LEGAL RULINGS, LEGISLATION AND SOCIAL CHANGE IN SCOTLAND RELATING TO ASSISTED DYING

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

Abstract

An examination of legal precedents that have operated in concert with demographic and political developments in Scotland leading to the Assisted Dying For Terminally Ill Adults (Scotland) Bill (2024). In understanding why legislative change now appears possible in Scotland, this document 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 (AD), as of January 2026 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. The French National Assembly has passed a bill to legalise AD. Iceland has introduced a bill on AD. The Isle of Man have legalised AD. Jersey has voted to introduce AD, and on the 24th February 2026 the Welsh Senedd voted in favour of assisted dying. Over the summer of 2025 Slovenia passed a law allowing terminally ill people to access voluntary assisted deaths. In 2023 Cuba passed a right to die with dignity law. In December 2025 the Illinois End of Life Options for Terminally Ill Patients Act (SB1950) was signed into law. From January 1st 2026 the End of Life Options Act has been implemented in Delaware. In New York the Medical Aid in Dying Act received the governor's signature on 6th February 2026. Kentucky, Maryland, Massachusetts, Tennessee, Indiana, Missouri, New Hampshire, Maryland, Florida, and Nevada have introduced AD bills. Uruguay's Chamber of Representatives has passed an AD bill, which is expected to be passed in the Senate. A judicial decision in Peru approved euthanasia for Ana Estrada, setting a precedent.

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

In countries such as the Netherlands and Canada where the courts have allowed significant change, the resulting AD 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 AD in the Netherlands is based around the concepts of beneficence and necessity[1], 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[2] in Scotland. Other principles raised in debates in various global jurisdictions include a rights to freedom from torture and unreasonable suffering and the right to dignity.

Reed et al[3] note that "[r]egardless of eligibility criteria, the proportion of all deaths which were assisted deaths has increased over time in most countries, although assisted deaths make up only a relatively small percentage of total deaths in any given year (0.1–5.3% in 2023)."

Scobie et al[4] note that

> [m]ost of those accessing assisted dying services have a diagnosis of terminal illness. Even in countries where this is not a requirement, a large majority had a terminal diagnosis – 79% in Belgium and 96% in Canada. The majority, 75% or higher, were receiving palliative care. People who access assisted dying services tend to be older: the median average age in each jurisdiction studied ranged between 69 and 80 years old. Cancer was the most common diagnosis, with between 55% and 80% having a reported diagnosis. Loss of ability to engage in meaningful activity and loss of autonomy are the most commonly reported reasons why people access assisted dying services."

Scobie et al[5] further note that in states where individuals and family/carers are left without professional support to administer the lethal dose and to deal with any potential problems that arise, this appears to act as a disincentive to taking up AD. They observe that "[i]n jurisdictions that allow only self-administered dying, assisted deaths make up less than 1% of all deaths."

---

[1] Lewis, P. "The Dutch Experience of Euthanasia." Journal of Law and Society, Volume 25, Issue4 December 1998. https://doi.org/10.1111/1467-6478.00107

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

[3] Reed S, et al. Diverging paths: How other countries have designed and implemented assisted dying. Nuffield Trust. 2025. *https://www.nuffieldtrust.org.uk/news-item/diverging-paths-how-other-countries-have-designed-and-implemented-assisted-dying*

[4] Scobie S, et al. Assisted dying in practice: International experiences and implications for health and social care. Nuffield Trust, 2025. *https://www.nuffieldtrust.org.uk/research/assisted-dying-in-practice-international-experiences-and-implications-for-health-and-social-care*

[5] Scobie et al, Assisted dying in practice, 2025 as above.

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

Opposition to assisted dying

A range of well-organised and well-funded pressure groups continue to oppose AD. Key UK opposition groups include 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 AD legislation. Despite a 2019 Populus poll[6] finding that 80% of religious people supported a change in the law to allow assisted dying, the Church of Scotland, the Catholic Church in Scotland, and the Scottish Association of Mosques also oppose AD. More recently however, the 2025 Church of Scotland Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying expounded on a 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.[7]

However, the position of the report "recognising the integrity of the range of views that exist in the Church"[8] on AD (a possible move to neutrality) was rejected by the General Assembly by 149–145, and the Church's opposition to AD persists. The campaign against the Scottish legislation has also had contributions from opponents from other countries.[9] 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.

---

[6] Sherwood, Harriet. Religious leaders 'out of step with flocks' on assisted dying, says UK *rabbi*. Guardian. 2023. https://www.theguardian.com/society/2023/jul/03/religious-leaders-out-of-step-with-flocks-on-assisted-dying-says-uk-rabbi-jonathan-romain

[7] Church of Scotland. Joint Report of the Theological Forum and the Faith Action Programme Leadership Team on Assisted Dying. 2025. 12.9, 09. https://www.churchofscotland.org.uk/__data/assets/pdf_file/0018/133443/13.-Joint-Report-of-the-Theological-Forum-and-the-Faith-Action-Programme-Leadership-Team-on-Assisted-Dying.pdf

[8] Church of Scotland. Church recognises diversity of opinion but reaffirms opposition to Assisted Dying. 2025. https://www.churchofscotland.org.uk/news-and-events/news/articles/church-recognises-diversity-of-opinion-but-reaffirms-opposition-to-assisted-dying

[9] Humanist Society Scotland. We write to The Herald over inaccurate assisted dying article. November 27, 2024. https://www.humanism.scot/2024/11/27/we-write-to-the-herald-over-inaccurate-assisted-dying-article/?fbclid=IwY2xjawHCXkRleHRuA2FlbQIxMQABHZCvWulXj2YBk0teEYXAA4V6_dDhiZLRO_bfzwdJRyYQlRdoJmF_m_0cvg_aem_ha6bv6Jsu9SoFVAAj5OSNQ#AssistedDying

The strength of feeling, although consistently a minority view, amongst those who oppose AD is undeniable. Key arguments against AD are noted by Materstvedt et al[10]:

> 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.

As opposition to AD for purely religious reasons has lost traction, that argument has been superceded by arguments that any system of AD 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[11] argues that:

> [e]ssentially, 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.

Common arguments framed by those who oppose AD 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 AD 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 AD. Common claims by opponents involve the claim that any AD 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 where, for example, 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 AD, 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

---

[10] 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

[11] Schuklenk, Udo. Assisted Dying in Canada. Healthcare Papers Vol. 14 No. 1 42 https://www.academia.edu/9188749/Assisted_Dying_in_Canada?email_work_card=view-paper

> 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 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

---

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

[13] Beauchamp, TL & Childress, JF. The Principles of Biomedical Ethics, 7th Ed. Oxford University 1 Press (2013): 181

[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. Elder Law Journal. 2008: 363. 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. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833177

into homicide.[17]

As Justice Baudouin in Canada concluded after considering expert evidence, "[n]either 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."[18]

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."[19]

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 AD. 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 AD legislation in Scotland would require further legislation to be passed.

England/Wales and Assisted Dying.

In 1935 the Voluntary Euthanasia Society in the UK was established "with the support of influential medical men, churchmen, legal experts, and politicians…A movement to legalise an "easy death" for persons suffering from incurable and painful disease". in 1936 Lord Ponsonby's Voluntary Euthanasia (Legalisation) Bill was debated in Parliament, but failed.

AD 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

---

[17] Downie, Joyce. 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. 2016: 97 https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1906&context=scholarly_works

[18] Downie J, Schuklenk U. Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada. J Med Ethics. 2021 Oct;47(10):662-669. doi: 10.1136/medethics-2021-107493. Epub 2021 Aug 4. https://pmc.ncbi.nlm.nih.gov/articles/PMC8479744/

[19] Bernheim, JL & Raus, K *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. 2016 https://jme.bmj.com/content/43/8/489

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 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[20], 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[21], the Crown Prosecution Service (under DPP Keir Starmer) in 2010 (updated in 2014 and again in 2023, where an additional factor in support of prosecution would be if the person assisting a death was a health-care professional), 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[22]. 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[23] - 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 AD 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

---

[20] 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

[21] R (Purdy) v DPP [2009] UKHL 45. https://www.bailii.org/uk/cases/UKHL/2009/45.html

[22] Director of Public Prosecutions. Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide. February 2010, updated October 2014. https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide

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

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 of time. In 2022 Lord Forsyth tabled an amendment to the 2022 Health and Care Act seeking to introduce an additional clause enabling an AD 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 of early February 2026, as the Bill is a private member's Bill, that with over 1200 amendments raised by a small number of Lords opposing the Bill it may fail due to lack of time. However, a More in Common survey[24] found 83% of those surveyed believed that in such circumstances the Bill should be introduced again in the next session of Parliament.

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.

Scotland and Assisted Dying

It may be accurate to state that views both of the public (see below) and within the Scottish Parliament have to some degree, more closely aligned in recent years. In 2004 Jeremy Purvis (MSP) presented a consultation paper, "Dying with Dignity", but failed to raise enough support to be introduced as a Bill. The first successful attempt to formally introduce AD legislation in 2010, introduced by Margo MacDonald MSP, was broader in terms of access and provision than the current McArthur Bill, and was voted down at Stage 1 by 85 votes to 16 (with 2 abstentions). The MacDonald proposals were closer to 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".[25] The second attempt, the "Assisted Suicide (Scotland) Bill included a more detailed process than the first MacDonald Bill, and was developed by Margo MacDonald. After MacDonald's death in 2014 the Bill was then championed 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

---

[24] More in Common. Public opinion on assisted dying and Parliament. 2026 https://www.moreincommon.org.uk/latest-insights/public-opinion-on-assisted-dying-and-parliament-an-update/

[25] End of Life Assistance (Scotland) Bill 2010 [4]. https://webarchive.nrscotland.gov.uk/20240327012702/https://archive2021.parliament.scot/parliamentarybusiness/Bills/21272.aspx

progressive and "either terminal or life-shortening"[26] and "sees no prospect of any improvement in the person's quality of life".[27] 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 first two 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.

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)[28]:

> 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.

Scottish courts have been consistently unwilling to significantly offer clarifying and definitive guidance on AD, and ambiguity in terms of interpretations of 'recklessness' and 'wickedness' in relation to culpable homicide and murder have persisted. Fakonti & Papadopoulou state that "[t]he introduction of the new Scottish Bill is a significant opportunity to clarify the Scottish criminal law on the issue of assisted suicide."[29]

---

[26] Assisted Suicide (Scotland) Bill 2015 [8]5. https://webarchive.nrscotland.gov.uk/20240327012019/http://archive2021.parliament.scot/parliamentarybusiness/Bills/69604.aspx

[27] Assisted Suicide (Scotland) Bill, as above. 2015: [8]4.

[28] Health and Social Care Committee. Assisted Dying/Assisted Suicide, Second Report of Session 2023–24 [53] https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html

[29] 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

The McArthur Bill can be viewed as a pragmatic response to both previous attempts at legislation that failed (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 available online.[30] 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[31], 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.[32]

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[33] "[t]he 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[34] confirms:

> 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

---

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

[31] The Scottish Government. Cabinet Secretary for Social Justice. Terminal Illness. https://www.gov.scot/policies/social-security/terminal-illness/

[32] McArthur, L. Assisted Dying for Terminally Ill Adults (Scotland) Bill. 2024 [2]. https://www.parliament.scot/-/media/files/legislation/bills/s6-bills/assisted-dying-for-terminally-ill-adults-scotland-bill/introduction/bill-as-introduced.pdf

[33] Fakonti, C & Papadopoulou, N, Choice, autonomy, as above. 2025: A

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

> 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 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.

A key objective appear to be to establish a robust but workable set of safeguards. As Scobie et al[35] have noted however, a significant issue may be less the rigour of safeguards than the time taken for approval, as long timescales in Spain, for example, have resulted in 30% of applicants dying before approval.

The first reading of the Bill in Holyrood took place on 13 May 2025[36]. 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:

> [m]any 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.[37]

---

[35] Scobie S, et al. Research report August 2025: Assisted dying in practice - International experiences and implications for health and social care. Nuffield Trust. 2025:28. https://www.nuffieldtrust.org.uk/sites/default/files/2025-09/Nuffield%20Trust%20Assisted%20dying%20in%20practice_WEB-update.pdf

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

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

The most recent British Attitudes Survey[38] (September and October 2025) found that "a majority of the public might welcome a bigger change in the law than either of the two [English and Scottish] bills envisages." The McArthur Bill however, allows for self-administration only, close 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 AD would be naive. 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[39] notes in his research on voting patterns related to AD 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".[40] 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[41] 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.[42]

Living with numerous and often complex health problems is becoming the norm for older people and those from disadvantaged communities in Scotland.[43] People are

---

[38] National Centre for Social Research (NatCen). British Social Attitudes 43. 2026 https://natcen.ac.uk/publications/british-social-attitudes-43#assisted-dying

[39] 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

[40] Bache, Ian. How (and when) does party matter? As above. 2025: 4.

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

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

[43] Scottish Government. Health and Social Care Strategy, as above. 2022.

also living longer[44], but many of these additional years are spent with health problems, often multimorbidities[45] [46] [47]. In some cases palliative care is simply insufficient and/or unpalatable to chronic sufferers.[48] [49] The Scottish government has stated that

> [i]n 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.[50]

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.

Institutional positions on AD in British medicine

In terms of financing, the Westminster Impact Assessment for Assisted Dying[51] estimated that while introducing AD would not save the NHS money, it would not necessarily add significantly to the overall health-care budget.

---

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

[45] 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

[46] 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/

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

[48] 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

[49] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. Study conducted by the Office of Health Economics for Dignity in Dying. 2019 https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

[50] 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/

[51] 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

As detailed in 'The Inescapable Truth About Dying in Scotland'[52] "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. It has been alleged that doctors have been known to do this for other doctors suffering from an incurable condition with intractable pain. A 2009 survey[53] 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 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 and open to flawed practice[54]. It has been argued that the best interest of any patient and any medical practitioner is for all medical procedures to be subject to the strictures of legal regulation and professional administration[55].

Palliative care organisations were historically opposed to AD, and the Association for Palliative Medicine (of Great Britain and Ireland (APM) remains opposed, but the Association of Palliative Care Social Workers in their November 2024 Statement on Assisted Dying[56] take no position on AD, Hospice UK present a neutral tone of "no collective view"[57], 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"[58], although they expressed concerns. The British Geriatrics Society continues to oppose AD.

---

[52] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland, as above. 2019: 8

[53] 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 2019: 64

[54] 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

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

[56] 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

[57] Hospice UK. Our position on assisted dying. https://www.hospiceuk.org/assisted-dying 22/04/25

[58] Scottish Partnership for Palliative Care (SPPC). Response to Proposals for an Assisted Dying for Terminally Ill Adults (Scotland) Bill, December 2021. https://www.palliativecarescotland.org.uk/content/publications/SPPC-Response-to-Proposals-for-an-Assisted-Dying-Bill.pdf

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.[59]

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 AD legislation to neutrality on the issue. A 2020 British Medical Association survey[60] found that 50% supported doctors being able to prescribe life-ending drugs. 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 lobbied politicians and operated public information campaigns. Support for AD within the general public has been consistent for decades. Between 1983 and 2016, the British Social Attitudes Survey pegged UK public support for AD consistently at 75% to 82%[61]. In the 2025 British Social Attitudes Survey[62], 79% of the British public supported AD, consistent since 1995. In the same survey, 81% of Scots supported AD.

In 2005 the House of Lords First Report on the Assisted Dying for the Terminally Ill Bill[63] noted that a review of surveys over recent decades found that there was "a great deal of sympathy within society, at least for the concept of euthanasia" and "widespread and growing concern to legalise the situation of the terminally ill who wish to die and those prepared to help them". While Dignity in Dying recorded in 2013 that only only 45% agree that those suffering incurably but non-fatally should

---

[59] 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

[60] BMA. BMA Survey on physician-assisted dying: Research Report, 2020: 3 https://www.bma.org.uk/media/3367/bma-physician-assisted-dying-survey-report-oct-2020.pdf

[61] BMA. Public and professional opinion on physician-Assisted Dying. 2025: 1. https://www.bma.org.uk/media/ejcdado1/public-and-professional-opinion-on-pad-updated-jan-2025.pdf

[62] National Centre for Social Research (NatCen). British Social Attitudes 43, 2026 https://natcen.ac.uk/publications/british-social-attitudes-43#assisted-dying

[63] Select Committee on Assisted Dying for the Terminally Ill Bill First Report, Chapter 6: Public Opinion. https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8609.htm

be able to access an assisted death[64], the Autumn 2025 National Centre for Social Research British Social Attitudes survey found those who believed that doctors probably should be allowed to end the life of those suffering intractably but not terminally, from 1995 to 2025, rose from 41% to 62%.[65] The National Centre for Social Research, in written evidence submitted to Westminster confirmed that:

> [t]here 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.[66]

In the July 2024 survey 'Rethinking the UK's approach to dying'[67], 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 AD. It found that 73% of Britons believe that AD should be legal in the UK, with only 13% opposed. A majority - seven out of ten of those supporting AD - also supported AD for those suffering intractably but not terminally.[68]

A YouGov poll in 2023 found that "58% of Scots have seen a loved one suffer at the end of life."[69] Only 6% of Scots think the current law in relation to AD in Scotland is working well.[70] The most recent British Attitudes Survey (September and October 2025)[71] found that in Scotland

> four in five (81%) are in favour of assisted dying for someone with a terminal illness, while three in five (62%) say a doctor should be able to help someone to end their life if they have an incurable and painful illness that is not terminal.

---

64 Dignity in Dying. Assisted dying not assisted suicide. 2013. https://www.dignityindying.org.uk/blog-post/assisted-dying-not-assisted-suicide/

65 National Centre for Social Research (NatCen). British Social Attitudes 43 as above. 2026

66 National Centre for Social Research. Written evidence submitted by the National Centre for Social Research (ADY0262). 2023 [15]. https://committees.parliament.uk/writtenevidence/116429/pdf#:~:text=The proportion of respondents saying Table 1, 1.

67 Compassion in Dying. Rethinking the UK's Approach to Dying. 2024:10 https://cdn.compassionindying.org.uk/wp-content/uploads/rethinking-UKs-approach-dying-july-2024.pdf

68 Smith, M. YouGov: Three quarters support assisted dying law. 2024. https://yougov.co.uk/politics/articles/50989-three-quarters-support-assisted-dying-law

69 Dignity in Dying. Time For Choice: The truth about Scotland's ban on assisted dying...and how things could be better. 2023: 14. https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/Time-for-Choice-Scotland-report-September-2023.pdf

70 Dignity In Dying: The Inescapable Truth as above. 2019: 8.

71 National Centre for Social Research (NatCen). British Social Attitudes 43 as above. 2026

There continues to be strong and consistent support amongst the public for AD, and in a context of increasing instances of chronic suffering. The 2025 British Attitudes Study[72] describes "a public that largely seems to have made its mind up in favour of change a long time ago." Medical organisations have, despite continuing debate, by and large dropped their opposition to the legalisation of AD. The arguments for and against are clearer than ever in the minds of the public and legislators, and the practicalities of introducing AD have been studied and evaluated in detail.

Interpretations of wicked, depraved, murder and culpable homicide.

The Assisted Dying for Terminally Ill Adults (Scotland) Bill, introduced by Liam McArthur MSP, is at this time of writing moving towards the third and final stage in Holyrood.

Suicide is not illegal in Scotland. 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.

Each AD case in Scotland in the past 40 years that has gone to court has ultimately resulted in a non-punitive and non-custodial outcome. Other cases have not reached court, having been regarded as not in the public interest to pursue further by the Procurator Fiscal.

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

[72] National Centre for Social Research (NatCen). As above. 2026.

"unreasonable/unjustified risk-taking".[73] McDiarmid[74] notes that in Scots law 'recklessness' is a "lack of caution, or rashness, or disregard for consequences" 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 cases relating to AD 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"[75], 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."[76] In effect, it is separately labelled (from murder) and understood as: "blameworthy killing which is not murder".[77]

A successful defence of provocation can negate the elements of wicked intent or wicked recklessness, reducing the charge from murder to culpable homicide. The 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"[78]. 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"."[79] As Maher notes "culpable homicide is an unlawful killing where

---

[73] Stark, F. "The Reasonableness in Recklessness." Criminal Law and Philosophy 14, 9–29. 2020: first page. https://d-nb.info/1197826513/34

[74] McDiarmid, C. Between Accidental Killing and Murder: Culpable homicide. Juridical Review, 2023: 16 https://strathprints.strath.ac.uk/85039/1/McDiarmid_JR_2023_Between_accidental_killing_and_murder.pdf

[75] 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. https://strathprints.strath.ac.uk/66383/1/McDiarmid_2018_Killings_short_of_murder_culpable.pdf

[76] Ward, AJ. From Criminality, as before, 2022: 74

[77] 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: 13. https://www.pure.ed.ac.uk/ws/portalfiles/portal/16518952/GHG_Book_chapter_09_Dec.pdf

[78] McDiarmid, C. Between Accidental Killing as above. 2023: 5

[79] McDiarmid, C. Between Accidental Killing as above. 2023: 5

the accused lacks intention to kill or such wicked recklessness."[80] 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.

In Drury v HM Advocate[81] an appeal reduced the conviction of murder to culpable homicide. Chalmers and Leverick[82] describe the Drury full bench decision of five judges as "the most controversial judicial decision on Scots criminal law of recent years". The basis of the reduction was that despite the degree of violence involved, the act could be mitigated via a plea of diminished capacity (due to perceived infidelity), 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. Lord Justice-General (Rodger) stated that "just as the recklessness has to be wicked so also must the intention be wicked"[83] and that provocation in this case meant that the action taken by the accused "though culpable, was not wicked".[84] The plea of provocation on the basis of infidelity (a somewhat archaic notion of a threat to "ownership" of a partner that had applied in this and other Scottish cases, as cited by McPherson[85]) was accepted, although controversial in itself. Further controversy arose in relation to information arising subsequently - the relationship had ended some time previously and McKenna had turned to both civil and criminal law to protect her from Drury's stalking of both her and her children (somewhat calling into question the claim of immediacy of response, as compared to pre-meditation, required for a culpable homicide conclusion). As McDiarmid has noted, McKenna had ended the relationship.[86] She had also sought legal protection from stalking by Drury[87]. At the time of her death, she was trying to be rehoused 'outwith

---

[80] 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. https://www.pure.ed.ac.uk/ws/portalfiles/portal/16518952/GHG_Book_chapter_09_Dec.pdf

[81] Drury v HM Advocate (2001) https://www.casemine.com/judgement/uk/5a8ff7eb60d03e7f57eb2dc3

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

[83] Drury v HM Advocate (2001) as above [11]

[84] Drury v HM Advocate (2001) as above [18]

[85] McPherson, Rachel. Reflecting on Legal Responses to Intimate Partner Femicide in Scotland. Violence Against Women Vol. 29(3-4) 686–704. 2023. https://journals.sagepub.com/doi/pdf/10.1177/10778012221094068

[86] McDiarmid, Claire. Reflective Statement: Drury v HM Advocate. 126-130 in Scottish Feminist Judgments: (Re)Creating Law from the Outside In. Eds Sharon Cowan, Chloë Kennedy and Vanessa E Munro. Hart Publishing 2019: 117, 129 https://bloomsburycp3.codemantra.com/viewer/5f460b9cdc0e82000176faa4

[87] Chalmers, J., and Leverick, F. *Murder through the looking glass, as above*. 2007: 230

the area in which [he] was operating'.[88] None of this appears to have been taken into account during the appeal.

McDiarmid notes that the subsequent cases of Elsherkisi[89] and Meikle[90] 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[91], where on appeal, the court reaffirmed the law's requirement that there existed a reasonable proportionality between the provocation and the responding actions. While some useful clarification was achieved, the mens rea analysis in the Drury case was accepted as valid. Chalmers and Leverick argue that:

> [b]ecause 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.[92]

McDiarmid argues that the definition of culpable homicide remains broad and vague.[93] The ruling on Petto[94] was critical of such terms as wicked and depraved, describing them as limiting and anachronistic, meriting serious re-examination. As a result of the above ambiguity and perceived controversy of interpretation, a discussion paper[95] was published in 2021. However, AD 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."[96]

---

88 McDiarmid, Claire. Reflective Statement, as above. 2019: 130

89 Elsherkis v HM Adv 2011 SCCR 735.

90 Meikle v HMA 2014 SLT 1062

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

92 Chalmers, J., and Leverick, F. *Murder through the looking glass, as above*. 2007: 236

93 McDiarmid, C. Between Accidental Killing as above. 2023.

94 Petto v HMA, 2011 SCCR 519

95 Discussion Paper on the Mental Element in Homicide (Discussion Paper no 172). Scottish Law Commission. 2021. https://www.scotlawcom.gov.uk/files/9716/2254/8710/Discussion_Paper_on_the_Mental_Element_in_Homicide_-_DP_No_172.pdf

96 McDiarmid, C. Between Accidental Killing as above. 2023: 11.

Assisted deaths may be neither accidental nor characterised by wicked intent to kill or action of wicked recklessness. 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 witnessed the unbearable suffering of a loved one and agreed to assist a death, and the possibility of diminished responsibility. Ward notes that there can be an argument of diminished responsibility that 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.[97]

The public - in general and when participating in juries - have not regarded assistance to die in such circumstances as wicked in cases where suffering has been unbearable and intractable and where 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, Edge, Wilson and Gordon (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 AD, still likely to lead to a court case, prosecution and sentencing that recognises "the inherent wrongfulness of killing"[98]. McDiarmid argues that cases such as Ross v Lord Advocate (see later) leave "culpable homicide as rather an amorphous category, lacking even a clear definition of *actus reus* and *mens rea*."[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 where an awareness of possible consequences was overridden by a compassionate motivation to assist in ending the unbearable suffering of a loved one). 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

---

97 Ward, AJ. From Criminality, as before, 2022: 93.

98 McDiarmid, C. Examining Culpable Homicide, as above. 2018: 6

99 McDiarmid, C. Examining Culpable Homicide, as above: 5

100 McDiarmid, C. Examining Culpable Homicide, as above: 6

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.

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.

Opinions long-held by the public in relation to mercy killings appear to 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 (see later).

The crux of the current debate in relation to legal sanction, ongoing in the Scottish Parliament, 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 AD system as proposed by McArthur, with checks in place and consent confirmed and verified in advance (rather later and with the absence of the main witness) would in large part remove these cases from the court docket. 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 had assisted a loved one nor take up court time and resources.

Provision of a lethal substance.

In Scotland helping a person to die can lead to prosecution for murder, culpable homicide or reckless endangerment.[103] [104] 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.

---

[101] McDiarmid, C. Examining Culpable Homicide, as above: 10

[102] Husak, D. The Criminal Law as Last Resort, 24 Oxford Journal of Legal Studies 2004: 207, cited by McDiarmid, C. Examining Culpable Homicide in Scots Law in Reed, A et al (eds) Killings Short of Murder: A Research Companion London Routledge 2018: 20.

[103] Fakonti, C & Papadopoulou, N, Choice, autonomy, as above, 2025: C(1)

[104] Warlow, Charles. A new bill could legalise Assisted Dying in Scotland, as above. 2024: Paragraph 2.

The first cases worth examining relate to 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[105], and Ulhaq[106] 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 by the Lord Advocate[107], 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[108] 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[109].

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 ingestion of a drug by a competent adult was a *novus actus interveniens*[110] which broke the causal link."[111] 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 "[t]here was no effective difference between supply and administration in the circumstances of these cases".[112]

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

---

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

[106] Ulhaq v HMA 1991 SLT 614.

[107] Lord Advocate's Reference (No 1 of 1994) 1996 JC 76. https://www.casemine.com/judgement/uk/5a8ff8d660d03e7f57ece156

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

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

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

[111] McAngus & Kane v HMA 2009 HCJAC 9 [8] https://www.casemine.com/judgement/uk/5a8ff85160d03e7f57ebe30c#:~:text=The

[112] McAngus & Kane v HMA as above. 2009: [21]

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"[113], 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.[114]

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 and directness, the law may properly attribute responsibility for ingestion, and so for death, to the reckless offender.[115]

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"[116] and that "a deliberate decision by the victim of the reckless conduct to ingest the drug will not necessarily break the chain of causation."[117] As Chalmers[118] 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

---

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

[114] McAngus & Kane v HMA as above. 2009: [32]

[115] McAngus & Kane v HMA as above. 2009: [45]

[116] McAngus & Kane v HMA as above. 2009: [42]

[117] McAngus & Kane v HMA as above. 2009: [48]

[118] Chalmers, J. Assisted Suicide (Scotland) Bill: Response to Question Paper: The Position Under Existing Scots Criminal Law. 2015

> 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[119] concludes that "[s]uch 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[120] 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, at that point in time, both by supply and by administration of a lethal substance subject to a charge of both culpable and reckless behaviour.

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[121] 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[122] 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.

Specific cases of assisting a consenting adult with capacity to die.

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.

---

[119] McDiarmid, C. Killings Short of Murder: Examining Culpable Homicide, as above. 2018: 25.

[120] Ward, AJ. From Criminality, as before, 2022: 156.

[121] Ward, AJ. From Criminality, as before, 2022: 106.

[122] Ward, AJ. From Criminality, as before, 2022: 107.

In 1980 Robert Hunter[123] 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[124] [125] smothered his brother after administering alcohol and pills, and walked free with a charge of culpable homicide and an admonition. In a 1997 High Court case, David Hainsworth[126] 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)[127], 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[128] 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[129] 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[130]. The sentence was appealed[131] and the sentence for an act described as a "final act of love"[132] while suffering a depressive episode, was quashed and an admonition substituted.

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

---

[123] Ward, AJ. From Criminality, as before, 2022: 104.

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

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

[126] Ward, AJ. From Criminality, as before, 2022: 105.

[127] Ward, AJ. From Criminality, as before, 2022: 106.

[128] Ward, AJ. From Criminality, as before, 2022: 155.

[129] Ward, AJ. From Criminality, as before, 2022: 108.

[130] HMA v Gordon [2018] JC 139 https://judiciary.scot/home/sentences-judgments/sentences-and-opinions/2023/05/17/hma-v-james-gordon

[131] Gordon v. HMA [2018] HCJAC 21 https://vlex.co.uk/vid/gordon-v-hm-advocate-818741389

[132] 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

Gordon Ross seeks clarity on assisted deaths

Gordon Ross challenged the Lord Advocate in court[133], 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.[134]

Ward argues that a refusal to do this was at odds with the outcome of the Purdy case in England:[135]

> At issue in Ross was whether the Lord Advocate was breaching Article 8 by not publishing guidance regarding the factors weighing for and 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 AD, 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"[136], but also iterated 13 factors that could be taken into consideration in relation to a choice to prosecute[137].

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

---

[133] 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

[134] Gordon Ross v Lord Advocate 2015 as above: [6]

[135] Ward, AJ. From Criminality, as before, 2022: 140.

[136] Gordon Ross v Lord Advocate 2015 as above: [42]

[137] Gordon Ross v Lord Advocate 2015 as above: [5]i to [5](xiii)

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.

The Ross Appeal[138]

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"[139] 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".[140] 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".[141] 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."[142]

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."[143]

---

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

[139] Gordon Ross (reclaimer) v Lord Advocate 2016: [74]

[140] Gordon Ross (reclaimer) v Lord Advocate 2016: [7]

[141] Gordon Ross (reclaimer) v Lord Advocate 2016: [5]

[142] Gordon Ross (reclaimer) v Lord Advocate 2016: [29]

[143] Gordon Ross (reclaimer) v Lord Advocate 2016: [39]

She notes that, "there is in Scotland no offence of 'assisted suicide'."[144] 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.[145]

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."[146] 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".[147] 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.[148]

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".[149]

---

[144] Gordon Ross (reclaimer) v Lord Advocate 2016: [43]

[145] Gordon Ross (reclaimer) v Lord Advocate 2016: [50]

[146] Gordon Ross (reclaimer) v Lord Advocate 2016: [4]

[147] Gordon Ross (reclaimer) v Lord Advocate 2016: [29]

[148] Gordon Ross (reclaimer) v Lord Advocate 2016: [30] [31] [32]

[149] Gordon Ross (reclaimer) v Lord Advocate 2016: [62]

Scottish courts have consistently insisted that substantive change in the law vis-a-vis AD 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 rule will inevitably be surrounded by a penumbra of uncertainty."[150] 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".[151] Young also confirmed a reluctance to engage in a change in the law led by the courts, noting that while

> [a]ssisted 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.[152]

It was his view that the law is "a matter for legislators".[153]

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 some will take up court time.

The law and end-of-life medical practice [as at February 2026] choices for those suffering from an incurable and intractable condition(s) in Scotland.

Firstly, a brief overview of illegal practice as it related to medical practitioners. 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. Following on from this, an overview of legal end-of-life medical options available to practitioners and individual members of the public is useful.

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

---

[150] Gordon Ross (reclaimer) v Lord Advocate 2016: [71]

[151] Gordon Ross (reclaimer) v Lord Advocate 2016: [84]

[152] Gordon Ross (reclaimer) v Lord Advocate 2016: [85]

[153] Gordon Ross (reclaimer) v Lord Advocate 2016: [78]

relieved by the best palliative care[154]. 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".[155] According to the Office of Health Economics[156], 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 life." 41% of Scots have witnessed a dying family member or friend suffer unbearably towards the end of their life.[157] 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.[158] The report, "The Inescapable Truth About Dying in Scotland", 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.[159]

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'. According to Dignity in Dying[160] "[t]here is no formal oversight of how often palliative sedation is used, but in one study 17% of doctors said it was used in the last death they attended."

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". The phrase "foreseen but not intended" is somewhat aspirational, but remains a grey area of interpretation that may provide some medics latitude to assist death. The claimed distinction between

---

[154] Dignity In Dying: The Inescapable Truth as above. 2019: 5, 20,80.

[155] Leadbetter, Kim. Evidence given, 2nd reading, Terminally Ill Adults (End of Life) Bill. House of Commons, Friday 29 November 2024. https://hansard.parliament.uk/commons/2024-11-29/debates/796D6D96-3FCB-4B39-BD89-67B2B61086E6/TerminallyIllAdults(EndOfLife)Bill

[156] 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

[157] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. As above, 2019: 8

[158] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. As above, 2019: 8

[159] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. As above, 2019: 6, 20

[160] Dignity in Dying. Time For Choice: The truth about Scotland's ban on assisted dying, as above. 2023: 14.

'foreseeing death' and 'intending death' can appear very narrow in practice. It has been argued that heavy/terminal sedation can simply prolong an unpleasant dying process rather than extending any kind of beneficial life. 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."[161]

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[162] 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[163] can result in unpleasant side effects and suffering at the end 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 (the loss of any of the things that make life bearable) 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. 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[164], the process risks the patient experiencing discomfort and ICU delirium[165] - a common disorganised cognitive experience which can commonly be experienced in an unconscious state under heavy sedation, where a person is apparently at peace but can

---

[161] 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/

[162] Nazari R et al. 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. https://pmc.ncbi.nlm.nih.gov/articles/PMC9067504/

[163] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. As above, 2019: 26-30.

[164] 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/

[165] 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

actually be undergoing a deeply unpleasant and confused dream state - although they remain unresponsive until death. As noted by Sheen & Oates[166], "[t]he absence of physical responses should not be misinterpreted to mean that cognitive processes are not occurring." Bender et al[167] note that "37% to 43% of patients who receive the diagnosis of a persistent vegetative state can be demonstrated by careful, standardised clinical examination on the basis of the Coma Recovery Scale (CRS-R) to have at least minimally preserved consciousness. O'Connor et al[168] 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."[169]

The process has also been criticised as an unnecessarily prolonged death. As Professor Stephen Duckworth argues:[170]

> 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.

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 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:

> 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

---

166 Sheen, L & Oates, J. A phenomenological study, as above. 2005: 25-32.

167 Bender A et al. 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. https://pmc.ncbi.nlm.nih.gov/articles/PMC4413244/

168 O'CONNOR, T et al. The conscious state of the dying patient: an integrative review. Palliative supportive care [online], 20(5), 2022: 731-743. 4 https://doi.org/10.1017/S1478951521001541

169 Keela Herr et al. 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

170 Duckworth, S. Written evidence submitted, as above. 2022

> a statement saying that doctors who allowed patients to die with court approval would not be prosecuted.[171]

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.[172]

In relation to the Bland case[173] 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.[174]

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. In addition, many simply cannot afford this option.

Voluntary Stopping of Eating and Drinking (VSED).

The law in Scotland already allows this particular version of AD, enabled by the simple process of signing an advance directive form. VSED has been practiced for

---

171 Dyer, C. "Scottish court gives right to die." BMJ Volume312, 4 MAY 1996. https://pmc.ncbi.nlm.nih.gov/articles/PMC2350638/

172 Law Hospital NHS Trust v Lord Advocate SC 301 1996 paragraph 1, The Function of the Court. https://www.bailii.org/scot/cases/ScotCS/1996/1996_SC_301.html

173 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.

174 Ferguson, Pamela R. Causing death or allowing to die? Developments in the law. Journal of Medical Ethics 1997; 23: 370 https://www.academia.edu/619983/Causing_death_or_allowing_to_die_Developments_in_the_law

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 AD. Both enable an individual to take their own life. Both tend to involve palliative support, including the administration of drugs in an attempt to lessen suffering in the process of an individual successfully taking their own life. Jox et al[175] 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."

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"[176], while Quill et al found that "[t]he process of VSED until death may take up to 21 days"[177].

Quill & Byock[178] 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.

---

[175] Jox, Ralf J, et al. Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015. 2017 https://doi.org/10.1186/s12916-017-0950-1

[176] Bolt EE et al. "Primary care patients hastening death by voluntarily stopping eating and drinking." Ann Fam Med. Sep;13 2015 (5):421-8.https://www.annfammed.org/content/13/5/421

[177] 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. Dec 17;278(23):2099-104. 1997https://www.researchgate.net/publication/226640394_Palliative_Options_of_Last_Resort_A_Comparison_of_Voluntarily_Stopping_Eating_and_Drinking_Terminal_Sedation_Physician-Assisted_Suicide_and_Voluntary_Active_Euthanasia

[178] 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[179] [180] [181] [182]. 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.[183]

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. There also appears to have been little public attempt on the part of opponents of AD to raise the same concerns or to introduce strong, standardised and consistent guidelines for VSED.

---

[179] Mason, T & West, A. "Legal Briefing: Voluntarily Stopping Eating and Drinking," The Journal of Clinical Ethics 25, no. 1, Spring 2014: 68-80. https://www.researchgate.net/publication/261996427_Legal_briefing_Voluntarily_stopping_eating_and_drinking

[180] Bolt EE et al. Primary care patients hastening death, as above. 2015

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

[182] 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

[183] The Patients Rights Council. Voluntarily Stopping Eating & Drinking: Important Questions & Answers. 2011: 2 https://www.patientsrightscouncil.org/site/wp-content/uploads/2013/03/VSED_Questions.pdf

Conclusion

Assisted dying systems are already established and operating across the world, with legislation being explored in an increasing number of new jurisdictions. This has provided real-life case-studies with which to examine and test the claims of supporters and opponents to AD. A significant amount of detailed independent research in various jurisdictions has gone into investigating the claims of opponents and the viability of introducing AD. There appears to be a genuine lacuna of evidence to support key claims of opponents, although there nonetheless remains a well-funded and effective campaign to continue to "flood the zone". A majority of British medical organisation have however now adopted a neutral stance on AD. Public support for AD in the UK has persistently remained around 75-83% over the past four decades.

A very small minority of deaths in states where AD is a legally available choice are assisted. A majority of those deaths are cancer-related. It is generally understood that approximately a third of the small minority who choose access to AD ultimately do no make use of the option. It may also be possible to infer that two thirds of that small minority do experience suffering at the most extreme level, that cannot be ameliorated by the best palliative care that modern science and medication can provide. The Scottish population is living longer, but with increasing morbidities, co-morbidities and multi-morbidities. It is not illegal for a person to end their own life. It seems inevitable that, in the absence of legalised assisted dying, an increasing number of cases will arise where those intractably suffering will attempt to end their lives. The law is it currently stands has not and will not stop those who determined to end their life, or indeed those determined to assist loved ones to do so. Scottish courts also appear unlikely to direct any punitive sentence towards them. Attempts by Scots to end their unbearable suffering without assistance or the presence of others in Scotland run clear risks of being botched or causing an unnecessarily unpleasant death. Isolated individuals may also simply feel forced to end their lives prematurely as they fear that due to the nature of their condition waiting may leave them incapable of ending their own lives.

As the number of 'bad deaths' increase, along with a concomitant increase in a more direct experience and awareness amongst the general public, it is difficult to imagine that the clear and consistent majority support over the past four decades for AD in Scotland will decrease. The court verdicts in such cases in the past four decades, as well as consistent and reliable polling of the Scottish public over the same period, imply that support for AD is a matter that is already settled in the minds of the Scottish people.

It can be argued that in the absence of the processes and protections proposed by McArthur, if malfeasance (such as murder) is suspected in a directly assisted death, prosecution is currently most likely to occur after-the-fact, once the main witness (the victim) is most likely already deceased. Investigation and intervention currently remains reactive, not preventative.

Any person can accompany a patient abroad to end their life now with little to no fear of prosecution, although few can afford this. In this sense the effectuation of the law has been argued to discriminate against the poor. Medical practitioners in Scotland who have provided advice and (in one case) the medication to facilitate

death have not been prosecuted. It also seems undeniable that mercy-killings by medical staff have occurred in situations where patients are experiencing intractable suffering at the end of life, often citing the doctrine of double-effect. How many are truly and fully unintended remains open to debate. Medical staff in Scotland can already legally refuse or withdraw life-maintaining treatment. In addition, medical staff can legally provide terminal sedation to a dying patient, inducing a coma until death. Where extreme heavy dosage is used, patients have been witnessed to experience dissociative, severe side-effects, and experience a loss of dignity. Where heavy dosage leads to an induced coma, patients are unable to express feelings of discomfort or delirium they may be experiencing, and loved ones endure a traumatic deathwatch.

Any individual has the right to die by voluntary stopping eating and drinking, and this process can and is supported by NHS palliative care staff. The outcome of death in this case is both foreseeable and intended. VSED can be a prolonged and unpleasant death. VSED already operates beyond the strictures of the McArthur proposals as this choice is already available to those suffering unbearably but unlikely to die within an arbitrary period. VSED with medical support has been an available choice for decades and has operated without the detailed protections against potential abuse included in the McArthur Bill.

There remains an ambiguity in definition and interpretation of wickedness and recklessness in relation to potential culpable homicide or murder charges, (or indeed reckless endangerment). A preference persists for a degree of flexibility on interpretation of wickedness and recklessness by the Scottish legal authorities to allow flexibility in sentencing, despite efforts to force further clarification in relation to AD. It is difficult to reconcile notions of wickedness or recklessness with cases where an individual out of compassion helps another to end a life of unbearable suffering. There persists an unresolved degree of ambiguity as to how much assistance can be provided by another party without being subject to prosecution. Carloway does however suggest that the supply of a lethal substance alone does not qualify as causation where another individual, with capacity, chooses to ingest.

AD by its nature is rarely sudden and unpremeditated. Provocation in such cases appears to have played no significant part in defences considered, although diminished responsibility has played a part in final considerations. In the past four decades court rulings in Scotland have consistently reflected public consensus on AD. Each person who has assisted another person to die within the context of unbearable and intractable suffering, described by Ward as “amateur citizen-assisted deaths”[184], have all retained their freedom. Assistance has ranged from accompanying somebody to Switzerland to assisting an overdose and smothering the individual. In each case there has either been no prosecution, or a ruling of assault but granted probation, or a culpable homicide verdict resulting solely in an admonition. Whilst culpable homicide remains the most obvious ruling available under current Scottish law, it retains a stigma (the term manslaughter even more so) that is not entirely compatible with an act that courts can simultaneously regard as loving and compassionate. It is

---

[184] Ward, AJ. From Criminality, as before, 2022: 171.

not unreasonable to infer that assisting a death in such circumstances is no longer 'punishable', i.e. subject to punitive verdicts in Scottish courts, certainly in terms of a custodial sentence. It bears reiteration that no case relating to AD in the past forty years in Scotland has resulted ultimately in a punitive sentence. As the Scottish public ages and becomes more prone to morbidities that cause great suffering, it is possible to foresee an increase in similar AD cases to those discussed earlier reaching court and continuing to result in no punitive action. Support for AD amongst the Scottish public appears settled, currently with four out of five Scots in favour of legalising AD.

Scottish courts have assiduously declined to set policy, insisting that is a matter for the Scottish Parliament. A response by Friends at the End to the The Scottish Parliament Cross Party Group on End of Life Choices[185] noted:

> 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.

Commenting on Ross v Lord Advocate, McDiarmid[186] 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 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.

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 a third introduction of AD legislation to the Scottish Parliament. It is clear that any definitive clarification and codification of the law as it relates to AD can only occur via legislation in Holyrood. The current proposals within the Assisted Dying for Terminally Ill Adults (Scotland) Bill does not appear to stray beyond already existing legal practice, precedents or outcomes.

All citations and web-addresses checked and confirmed 23rd February 2026.

Competing interests: The author declares none.

---

[185] 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

[186] McDiarmid, C. Killings Short of Murder: Examining Culpable Homicide, as above. 2018:8