[114] McAngus & Kane [8]

[115] McAngus & Kane [21]

[116] Williams G. The Cambridge Law Journal, Vol. 48, No. 3 (Nov., 1989), 391-416 available at https://www.jstor.org/stable/4507320 as cited in McAngus & Kane v HMA [32] available at https://www.casemine.com/judgement/uk/5a8ff85160d03e7f57ebe30c#:~:text=Conclusion%3A,in%20cases%20of%20culpable%20homicide.

[117] McAngus & Kane as above [32]

> and directness, the law may properly attribute responsibility for ingestion, and so for death, to the reckless offender.[118]

The ruling noted that "the actions (including in some cases deliberate actions) of victims, among them victims of full age and without mental disability, do not necessarily break the chain of causation"[119] and that "a deliberate decision by the victim of the reckless conduct to ingest the drug will not necessarily break the chain of causation."[120] As Chalmers[121] observed:

> The "not necessarily" conclusion reached by the High Court gives little concrete guidance on how the law would approach the facts of any future case. It at least leaves open the possibility that provision of the means of suicide would be regarded as the legal cause of death. If the provider knew the purpose for which the means were provided, they would almost certainly have the necessary mens rea for murder, or at least culpable homicide.

McDiarmid[122] concludes that "Such a formulation effectively removes the agency of the victim in deciding to ingest a potentially harmful substance and relies heavily on the accused's recklessness as a justification." However, Ward[123] details the conclusion of the MacAngus case:

> Proceedings were raised for culpable homicide, but the Appeal Court decided that culpable homicide could not be established because the accused's act was not directed in some way against the victim. The case was reconsidered for prosecution in light of that decision, and it was decided that the evidence was unlikely to result in a conviction.

The proceedings in relation to McAngus left an ambiguity, as although it was felt that there was insufficient evidence to secure a conviction, voluntary ingestion of a lethal substance was regarded as not necessarily breaking the chain of causation, and therefore not only could the direct administration of a lethal drug be seen to directly and recklessly cause a death, but the supply (alone) of a lethal substance could be regarded as reckless and the cause of death, and therefore subject to a charge of culpable homicide. In effect, this left any assisted death, both by supply and by administration of a lethal substance subject to a charge of both culpable and reckless behaviour.

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[118] McAngus & Kane as above [45]

[119] McAngus & Kane as above [42]

[120] McAngus & Kane as above [48]

[121] Chalmers 2015 as above.

[122] McDiarmid as above 25.

[123] Ward 2022 as above 156

Around the same time as McAngus, therefore also two examples of medical practitioners providing advice, and in the case of Kerr prescriptions to facilitate death. In 2008, Dr Ian Kerr[124] provided advice and prescriptions to patients who indicated that they were considering ending their lives. He was suspended by the General Medical Council, and although three cases were reported, the Crown Office Procurator Fiscal Service decided it was not in the public interest to prosecute. In 2010, Surrey Police arrested Glasgow resident and retired family planning practitioner Elizabeth Wilson[125] for advising Surrey resident Cari Loder how to take her own life. Loder succeeded in her attempt. The Crown Prosecution Service decided that a prosecution was not in the public interest.

Although the number of reported cases is too limited to establish a trend, the cases above suggest the above level of involvement and causality was regarded as insufficient to warrant prosecution.

Assistance in the death of a consenting adult with capacity.

Ward details a number of cases, and notes that while there is a clear degree of inconsistency, an overall liberal inclination in Scotland towards leniency is evident.

In 1980 Robert Hunter[126] claimed ending his wife's life was a mercy-killing. He was charged with culpable homicide and sent to prison for two years. In 1996, Paul Brady[127] [128] [129] smothered his brother after administering alcohol and pills, and walked free with a charge of culpable homicide and an admonition.[130] In a 1997 High Court case, David Hainsworth[131] was charged with the unsuccessful attempt to end the life of his father who was dying of cancer. The murder charge was reduced to assault, with a two-year probation order. In HMA v Edge (2005)[132], suffering from severe depression Edge smothered his wife who suffered from dementia, and had pled guilty to culpable homicide. Edge was admonished. In 2011 Helen Cowie[133]

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[124] Ward 2022 as above 106

[125] Ward 2022 as above 107

[126] Ward 2022 as above 104

[127] McDiarmid as above 27.

[128] BMJ 1996;313:961 doi: https://doi.org/10.1136/bmj.313.7063.961

[129] Herald, The (no attribution). "Mercy killing brother admonished". 15 October 1996 available at https://www.heraldscotland.com/news/12085275.mercy-killing-brother-admonished/

[130] Brady 1997 as before.

[131] Ward 2022 as above 105

[132] Ward 2022 as above 106

[133] Ward 2022 as above 155

admitted on a BBC Radio Scotland show 'Call Kaye' that she had taken her 33 year-old son Robert, who was paralysed from the neck down, to Dignitas where his life was ended. After consideration, Strathclyde Police chose to conduct no further investigation into the death. In HMA v Susanne Wilson 2018 Susanne Wilson[134] was initially charged with murder. Mr Wilson was chronically ill and had already attempted suicide. Mrs Wilson smothered her husband after he had taken pills with a view to ending his life. Diminished responsibility was cited, and Mrs Wilson admitted culpable homicide and was eventually admonished. Ian Gordon's wife took an overdose and then he smothered her. He was convicted of culpable homicide and jailed for four years and three months[135]. The sentence was appealed[136] and the sentence for an act described as a "final act of love" while suffering a depressive episode, was quashed[137] and an admonition substituted.

The outcome in each case indicates a clear pattern and likely non-punitive outcome for any similar assisted dying cases in the future in Scotland, regardless of a change in the law.

Gordon Ross seeks clarity on assisted deaths

Gordon Ross challenged the Lord Advocate in court[138], claiming that the Lord Advocate had failed

> to promulgate a policy identifying the facts and circumstances which he will take into account in deciding whether or not to authorise the prosecution in Scotland of a person who helps another person to commit suicide.[139]

Ward argues that a refusal to do this was at odds with the outcome of the Purdy case in England:[140]

> At issue in Ross was whether the Lord Advocate was breaching Article 8 by not publishing guidance regarding the factors weighing for and

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[134] Ward 2022 as above 108

[135] HMA v Gordon [2018] JC 139 as before.

[136] Gordon v. HMA [2018] HCJAC 21 as before.

[137] Scottish Legal News. "Husband jailed for culpable homicide over 'mercy killing' of terminally wife admonished following appeal". 12 Mar 2018. https://www.scottishlegal.com/articles/husband-jailed-culpable-homicide-mercy-killing-terminally-wife-admonished-following-appeal

[138] Gordon Ross (petitioner) against Lord Advocate (respondent). Petition of Gordon Ross (AP) for Judicial Review, Outer House, Court of Session [2015] CSOH 123 P1036/14. at http://www.europeanrights.eu/public/sentenze/CSOH_8sett.pdf

[139] Ross [2015] as above [6]

[140] Ward, 2022. as above 140.

against prosecution of someone who assists another person in ending their life.

Ross sought specific guidance, as had occurred in England after Purdy, from Scotland's Lord Advocate on criteria applied and likely outcome of assessment of cases of Assisted Dying, i.e. where one individual provided assistance to another in dying. The DPP in England had published clearer guidelines for a decision to not prosecute. The Lord Advocate's response was that this was not appropriate, as while under the European Convention on Human Rights the right to respect was recognised for private life encompassing respect for an individual's right to die - particularly to avoid an undignified and distressing death - the substantive law was not in breach of the petitioner's rights. Lord Doherty ruled that he was "satisfied that the foreseeability requirement is met"[141], but also iterated 13 factors that could be taken into consideration in relation to a choice to prosecute[142].

Ross had expressed concern that while self-administration of a lethal substance remained less likely to attract prosecution, direct assistance in administration of a lethal substance could be more likely to attract prosecution. As such, he and individuals in similar circumstances could feel pressurised to end their lives earlier than necessary by their own hands, and not later when physically incapable and requiring assistance. Ross argued that the lack of clarity placed undue stress upon sufferers and those who may seek to assist them in ending their lives.

The legal position in Scotland remained that as no law specifically enables another person to assist somebody to end their life, discretion in relation to prosecution remains with the prosecutor, and assessment occurs after the attempt, not before, and on a case-by-case basis. The Prosecution code was regarded to allow sufficient scope and discretion to deal with such cases. An example cited was that it was evident that in the absence of coercion, no crime was committed in accompanying a person abroad where that person killed themself by self-administering a lethal dose.

Ross petitioned for judicial review in the Court of Session seeking clarification. Ross's continuing concern was that at the time where he may find life unbearable he would require assistance to take his own life. Ross hoped to elicit similar new guidelines for (non) prosecution, as had been produced in England by the DPP. Ross died before the ruling was published, and the appeal was unsuccessful overall, although it elicited further clarification.

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[141] Opinion of Lord Doherty in the Petition of Gordon Ross [2015) CSOH 123 P1036/14 [42]

[142] as above [5]i to [5](xiii)

The Ross Appeal[143]

On February 19th, 2016. Lord Justice Clerk Carloway, Lady Dorrian and Lord Drummond Young heard the appeal. They offered some key clarifications The ruling supported the Lord Advocate's refusal to produce specific guidelines.

Lord Drummond Young notes that under Scots law suicide is not a crime, and in the case of an assisted death "exceptional cases may exist where a prosecution will not be appropriate"[144] However, he qualifies this by noting that each potential prosecution must be reviewed on its own individual merits. In the case of provided assistance, Drummond Young notes that various precedents in relation to causation can be applied in judging the level of direct causal link. Prosecution can be expected in cases where sufficient admissible evidence is perceived to exist of murder or culpable homicide, or culpable and reckless conduct is suspected. Factors may mitigate against prosecution, such as "the age and circumstances of the victim, the attitude of the victim, and the motive for the crime".[145] Criteria that may support action against any person who is seen to assist another in killing themselves, under current legal conditions, include sufficient evidence existing of an element of coercion, "undue influence, or other acts which could circumvent their will".[146] As the ruling notes, "exactly where the line of causation falls to be drawn is a matter of fact and circumstance for determination in each individual case."[147]

Lady Dorian notes that "As parties have agreed, suicide is not a crime in the law of Scotland. Moreover, it seems that suicide has never been a crime in Scots law."[148] She notes that, "there is in Scotland no offence of 'assisted suicide'."[149] She further notes that

> as the Dean of Faculty agreed during the hearing in this court, the clear situation of taking someone of sound mind and clear views to Switzerland to carry out a free and voluntary act would not even constitute the crime of culpable homicide in Scotland.[150]

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[143] Gordon Ross (reclaimer) against Lord Advocate (respondent), appeal as heard by Lord Justice Clerk Carloway, Lady Dorrian and Lord Drummond Young. [2016] CSIH 12 P1036/14 Scottish Court of Session at https://www.biodiritto.org/ocmultibinary/download/3033/29374/9/b701678c234eece5a1bd6ac39d5423c1.pdf/file/ross.pdf

[144] Ross Appeal as above [74]

[145] Ross Appeal as above [7]

[146] Ross Appeal as above [5]

[147] Ross Appeal as above [29]

[148] Ross Appeal as above [39]

[149] Ross Appeal as above [43]

[150] Ross Appeal as above [50]

Lord Carloway proposed that the petition "does not address the issue of "mercy killing" or euthanasia. It is restricted to acts of suicide which require some form of assistance from a third party."[151] He confirms the Lord Advocate's observation that neither taking one's own life nor attempting such are illegal in Scotland. The ruling also notes that "the criminal law in relation to assisted suicide in Scotland is clear. It is not a crime "to assist" another to commit suicide".[152] Clearly expressed and understood consent must however apply, and the degree of direct assistance and causality permissible retains limits. Assisting in the transport of a person to a location where they end their life would not qualify. Placing a pill in the hand of a consenting adult so that they can put it in their own mouth and therefore die by their own hand is permissible, but placing it in his or her mouth remains a grey area. Carloway argues that while administration of a lethal substance can qualify as homicide,

> the voluntary ingestion of a drug will normally break the causal chain. When an adult with full capacity freely and voluntarily consumes a drug with the intention of ending his life, it is this act which is the immediate and direct cause of death. It breaks the causal link between any act of supply and the death.….In the same way, other acts which do not amount to an immediate and direct cause are not criminal. Such acts, including taking persons to places where they may commit, or seek assistance to commit, suicide, fall firmly on the other side of the line of criminality. They do not, in a legal sense, cause the death, even if that death was predicted as the likely outcome of the visit...There is no difficulty in understanding these concepts in legal terms, even if, as is often the case in many areas of the law, there may be grey areas worthy of debate in unusual circumstances. There is no need for the respondent to set these concepts out in offence-specific guidelines.[153]

Dorrian concludes that the law meets the test for foreseeability, namely, that the ordinary citizen would "be able – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given course of action may entail".[154] Whether members of the public, even with knowledge of all the cases above, could confidently foresee the outcome of a trial however remains debatable.

Scottish courts have consistently insisted that substantive change in the law vis-a-vis assisted dying is a matter not for court but for the Scottish Parliament. Lord Drummond Young noted that in relation to the specificity sought by the petitioner, and in general, "absolute certainty is impossible. Every legal concept and every legal

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[151] Ross Appeal as above [4]

[152] Ross Appeal as above [29]

[153] Ross Appeal as above [30] [31] [32]

[154] Ross Appeal as above [62]

rule will inevitably be surrounded by a penumbra of uncertainty."[155] In effect, a decision to prosecute is always based on a broad and varying range of facts and precedents that will be taken into account, and such discretion is preferable. The ruling argues that "[t]he function of the prosecutor is to secure the due application of the law, and nothing more. Any major change in the law is a matter for Parliament".[156] Young also confirmed a reluctance to engage in a change in the law led by the courts, noting that while

> Assisted suicide is a subject that, on any view, raises profound moral issues. It also raises very strong feelings, both for and against. In such a case it is in my opinion wholly inappropriate for the courts to attempt any major change in the law.[157]

It was his view that the law is "a matter for legislators".[158]

As a result of such continuing grey area (some may continue to prefer to regard it as flexibility in discretion and scope for prosecution) in the law, it remains highly likely that after the fact, a good number of cases arising of assisted death will continue to require investigation and possibly court time.

The law and end-of-life medical practices [as at December 2025] for those suffering from an incurable and intractable condition (or conditions) in Scotland.

Illegal practice

Euthanasia, that is to say a fatal dose administered by a medical practitioner is illegal, but anecdotal sources and studies indicate that for compassionate and well-meaning reasons, medical professionals have been understood to curtail the unnecessary suffering of terminal patients. However, leaving such decisions to individuals, and to the vagaries and inconsistencies of individual opinion is a poor substitute for a consistent and well-regulated system. As detailed in 'The Inescapable Truth About Dying in Scotland'[159] "62% of Scottish healthcare professionals believe there are circumstances in the UK in which doctors or nurses have intentionally hastened death as a compassionate response to patients' request to end their suffering" at the end of life. Doctors have allegedly been known to do this for other doctors suffering from

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[155] Ross Appeal as above [71]

[156] Ross Appeal as above [84]

[157] Ross Appeal as above [85]

[158] Ross Appeal as above [78]

[159] Dignity in Dying, as above. 8

an incurable condition with intractable pain. A 2009 survey[160] of doctors found that 28.9% had made decisions involving providing, withdrawing or withholding treatment that they expected would hasten the death of a person under their care. A further 7.4% reported they had made decisions with, to some degree, the intention to hasten a person's death. These decisions were more likely to be made when responding to a person's request for a hastened death. Some healthcare professionals discussed the possibility that former colleagues may have actively hastened death. Some may see the hastening of a death in such desperate circumstances as morally acceptable, but both the unregulated decision and the legal jeopardy remain deeply problematic. The best interest of any patient and the medical practitioner is for any medical process to be subject to the strictures of legal regulation and professional administration[161]. The lack of regulation and supervision can allow flawed practice to occur[162].

Legal end-of-life medical options available to practitioners

A continuation of suffering, with palliative care providing whatever support it can until death. While some of the best palliative support in the world is available in Scotland, and the UK in general, palliative care provides insufficient relief from suffering for some. On average, 17 people a day in the UK experience painful deaths that cannot be relieved by the best palliative care[163]. In evidence to Westminster Kim Leadbeater gave the example where Tom's family begged doctors to intervene, while "Tom vomited faecal matter for five hours before he ultimately inhaled the faeces and died. He was vomiting so violently that he could not be sedated, and was conscious throughout".[164] According to the Office of Health Economics[165], in the UK there are "50,709 palliative care patients dying in some level of pain each year. Of these patients, 5,298 would still experience no pain relief at all in the last three months of

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[160] Seale, C, Hastening death in end-of-life care: A survey of doctors. Social Science & Medicine, 69(11), 1659 - 1666, 2009 as cited by Dignity in Dying, as above. 64

[161] Sharma, BR. "Assisted Suicide – How Far Justifiable?" in Physician Assisted Euthanasia. Amicus Books, 2008 65-85. https://www.academia.edu/4930108/Euthanasia_A_Dignified_End_of_Life_page_45_64

[162] Magnusson, R. "Euthanasia: Above ground, below ground." Journal of Medical Ethics 30(5):441-6, November 2004 DOI:10.1136/jme.2003.005090 https://www.researchgate.net/publication/8248731_Euthanasia_Above_ground_below_ground

[163] Dignity In Dying: The Inescapable Truth About Dying in Scotland (2019): study commissioned by the campaign group Dignity in Dying and conducted by the Office of Health Economics, a research company. https://features.dignityindying.org.uk/inescapable-truth/

[164] https://www.theguardian.com/commentisfree/2024/nov/29/assisted-dying-bill-life-death-mps

[165] Cookson et al (2019) Unrelieved Pain in Palliative Care in England. National Institute for Health Research. https://www.ohe.org/publications/unrelieved-pain-palliative-care-england

life." 41% of Scots have witnessed a dying family member or friend suffer unbearably towards the end of their life.[166] 46% of Scottish healthcare professionals have experience of caring for someone who has suffered at the end of their life despite receiving high quality palliative care.[167] The report "The Inescapable Truth About Dying in Scotland"[168] provides compelling case-studies and evidence that palliative support as it currently legally operates is insufficient in a range of cases. In the report:

> the Office of Health Economics concludes that, even if every dying person in Scotland who needed it had access to the excellent level of care currently provided in hospices, 591 people a year would still have no effective relief of their pain in the final three months of their life. Evidence suggests that if people suffering from other unrelieved symptoms during the dying process were included this number would be much higher.[169]

Within the context of palliative care, it is however seen as acceptable in certain circumstances for a patient to die due to treatment prescribed, under the doctrine of double effect.

Double effect. In such cases, the dosage of pain-killers judged to be required to deal with suffering may lead to death, but death is "foreseen but not intended"[170]. The claimed distinction between 'foreseeing death' and 'intending death' can appear very narrow in practice. It has been argued that heavy/terminal sedation simply prolongs death. Dr Erich H. Loewy suggests that some health professionals believe the doctrine of double-effect is a conceptual convenience that "'lets them off the hook' ethically…. the belief that their ethical virginity has been preserved is, like Pontius Pilate's notorious symbolic hand washing, a dangerous delusion."[171]

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[166] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[167] https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[168] https://features.dignityindying.org.uk/inescapable-truth-scotland/

[169] ibid

[170] The phrase "foreseen but not intended" is somewhat aspirational but also to some critics of the doctrine of double-effect somewhat disingenuous, somewhat akin to Pontius Pilate washing his hands - such critics would argue that if the outcome is foreseen, then the choice is surely to a degree intentional. This grey area of interpretation has no doubt provided some medics the latitude to assist death.

[171] Loewy, E. H. (2004). "Euthanasia, Physician Assisted Suicide and Other Methods of Helping Along Death." Health Care Analysis, 12(3), 192. https://doi.org/10.1023/B:HCAN.0000044925.40069.C7 https://www.academia.edu/113873484/

Heavy dosage drug administration short of inducing a coma. A suffering patient remains conscious but may lose themselves in a haze of drugs that can steal dignity and quality of life via increasingly heavy sedation. Nazari et al[172] note:

> "most patients in ICU cannot report their pain due to altered consciousness, mechanical ventilation, or sedation. Despite great efforts to accurately assess pain in patients in the ICU, their pain is still underestimated or remains undiagnosed and unmanaged."

Heavy dosage can result in unpleasant side effects and suffering at the end[173] such as nausea, vomiting, constipation, drowsiness, delirium and hallucinations, and an inability to communicate, comprehend or engage - some regard this as loss of dignity as social death long before physical death. Some sufferers, in particular those with cancer, in their final days or hours experience traumatic developments such as terminal haemorrhages, malignant fungating wounds, open stinking wounds, or a bowel obstruction and subsequent vomiting of faeces[174]. This also proves traumatic for their loved ones.

Heavy dosage drug administration involving an induced coma. Regarded as the closest legal analog, along with VSED, to an assisted death[175], the process risks the patient experiencing ICU delirium[176] [177] and discomfort, although they remain unresponsive until death. As noted by Sheen & Oates[178], "[t]he absence of physical responses should not be misinterpreted to mean that cognitive processes are not

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[172] Nazari R, Froelicher ES, Nia HS, Hajihosseini F, Mousazadeh N. Diagnostic Values of the Critical Care Pain Observation Tool and the Behavioral Pain Scale for Pain Assessment among Unconscious Patients: A Comparative Study. Indian J Crit Care Med. 2022 Summer;26(4):472-476. doi: 10.5005/jp-journals-10071-24154. PMID: 35656052; PMCID: PMC9067504.

[173] Dignity in Dying, as above 26-30.

[174] Dignity in Dying, as above 26-30.

[175] Duckworth, S. Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002) UK Parliament. 2022 available at https://committees.parliament.uk/writtenevidence/114065/pdf/

[176] ICU Delirium - This is a common disorganised cognitive experience related to post-anesthesia, drug-withdrawal and to sedation. ICU is commonly experienced when awake, but also in an unconscious state where, invisible to anybody else, a person is apparently at peace but can actually be undergoing a deeply unpleasant and confused dream state.

[177] Sheen, L & Oates, J. A phenomenological study of medically induced unconsciousness in intensive care. Australian Critical Care Volume 18, Issue 1, February 2005, Pages 25-32. https://www.sciencedirect.com/science/article/abs/pii/S1036731405800219#preview-section-abstract

[178] Sheen, L & Oates, J. A phenomenological study of medically induced unconsciousness in intensive care. Australian Critical Care Volume 18, Issue 1, February 2005, Pages 25-32. https://www.sciencedirect.com/science/article/abs/pii/S1036731405800219#preview-section-abstract

occurring." O'Connor et al[179] note that in dying patients as "conscious level deteriorates so too does their ability to reason, to process information and instructions, and articulate their needs or a response to stimuli", recommending that based on available evidence of continued cognition that patients should be regarded as unresponsive rather than unconscious. Herr et al observe that "[i]ndividuals who are unable to communicate their pain are at greater risk for under recognition and under-treatment of pain."[180] Owen et[181] al note that "37% to 43% of patients who receive the diagnosis of a persistent vegetative state can be demonstrated by careful, standardized clinical examination on the basis of the Coma Recovery Scale (CRS-R) to have at least minimally preserved consciousness.[182]

The process has also been criticised as an unnecessarily prolonged death. As Professor Stephen Duckworth argues[183]

> Being unconscious for medication to treat intractable pain is the same as being dead, and Continuous Deep Sedation (CDS) induces unconsciousness just as Assisted Dying causes death. So, the "Doctrine of Double Effect" does not establish a moral difference between CDS and Assisted Dying.

Denial or withdrawal of treatment and sustenance by medical staff, independent of the patient's consent.[184] Doctors in Scotland can withhold or withdraw treatment from a patient, where it is perceived to be futile, in the knowledge that the patient will die. Janet Johnston[185] was in a persistent vegetative state after a suicide attempt. The ruling confirmed that where 'futility' is agreed, there can be active involvement of medical staff in the ending of a life:

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[179] O'CONNOR, T., PATERSON, C., GIBSON, J. and STRICKLAND, K. 2022. The conscious state of the dying patient: an integrative review. Palliative supportive care [online], 20(5), pages 731-743. 4 https://doi.org/10.1017/S1478951521001541

[180] Keela Herr, Patrick J. Coyne, Margo McCaffery, Renee Manworren, & Sandra Merkel. Pain Assessment in the Patient Unable to Self-Report: Position Statement with Clinical Practice Recommendations. Pain Management Nursing Volume 12, Issue 4, December 2011, Pages 230-250 https://www.sciencedirect.com/science/article/abs/pii/S1524904211001883

[181] Owen AM, Coleman MR, Boly M, Davis MH, Laureys S, Pickard JD. Detecting awareness in the vegetative state. Science. 2006 Sep 8;313(5792):1402. doi: 10.1126/science.1130197. PMID: 16959998.

[182] Bender A, Jox RJ, Grill E, Straube A, Lulé D. Persistent vegetative state and minimally conscious state: a systematic review and meta-analysis of diagnostic procedures. Dtsch Arztebl Int. 2015 Apr 3;112(14):235-42. doi: 10.3238/arztebl.2015.0235. PMID: 25891806; PMCID: PMC4413244. https://pmc.ncbi.nlm.nih.gov/articles/PMC4413244/

[183] Duckworth, 2022 as above

[184] See Law Hospital NHS Trust later 15

[185] Law Hospital NHS Trust v Lord Advocate 1996 SC 301 at https://www.bailii.org/scot/cases/ScotCS/1996/1996_SC_301.html

> Lord Cameron of Lochbroom ruled that it was no longer in Janet Johnston's best interests to keep her alive. The way was cleared for the ruling after five senior judges held last month that a single judge could give permission for patients in persistent vegetative states to be allowed to die…. Scotland's Lord Advocate, Lord Mackay of Drumadoon, issued a statement saying that doctors who allowed patients to die with court approval would not be prosecuted.[186]

It was stated in that case:

> It is not in doubt that a medical practitioner who acts or omits to act with the consent of his patient requires no sanction or other authority from the court. The patient's consent renders lawful that which would otherwise be unlawful. It is not for the court to substitute its own views as to what may or may not be in the patient's best interests for the decision of the patient, if of full age and capacity.[187]

In relation to the Bland case[188] in England and the Johnstone case above, Ferguson notes that:

> [Lord Goff] conceded that the drawing of a distinction between the giving of a lethal injection (an act) and the discontinuation of treatment (an omission) "may lead to a charge of hypocrisy.[189]

Suicide attempt. This can be an attempt by an individual to end their life in isolation. Such attempts can be botched and lead to further and greater suffering. Sufferers with encroaching mobility issues, to ensure that they are able to cause their own death without assistance, may feel forced to end their lives earlier than they would choose. If sufferers are assisted, with consent, in ending their life while in Scotland, prosecution remains a possibility.

Dignitas or a similar foreign facility - this option is available for those who who can afford it and remain in sufficient health to be able to travel. Critics feel that sufferers, to ensure that they are able to travel, may end their lives earlier than they would otherwise have chosen.

Voluntary Stopping of Eating and Drinking (VSED). The law in Scotland already allows this particular version of Assisted Dying, enabled by the simple but common

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[186] Dyer, C. "Scottish court gives right to die." BMJ VOLUME 312, 4 MAY 1996. https://pmc.ncbi.nlm.nih.gov/articles/PMC2350638/

[187] Law Hospital NHS Trust as above at para 1, The Function of the Court.

[188] Both cases involved patients in a persistent vegetative state where, in the absence of consent being able to be given by the patients, leave from the court was requested and granted to cease life-maintaining support. The Supreme Court in 2018 ruled that in England and Wales legal permission was no longer required to withdraw treatment from patients in permanent vegetative state.

[189] Ferguson, Pamela R. Causing death or allowing to die? Developments in the law. Journal of Medical Ethics 1997; 23: 370

process of signing an advance directive form.[190] VSED has been practiced for decades. VSED is commonly accompanied by heavy dosage drug administration (often but not always to induce a coma) until death.

VSED merits an examination as a counterpoint to, and as the closest legally practiced analog in Scotland, to Assisted Dying. Both enable an individual to take their own life. Both tend to involve palliative support. Both tend to involve the administration of drugs in an attempt to lessen suffering in the process of an individual successfully taking their own life. Jox et al[191] argue that there is inconsistency in the support of palliative care societies, professional bodies of physicians, legal scholars, and ethicists of VSED while opposition to AD remains "medically supported VSED is, at least in some instances, tantamount to assisted suicide. This is especially the case if a patient's choice of VSED depends on the physician's assurance to provide medical support" and that "the assisting person knows and at least partially shares the patient's intention to induce death."[192]

Starvation and dehydration is a slow process. Bolt et al found that "in 8% of cases, dying was a prolonged process of more than 14 days"[193], while Quill et al found that "[t]he process of VSED until death may take up to 21 days"[194].

Quill & Byock[195] note:

> When unacceptable suffering persists despite standard palliative measures, terminal sedation and voluntary refusal of food and fluids are imperfect but useful last-resort options that can be openly pursued.

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[190] As long as the form contains the required elements to specify what is and is no longer allowable.

[191] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

[192] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

[193] Bolt EE et al. "Primary care patients hastening death by voluntarily stopping eating and drinking." Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

[194] Quill TE, Lo B, Brock DW. Palliative options of last resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia. JAMA. 1997 Dec 17;278(23):2099-104. doi: 10.1001/jama.278.23.2099. PMID: 9403426.

[195] Quill, TE. & Byock, IR. Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids. Annals of Internal Medicine· Volume 132· Number 5. March 2000. https://www.acponline.org/sites/default/files/documents/clinical_information/resources/end_of_life_care/intractable_suffering.pdf

However, there is anecdotal and research evidence that patients who have chosen VSED have been observed to experience delirium, pain and anxiety[196] [197] [198] [199]. The Patients Rights Council describes the VSED process as follows:

> As a person dies from dehydration, his or her mouth dries out and becomes caked or coated with thick material; lips become parched and cracked; the tongue swells and could crack; eyes recede back into their orbits; cheeks become hollow; lining of the nose might crack and cause the nose to bleed; skin begins to hang loose on the body and becomes dry and scaly; urine would become highly concentrated, leading to burning of the bladder; lining of the stomach dries out, likely causing the person to experience dry heaves and vomiting; body temperature can become very high; brain cells dry out, causing convulsions; respiratory tract also dries out causing thick secretions that could plug the lungs and cause death. At some point the person's major organs, including the lungs, heart, and brain give out and death occurs.[200]

As noted above, although a patient in an induced coma may remain unresponsive, this does not preclude the experiences of discomfort. The same option to access medication in response to visible expressions of suffering, or anti-psychotics where delirium may be experienced, is not available to those in an induced coma whose peaceful stillness and inability to express need may belie a far from peaceful experience. The 'deathwatch' experience can also be traumatising for loved ones.

The Domestic Abuse (Scotland) Act 2018, making coercive control illegal, came into force on 1 April 2019, and it is worth noting that no cases of coercion appear to have been identified in relation to VSED since then, or indeed before.

Substantive change in law in Scotland.

Commenting on Ross v Lord Advocate, McDiarmid argues:

> [w]hile clearly the so-called right to die raises particularly fraught issues of law, ethics, morality and compassion it is precisely in such cases, and

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[196] Mason, T & West, A. "Legal Briefing: Voluntarily Stopping Eating and Drinking," The Journal of Clinical Ethics 25, no. 1 (Spring 2014): 68-80.

[197] Bolt EE et al. 2015, as above.

[198] Wax JW et al. "Voluntary Stopping Eating and Drinking." J Am Geriatr Soc.;66(3):441-445. 2018 March.

[199] Topping, A. "Right-to-die campaigner who starved herself said she had 'no alternative". Guardian. Sun 19 Oct 2014 14.19 BST available at https://www.theguardian.com/society/2014/oct/19/right-to-die-campaigner-starved-herself-jean-davies

[200] The Patients Rights Council. Voluntarily Stopping Eating & Drinking: Important Questions & Answers https://www.patientsrightscouncil.org/site/wp-content/uploads/2013/03/VSED_Questions.pdf 28/04/25

> because of the intense anxiety which attends them, that clearer legal principle is particularly valuable and necessary. Without bespoke legislation in relation to assisted suicide, the common law on homicide requires to do this work.[201]

Ambiguity exists in Carloway's statement (and in the existing precedents in Scots Law in general) in relation to whether administering a lethal substance 'breaks the chain of causation' or may constitute a crime and is in the public interest to prosecute. The level of assistance given, therefore leaves potential for consideration for prosecutorial challenge, and indeed custodial sentencing. As a response by Friends at the End to the The Scottish Parliament Cross Party Group on End of Life Choices noted[202]:

> Scotland has failed to produce legislation to govern this area, condemning the legal landscape to 'an alarming lack of legal clarity', a situation described by Scots legal experts as 'shameful'. The Lord Advocate has refused to produce guidelines, stating that the Scottish prosecution code is suffice. It has been argued that the general prosecution code for homicide is not fit for purpose in the context of AD and that specific guidance should be offered. In Scotland, AD is governed by common law but had never been tested in the Scottish courts until Ross.

If malfeasance (such as coercion) is suspected in a directly assisted death, prosecution is most likely to occur after-the-fact, once the main witness is most likely already deceased. Investigation and intervention remains reactive, not preventative. Court proceedings can be lengthy and very traumatic, as well as taking up time and resources within the Scottish court system. Assisted dying legislation would go a long way to resolving this.

Supporters of Assisted Dying also argue that without a process introduced by law to medically monitor and assist individuals seeking assistance to end their own lives, such individuals can remain isolated, more vulnerable to coercion, and in danger of unpleasant deaths or deeply traumatising failed suicide attempts, or simply forced to end their lives prematurely.

The demand for clarification of the legal position in Scotland has grown significantly over the years. Scottish courts have refused to make substantive changes to the law, hence the introduction of legislation to the Scottish Parliament this year.

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[201] McDiarmid as above 8.

[202] Friends at the End. Submission to the Scottish Law Commission on its tenth programme for reform, 2018-22. Accessed 21/04/25 https://www.scotlawcom.gov.uk/files/1815/0669/5167/35.__CEO_Friends_at_the_End.pdf

Conclusion

Under Scots law, ending your own life is not illegal. There remains a degree of ambiguity as to how much assistance can be provided by another party without being subject to prosecution. Medical staff in Scotland can already legally refuse or withdraw life-maintaining treatment[203], can already legally administer a heavy drug dosage in the knowledge that it may be likely to cause the death of the patient, can already legally provide terminal sedation to a dying patient, inducing a coma until death, and can already legally facilitate a patient in ending their own life by dehydration and starvation (VSED). The outcome of death in this last case is both foreseeable and intended. Medical practitioners in Scotland who have provided advice and in one case the medication to facilitate death have not been prosecuted[204]. Supplying a lethal substance, but in situations where another chooses to ingest, the chain of causality is broken.[205] In the past four decades court rulings in Scotland have reflected public consensus, insofar as each person who has assisted a loved one to die, described by Ward as "amateur citizen-assisted deaths"[206] - ranging from accompanying somebody to Switzerland[207] to assisting an overdose and smothering the individual[208] - has either not been prosecuted, or charged with assault and granted probation, or eventually walked away free with an admonition. It is not unreasonable to infer that assisting a death in such circumstances is no longer 'punishable', i.e. subject to punitive verdicts in Scottish courts. It is clear however that any definitive clarification and codification of the law can only occur via legislation in Holyrood. The current proposals within the conservative ASSISTED DYING FOR TERMINALLY ILL ADULTS (SCOTLAND) BILL does not stray beyond existing legislation, practice or legal outcomes in such cases.

The law is it currently stands has not and will not stop those determined to end their life, or indeed those determined to assist loved ones to do so. If the legal status-quo remains vis-a-vis assisted dying, those who out of compassion provide assistance to another consenting adult to ensure their life ends could in increasing numbers be subject to prosecution. Such prosecutions, traumatic to those involved, appear to now be unlikely to result in a punitive outcome. Valuable court time may be taken up, and the key witness (the deceased) will be unavailable.

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[203] see Johnson above.

[204] see Kerr, Wilson above.

[205] see McAngus & Kane, also Carloway's opinion in the Ross appeal above.

[206] Ward 2022 171 as above.

[207] see Cowie above, see also the ruling on the Ross appeal above.

[208] see Brady, Hainsworth,, Edge, Wilson and Gordon above.

Competing interests: The author declares none.