Legal Rulings, Legislation and Social Change in Scotland Relating to Assisted Dying.

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

Abstract.

An examination of legal precedents that have operated in concert with demographic, legal and political developments in Scotland leading to the Assisted Dying For Terminally Ill Adults (Scotland) Bill (2024). This document will examine legal changes globally and closer to home, the persistence of public support, changes in the view of a majority of medical representative institutions, and incremental developments within Scots common law. In the absence of successful legislation to introduce assisted dying, there is an examination of what options are available already for those Scots seeking to end their lives, as well as concomitant inconsistencies that remain in Scots law in relation to assisted dying as a result of the failure of the McArthur Bill. 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 April 2026, is practised legally in Belgium, Canada, Austria, Luxembourg, the Netherlands, Oregon, Washington, New Jersey, New Mexico, Hawaii, Montana, Maine, Colorado, California, the District of Columbia, Vermont, Illinois, Delaware, 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 has legalised AD. Jersey voted 32 to 16 to introduce AD, and on 24th February 2026, the Welsh Senedd voted in favour of assisted dying. 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, Florida, and Nevada have introduced AD bills, and bills in Missouri, Wisconsin, and Georgia are planned later in 2026. 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.

The McArthur Bill in Holyrood did not succeed, and the Leadbeater Bill in Westminster ran out of time in the Lords. There has also been a successful reversal of the referendum in Slovenia, orchestrated in part by 'Voice for the Children and the Family', supported by the Catholic Church and conservative politicians, with a move in a second referendum from 55% supporting AD to 53% rejecting.[1]

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. 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.

[1] Al Jazeera. Slovenia referendum rejects assisted dying law for terminally ill adults. 23 November 2025.https://www.aljazeera.com/news/2025/11/23/slovenia-referendum-rejects-assisted-dying-law-for-terminally-ill-adults

In both Holyrood and Westminster, both Bills have been 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.

The key concept of justification of AD in the Netherlands is based around the concepts of beneficence and necessity[2], while in Canada, the US, and the UK, the core justifying concept leans more towards personal autonomy. In addition, compassion was a key stated concept behind the McArthur Bill[3] in Scotland. Other principles raised in debates in various global jurisdictions include the right to freedom from torture and unreasonable suffering and the right to dignity.

Reed et al 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)."[4]

Scobie et al 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."[5]

Scobie et al 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."[6]

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 recent 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

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[2] 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

[3] 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

[4] 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*

[5] 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*

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

legislation. 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. Saunders[7] however, argues that television, and in particular the BBC, by contrast, has been partial in presenting pro-AD stories.

Despite a 2019 Populus poll[8] 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 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.[9]

However, the position of the report "recognising the integrity of the range of views that exist in the Church"[10] 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 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:

> If euthanasia is legalised 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 medicalised killing; (vi) killing to become accepted within society.[11]

The first point (i) on coercion is addressed below, as are the final three points(iv, v, vi) on slippery slope. McArthur offered clear examples contradicting the second claim (ii) on devaluation

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[7] Saunders, P. 2011. The role of the media in shaping the UK debate on 'assisted dying', Medical Law International 11:3. https://journals.sagepub.com/doi/abs/10.1177/096853321101100307

[8] 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

[9] 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

[10] 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

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

of palliative care.[12] The third point (iii) on protections and right to refuse proved problematic but was addressed by the final draft and third reading, detailed below.

Bache[13] notes that "religious actors have increasingly employed secular rather than theological modes of argumentation" as arguments based on their religious core beliefs have proven to be counter-productive. A common criticism, however, persists that opposition is fundamentally religious at its core.

Toynbee cites a Care Not Killing online campaign of targeting politicians' constituents with misleading information.[14] The Humanist Society Scotland describes the activities of Care Not Killing, and of Logos as "an ongoing campaign of underhand tactics by reactionary religious voices to manipulate the assisted dying debate".[15] Das reports that "[c]ampaigns against assisted dying that claim to be led by healthcare workers and disabled people are being secretly coordinated and paid for by conservative Christian pressure groups."[16] Our Duty of Care is one of a number of lobbying groups with links to the Christian Medical Fellowship and is funded by the religious lobby group Care (Christian Action, Research and Education), which is known for its opposition to abortion, sex education, gay marriage, LGBTQ+ rights in general, and assisted dying.

The campaign against the Scottish legislation has also had contributions from opponents external to Scotland.[17] Research by Prost & Ramsay[18] identified that US Christian fundamentalist groups had already spent millions by 2019 in supporting causes and campaigns across Europe. Kirchgaessner reported that "Alliance Defending Freedom, the conservative legal advocacy group behind the overturning of Roe v Wade, has ramped up its global spending on litigation and other

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[12] McArthur, Liam. Assisted Dying for Terminally Ill Adults (Scotland) Bill: A proposal for a Bill to enable competent adults who are terminally ill to be provided at their request with assistance to end their life.2021: 15 https://www.parliament.scot/-/media/files/legislation/proposed-members-bills/assisted-dying-for-terminally-ill-adults-scotland-consultation-2021-final.pdf

[13] 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: 8. https://www.academia.edu/128612404/How_and_when_does_party_matter_Explaining_MPs_positions_on_assisted_dying_assisted_suicide

[14] Toynbee, P. The concerted attack on assisted dying won't stop the public supporting this bill. 14 February 2025. https://www.theguardian.com/commentisfree/2025/feb/14/campaign-against-assisted-dying-bill-kim-leadbeater-public-support?utm_term=Autofeed&CMP=fb_gu&utm_medium=Social&utm_source=Facebook&fbclid=IwY2xjawIfn3FleHRuA2FlbQIxMQABHaF7tbuM-QymN81AgIRDCBO5klBIqTA9lXPr-nCrd0poeTg5f48njV-6lw_aem_HjEl6SqTQxmxi-QxdJdjMg#Echobox=1739527320

[15] Humanist Society Scotland. Calls for inquiry over actions of Assisted Dying Bill opponents. October 7 2024. https://www.humanism.scot/2024/10/07/humanist-society-speaks-out-on-underhand-tactics-used-by-opponents-of-assisted-dying/

[16] Das, S. Revealed: 'Grassroots' campaigns opposed to assisted dying financed by conservative Christian pressure groups. Guardian, 16 November 2024. https://www.theguardian.com/society/2024/nov/16/revealed-grassroots-campaigns-opposed-to-assisted-dying-financed-by-conservative-christian-pressure-groups

[17] 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

[18] Provost C & Ramsay, A. Revealed: Trump-linked US Christian 'fundamentalists' pour millions of 'dark money' into Europe, boosting the far Right. Open Democracy, 27 March 2019. https://www.opendemocracy.net/en/5050/revealed-trump-linked-us-christian-fundamentalists-pour-millions-of-dark-money-into-europe-boosting-the-far-right/

campaigns, in what appears to be an attempt to export what critics call its hard-right Christian theocratic values beyond US borders."[19] ADF is designated a hate group by the Southern Poverty Law Centre in the US[20]. Ben Quinn observes that ADF UK has supported campaigns against assisted dying,[21] and Dignity in Dying has demonstrated links between ADF and groups and individuals in the UK lobbying against AD.[22]

A common and effective tactic of right-wing political and evangelical religious lobbying groups has been to "flood the zone", a strategy to achieve disorientation rather than persuasion[23], to sabotage the debate rather than win the argument. McKay observes that various forms of stealth lobbying[24] exist and has noted in relation to the AD debate in the UK that "grassroots" campaigns in opposition to AD appeared to be a clear example of astroturfing – the practice of disguising an orchestrated campaign as a spontaneous outpouring of public opinion, when in fact a lobbying organisation is financed and advised by hidden interests.[25] Giger & Klüver observed that the activities of "interest groups considerably affect the link between legislators and their voters"[26], and some may influence representatives to depart from and even undermine constituency preferences. As Bernhagen et al note, "while some interest groups function as intermediary organisations that aggregate societal interests and articulate these to policymakers, others work to derail the representative chain between citizens and policymakers."[27] Lacking in genuine democratic authorisation, one attempted outcome in particular of 'astroturfing' is manufacturing the impression that more people are opposed to reform than is the case in reality, while another outcome can be a

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[19] Kirchgaessner, S. Conservative legal group aims to export its rightwing Christian mission beyond US borders. Guardian 19 Dec 2025. https://www.theguardian.com/us-news/2025/dec/19/conservative-legal-christian-rightwing-group

[20] Southern Poverty Law Centre. Alliance Defending Freedom. https://www.splcenter.org/resources/extremist-files/alliance-defending-freedom/

[21] Quinn, B. US anti-abortion group expands campaign in UK. Guardian, 2April 2025. https://www.theguardian.com/uk-news/2025/apr/02/us-anti-abortion-group-expands-campaign-in-uk?fbclid=IwY2xjawJcZjFleHRuA2FlbQIxMQABHVAUQVWqHs9JulXL_sTAEmp1aNNWkMUgp4FJ4cWFylX_Lh56oGCTkXHTew_aem_JDzc4z9EJu6I9ueXdgK6Gw

[22] Dignity in Dying. Exposing the anti-choice networks trying to deny doctors a voice. 20 March 2019. https://www.dignityindying.org.uk/wp-content/uploads/Opposition-Networks-Report.pdf

[23] Stelter, B. This infamous Steve Bannon quote is key to understanding America's crazy politics. CNN Business. Tue November 16, 2021. https://edition.cnn.com/2021/11/16/media/steve-bannon-reliable-sources

[24] McKay, A. Stealth Lobbying: Interest Group Influence and Health Care Reform. Cambridge University Press, 2022.

[25] Das, Shanti. Revealed: 'Grassroots' campaigns opposed to assisted dying financed by conservative Christian pressure groups. Observer. 16 Nov 2024. https://www.theguardian.com/society/2024/nov/16/revealed-grassroots-campaigns-opposed-to-assisted-dying-financed-by-conservative-christian-pressure-groups

[26] Giger, N. and Klüver, H. Voting Against Your Constituents? How Lobbying Affects Representation. American Journal of Political Science, 60: 190-205. 2016 https://doi.org/10.1111/ajps.12183

[27] Bernhagen, P., Berkhout, J., Chalmers, A. et al. Interest groups and effective substantive representation. Int Groups Adv (2026). https://doi.org/10.1057/s41309-026-00261-5 citing Giger, N., and H. Klüver. Voting against your constituents? How lobbying affects representation. American Journal of Political Science 60 (1): 190–205. 2016 https://doi.org/10.1111/ajps.12183. https://link.springer.com/content/pdf/10.1057/s41309-026-00261-5.pdf

significant degree of misrepresentation[28]. In relation to the information disseminated by opponents of AD, Schuklenk argues that:

> [e]ssentially, it is a propaganda war between a fairly small band of deeply religious and well-organised 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.[29]

Bernheim and Raus echo a common criticism of opposition to AD, that it exhibits a "disregard of empirical evidence".[30] Certainly, during the lead-up to the final vote on the McArthur Bill, concerns were expressed that "a wide range of cherry-picked information, misinformation, and disinformation has been circulated by opponents."[31]

Coercion, the vulnerable, and the slippery slope.

The Domestic Abuse (Scotland) Act 2018, making coercive control illegal, came into force on 1 April 2019. As yet, there have been no cases of coercion in the practice of Voluntary Stopping Eating and Drinking (VSED), which has existed in Scotland for decades, or indeed in relation to those travelling abroad to end their lives. Perhaps surprisingly, there also appears to have been little public attempt on the part of opponents of AD to raise the same concerns or to introduce similar strong, standardised, and consistent guidelines for VSED as proposed in the McArthur Bill for AD.

One benefit to being behind so many other states that have successfully introduced AD legislation is that there are multiple case studies and data sets to examine both for good practice and to examine concerns raised by opponents. This would appear to be to the detriment of opposition to AD. However, Bache has observed that "developments overseas struggle to secure attention beyond those actively involved with the issue".[32]

One of the most successful elements of the campaign against AD was raising fears that the passing of the McArthur Bill could place the vulnerable and disabled in danger of coercion by others, and even self-created pressure. The argument of 'self-created coercion' proved to be a successful inversion by opponents of AD, to a negative, of the notion of personal autonomy. Supporters of AD may argue that further denying choice to those who are already denied so much

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[28] Toynbee, Polly. The concerted attack on assisted dying won't stop the public supporting this bill. Guardian, Feb 14 2025. https://www.theguardian.com/commentisfree/2025/feb/14/campaign-against-assisted-dying-bill-kim-leadbeater-public-support?utm_term=Autofeed&CMP=fb_gu&utm_medium=Social&utm_source=Facebook&fbclid=IwY2xjawIfn3FleHRuA2FlbQIxMQABHaF7tbuM-QymN81AgIRDCBO5klBIqTA9lXPr-nCrd0poeTg5f48njV-6lw_aem_HjEl6SqTQxmxi-QxdJdjMg#Echobox=1739527320

[29] 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

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

[31] Humanist Society Scotland. Humanist Society speaks out on underhand tactics used by opponents of assisted dying. https://www.humanism.scot/2024/10/07/humanist-society-speaks-out-on-underhand-tactics-used-by-opponents-of-assisted-dying/ 2024

[32] Bache, Ian. How (and when) does party matter? 2025: 11, as above.

can appear patronising and in direct opposition to the consistently stated and clear preferences of large majorities supporting AD amongst both the general and the disabled population. However, the argument to protect the vulnerable by retaining the status quo proved compelling for a number of MSPs.

Research data on AD has indicated that contrary to claims of coercion and systemic targeting of the vulnerable in states offering AD, those groups do not show up more in overall AD figures than the general population[33]. Research by Battin et al[34] on AD in both Oregon and the Netherlands concluded that AD was not disproportionately accessed by individuals from vulnerable groups, findings confirmed by Pickett:

> "[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."[35]

Deliens, with reference to Wels and Hamarat[36], 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."[37]

Commenting on the empirical evidence from the Netherlands and the US State of Oregon in relation to the claims made by those opposed to AD, Professor Raymond Tallis of the Royal College of Physicians states that "[e]very single one of those assumptions is false."[38] Downar et al cite examples of misrepresentation by opponents of AD:

> "In Canada, the media widely reported the case of a woman with multiple chemical sensitivities who received AD, along with claims that she was driven to AD through poverty and lack of adequate housing rather than intolerable suffering related to her underlying condition. The patient herself refuted these claims in a note written before her death. Another person with a chronic debilitating condition was reported to be requesting AD purely due to impending homelessness. The patient himself

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[33] Colburn, B. Disability-based arguments against assisted dying laws. Bioethics, 1–7. 2022 https://doi.org/10.1111/bioe.13036

[34] Battin, M. et al. "Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in 'Vulnerable' Groups." Journal of Medical Ethics 33, 2007: 591–597. https://www.researchgate.net/publication/5939010_Legal_Physician-Assisted_Dying_in_Oregon_and_The_Netherlands_Evidence_Concerning_the_Impact_on_Patients_in_Vulnerable_Groups

[35] 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

[36] 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

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

[38] 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

contradicted this assessment, and wrote that his story was ‘‘hijacked by the right trying to spin it into their own agenda.’’[39]

While disabled advocates opposing AD present strong optics in both media appearances and in presenting their arguments to politicians, the inference that disabled people oppose AD remains disingenuous. As Colburn notes: “At best, such assertions are emphatic expressions of the convictions only of individual people with disabilities; at worst, they look like morally dubious attempts at misrepresentation.”[40] There is in fact a significant disparity between the views of disability activists opposing AD and the consistent support for AD in the general disabled population. A 2021 survey of 140 disability rights organisations in the UK indicated that only 4% explicitly oppose assisted dying laws.[41] A substantial majority either remain silent (84%) or explicitly endorse neutrality (4%) on assisted dying. While a number of disability activists took a stance opposing assisted dying in 2007, 75% of disabled people taking part in the 2007 British Social Attitudes Survey believed that those with a terminal and painful illness should be allowed an assisted death.[42] According to a 2013 YouGov poll, only 8% of disabled people surveyed believed that disability rights groups should maintain their opposition to assisted dying, while of the 1,036 disabled people asked, 79% supported a change in the law.[43] A 2014 YouGov poll of 1,000 disabled people found that 79% would support a change in the law to allow assisted dying for terminally ill adults.[44] A 2023 YouGov poll in Scotland found that 79% of disabled people support legalising assisted dying.[45]

The University of Glasgow study ‘Disability-based arguments against assisted dying laws’ (also summarised in “Disability and Assisted Dying Laws Policy Briefing”[46]) concluded that:

1. People with disabilities are not generally opposed to assisted dying laws.
2. Assisted dying laws do not harm people with disabilities.
3. Assisted dying laws do not show disrespect for people with disabilities.
4. Assisted dying laws don’t damage healthcare for people with disabilities.[47]

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[39] Downar et al (2023) Medical Assistance in Dying, Palliative Care, Safety, and Structural Vulnerability. J Palliat Med. 2023 Sep;26(9):1175-1179. doi: 10.1089/jpm.2023.0210. Epub 2023 Jul 3. https://pubmed.ncbi.nlm.nih.gov/37404196

[40] Colburn 2022: 2, as above.

[41] Box, G. & Chambaere, K. Views of disability rights organisations on assisted dying legislation in England, Wales and Scotland: an analysis of position statements. Journal of Medical Ethics, 2021. Published online first 5 January 2021. doi: 10.1136/medethics-2020-107021. Cited in Colburn 2022: 1, as above.

[42] Slouch, Roddy. Assisted dying: the search for a good death. Critical and Radical Social Work vol 4, no 1: 93–102 2016. https://www.academia.edu/78819091/Assisted_dying_the_search_for_a_good_death

[43] Dignity in Dying. Just 8% of disabled people surveyed believe disability rights groups should maintain their opposition to assisted dying. https://www.dignityindying.org.uk/news/just-8-disabled-people-surveyed-believe-disability-rights-groups-maintain-opposition-assisted-dying/

[44] YouGov/Dignity in Dying. Survey Results. 2014: 3. https://d3nkl3psvxxpe9.cloudfront.net/documents/DignityinDyingResults_141020_assisted_dying_Website.pdf

[45] Carrell, S. Majority of Scottish voters support assisted dying bill, poll reports. 17 Sept 2023. https://www.theguardian.com/uk-news/2023/sep/17/majority-of-scottish-voters-support-assisted-dying-bill-poll-reports

[46] Colburn B. Disability and Assisted Dying Laws Policy Briefing. University of Glasgow 2021. https://policyscotland.gla.ac.uk/wp-content/uploads/2021/09/PolicyBriefingDisabilityAndAssistedDyingLaws.pdf

[47] Colburn 2021: 1, as above.

Colburn makes a case in support of the above conclusions, in the process citing a range of research, including Rietjens et al that confirm that "there is no clear evidence for a slippery slope", Steck et al that there was "no correlation with vulnerability in general or with disability specifically", and Emanuel et al that ""[i]n no jurisdiction was there evidence that vulnerable patients have been receiving euthanasia or physician-assisted suicide at rates higher than in the general population"".[48]

Professor Emeritus Jocelyn Downie, in her review of the Supreme Court of Canada's ruling, records that the Supreme Court confirmed that there is:

> no evidence from permissive regimes that people with disabilities are at heightened risk of accessing physician-assisted dying; no evidence of inordinate impact on socially vulnerable populations in permissive jurisdictions; in some cases palliative care actually improved post-legalisation; physicians were better able to provide overall end-of-life treatment once assisted death legalised; the trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide.[49]

In addition and specifically in relation to states where intractable suffering is the key criterion for access and no six or twelve-month mortality limit exists, the same conclusion applies. 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."[50]

The slippery slope argument is predicated on the assumption that further dangerous expansion is inevitable. This has not been the case in Oregon where, for example, legislation has remained relatively unchanged since it passed in 1994 and was enacted since 1997. Beauchamp & Childress note:

> "To date, none of the abuses some predicted have materialised 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."[51]

Sivers observes that 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

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[48] Colburn 2022: 3, as above.

[49] 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

[50] 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/

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

> criteria specified in an Act is not a foregone conclusion, and the law can and does stand as a bulwark against sliding down the slippery slope.[52]

Laws have been adapted in some states. It is true 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. At the time of writing, other Australian states are investigating adapting from six to twelve months, in line with Victoria and Queensland, in particular for neurodegenerative conditions where an unpleasant death is recognised to be more drawn out than for conditions like cancer. Much more controversially[53], 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. Some opponents of AD may mistake democratic process for a 'slippery slope' when the outcome is not to their liking.

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[54], but failed. Subsequently, attempts by Lord Chorley of Kendal in 1950, Lord Raglan in 1969, and a 1994 House of Lords Select Committee review all resulted in the preservation of the status quo.

Imminence of death rather than degree of suffering is prime within the most recent Westminster (and Scottish) proposals. Attempts to seek clarification through judicial review in UK courts have tended to do so on the basis that the right to an assisted death was compatible with the right to a private life, bodily autonomy, and self-determination guaranteed by Article 8 of the European Convention on Human Rights. It is worth briefly examining the Westminster path to the current proposals. As Scotland and England/Wales are part of the United Kingdom, legal developments in each country are often cross-referenced, and the courts in each jurisdiction have remained relatively unwilling to significantly change existing legislation. Despite the judiciary having provided indications and a degree of foreseeability - via guidelines, prosecution outcomes, and indeed decisions not to prosecute - it can be argued that the existing approach to the law in relation to AD continues to be ambiguous and not fit-for-purpose.

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[52] 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/

[53] Although it can be noted that a UK study by the Nuffield Council on Bioethics - Exploring public views on assisted dying: Survey 2 – September 2024 (https://cdn.nuffieldbioethics.org/wp-content/uploads/Nuffield-Assisted-Dying-Survey-2-Results-FINAL.pdf) - found that "[w]hen considering a child child with a terminal illness, the majority [57% of respondents] still support their choice of an assisted death".

[54] Hansard. https://hansard.parliament.uk/Lords/1936-12-01/debates/38e7926b-07b7-4acf-b9cd-67fc10fce643/VoluntaryEuthanasia(Legalisation)BillHl

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[55], 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[56], the Crown Prosecution Service (under DPP Keir Starmer) in 2010 (updated in 2014[57] and again in 2023[58]), 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[59]. Cases where individuals charged with murder by claiming to be compassionately ending the lives of intractable suffering also provided some clarity in terms of likely prosecution outcome[60] - 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. Unlike Scotland, figures on referrals relating to AD in England and Wales are published by the CPS. From 1st April 2009 up to 31 March 2026, 209 AD cases were referred, and "[o]f these 209 cases, 131 were not proceeded with by the CPS and 42 cases were withdrawn by the police."[61]

Since the beginning of this new century, there have been eight attempts to introduce AD legislation for England and Wales in Westminster. The first seven attempts failed, while the eighth passed its first stage, but subsequently became bogged down in the Lords.

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. The Bill was ultimately killed by peers voting 148 to 100 to delay it for six months. In 2014, and then in 2016, Lord Falconer's attempts lacked government support and ran out of time. In 2015, Rob Marris MP introduced a Private Member's Bill which was voted down by 330 votes to 118. In 2016/17, Lord Hayward introduced a private member's bill, which also ran out of time. In 2019, Nick Boles requested that the Secretary of State for Justice commission a call for a comprehensive independent evaluation of

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[55] 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

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

[57] After R (Nicklinson and Lamb) v Ministry of Justice and R (AM) v Director of Public Prosecutions [2014] UKSC 38

[58] Where an additional factor in support of prosecution would be if the person assisting a death was the personal health-care professional of the person seeking assistance to die (although not if currently not caring for the individual in question).

[59] 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

[60] 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

[61] Crown Prosecution Service Operational Information: Assisted Suicide. 31 March 2025. https://www.cps.gov.uk/publications/performance-management-and-case-outcomes/assisted-suicide

evidence relating to AD, but the request was rejected. 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 20th June 2025, passed in the House of Commons by 314 to 291 votes, 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. As the Bill is a private member's Bill, with over 1,200 amendments raised by a small number of Lords opposing the Bill, it failed due to lack of time in the Lords by late March 2026. However, a More in Common survey[62] found 83% of those surveyed believed that in such circumstances the Bill should be introduced again in the next session of Parliament.

Scotland and Assisted Dying.

The rulings of Scottish courts on AD cases have more closely aligned in recent years with the views of the public than have views within the Scottish Parliament. 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 recent 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".[63] 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 progressive and "either terminal or life-shortening"[64] and "sees no prospect of any improvement in the person's quality of life".[65] 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 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, had much in common in terms of process with the 2015 Bill and paid cognisance not only of the Oregon system but also of the various laws

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[62] 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/

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

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

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

successfully passed recently in Australia and New Zealand. As noted in the House of Commons Library, The Law on Assisted Suicide (July 2022):

> 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.[66]

Scottish courts have been consistently unwilling to dictate final law in relation to AD, although they have argued that there has been sufficient guidance given and preceding legal outcomes to ensure foreseeability of how the law will be applied and future outcomes can be anticipated. Assumptions can certainly be made, and outcomes can be extrapolated on the basis of court verdicts and published opinions (such as the Law Lord's opinions published in response to the Ross Appeal), but insistence remains by the Scottish judiciary that codification must be achieved via Holyrood. Fakonti & Papadopoulou stated 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."[67] With the result of the final vote, that opportunity was lost.

The McArthur Bill can be viewed as a pragmatic response to both the failure of previous attempts at legislation - in terms of presenting a more limited scope - and in aligning with and staying within the existing case law precedents and guidance in Scotland. The original draft is available online.[68] The initial proposal presented to the Scottish Parliament defined those eligible for assistance in dying, with reference to the current Scottish Government definition[69], 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.[70]

This definition remained debated, with pressure after the second reading to change to a six-month mortality limit (as per the model adopted in Oregon). The final version of the Bill limited access to those who are terminally ill and likely to die within six months. A medical professional

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[66] 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

[67] 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

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

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

[70] 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

could supply but not administer a fatal dosage - it must be self-administered by the patient. No medical professional needed to 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 the issue of causality under existing Scots law. In response to concerns over risks that may exist in relation to the vulnerable and disabled, the Bill also strengthened safeguards against potential coercion. As Fakonti & Papadopoulou note, "[t]he Scottish Bill treats coercion as a distinctive wrong, further protecting autonomy."[71]

Warlow's summary confirmed:

> The patient must administer any life-ending substance themselves. They must be an adult, resident in Scotland, registered with a GP in Scotland, and mentally competent, as confirmed by two independent doctors. Important lessons from the last attempts to pass a bill on Assisted Dying in Holyrood have been incorporated into the new bill. For example, it does not allow an assisted death for anyone who is not "terminal" (meaning close to death, but within no specific time period), even if they have a debilitating, incurable, and progressive disease, and certainly not if they have a mental disorder that might affect their decision. The safeguards against coercion and exploiting a dying person have been strengthened, as have safeguards for disabled people who are not terminally ill and who have no wish to end their lives. The life-ending 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.[72]

Although the Bill limited access to those who are terminally ill, the earlier 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 healthcare 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.[73]

The most recent British Attitudes Survey (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

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

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

[73] 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

Scottish] bills envisages."[74] The McArthur Bill, however, allowed for self-administration only, close to the Oregon and Antipodean models. A significant majority of those intractably suffering would have been enabled by the McArthur Bill to legally access an assisted death, although those with conditions that entail more prolonged suffering, and therefore not classed as imminently (within six months) terminal, would not, and those incapable of self-administration would also be excluded. These exclusions were likely to remain controversial.

The closeness of the vote on the first stage, however, with only 55.1% of MSPs supporting the Bill, and a number of those voicing continuing reservations[75] appeared to have justified the conservative nature of the Bill.

A key objective appears to have been to establish a robust but workable set of safeguards. As Scobie et al. 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.[76]

The first reading of the Bill in Holyrood took place on 13 May 2025[77]. 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 then returned to committee, and between Stages 2 and 3[78] almost 300 amendments were advanced and explored, of which 175 were accepted and incorporated into the final Bill. The resulting Bill was described by McArthur as "bulletproof"[79] and "tightly drawn, heavily safeguarded and legally defensible".[80] As Mhairi Black noted,

> "It is always worth remembering that legalising assisted dying does not mean aiding and enabling absolutely anyone to take their own life under any circumstance.

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

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

[76] 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

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

[78] The Stage 3 debate can be viewed at: https://www.youtube.com/watch?v=hmmNOs7UwSY; https://youtu.be/HrMvKKQy8GA?t=2; and https://youtu.be/A0d_4YMdHoQ?t=4330.

[79] BBC News. MSP says assisted dying bill is 'bullet proof' after 175 amendments. https://www.bbc.co.uk/news/articles/cnv6lpmv49lo 13 March 2026.

[80] Carrell, Severin. Scottish parliament votes against legalising assisted dying https://www.theguardian.com/society/2026/mar/17/scottish-parliament-votes-against-legalising-assisted-dying 17 March 2026.

> Rather, it is a tightly defined attempt to allow terminally ill, mentally competent adults to seek medical help to end their lives."[81]

The Scottish government raised issues[82] relating to elements of the Bill that impinged upon reserved matters (matters controlled by Westminster), and the removal of a 'no duty to serve' clause caused concern for seven professional medical bodies[83]. The final Bill (as amended at Stages 2 & 3) also included significantly more prescriptive detail on process.[84] These adapted and added details included:

In relation to eligibility, an individual must be 18 years old, and "[i]n order to be eligible for assistance under the Bill now, the terminally ill adult must also 'reasonably be expected to die within 6 months'."[85]

In relation to coercion, assessments of coercion involving a clear discussion of the subject (under a broader definition) with the applicant must take place with both the coordinating and independent doctor, and again with the doctor(s) in attendance when the lethal substance is supplied. The penalties for coercion were also adjusted.

In relation to capacity, any existing information must be sought from local authorities in relation to any existing support for conditions related to compromised capacity, with potential subsequent involvement from a social worker. Capacity is also defined, and is required to the point of ingestion of a lethal substance. Any doubts must lead to a psychiatric referral, with possible input from health, social care and social workers.

In relation to process, the amendments were more prescriptive in terms of required administration, information management, reporting and referrals, and now included an advanced care directive with the option to seek a palliative care plan, and an assessment to confirm palliative and social care options to have been explained, understood and provided where required. Prognosis, symptom/care management options and the process should be discussed, along with the lethal substance to be self-administered. The individual's reasons for requesting AD should be recorded. The process for signing by proxy and the right to advocacy support was also clarified.

In relation to participation and protection for staff, the right to conscientious objection with no detriment was clarified in Stage 2, along with training requirements, but then removed in Stage 3 (as they were regarded as reserved matters) and planned to be pursued separately through a 104 order.

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[81] Black, M. Misconceptions still persist about assisted dying. The National, 21st March 2026. https://www.thenational.scot/politics/25956397.misconceptions-still-persist-assisted-dying/?fbclid=IwY2xjawQtTstleHRuA2FlbQIxMABicmlkETFlZ1Q2azRhU1BlamwzOE9Kc3J0YwZhcHBfaWQQMjIyMDM5MTc4ODIwMDg5MgABHhLRn3dQ_Xzc7fTvm3uqtpQKc5kHjKXnrNf5gZ-d9p8ZPf6gdOxodpEAQKO0_aem_WOHByLvEncUT0yxy0yk_sA

[82] Gray, N. Correspondence to Haughey, Correspondence on Assisted Dying for Terminally Ill Adults (Scotland) Bill – Stage 3 Committee Consideration, 5 March 2026. https://www.parliament.scot/-/media/files/committees/health-social-care-and-sport-committee/correspondence/2026/assisted-dying-bill-letter-with-update-on-legislative-competence-and-stage-3-approach-from-cab-sec-h.pdf

[83] Consensus statement – concerns about ADTIA (Scotland) Bill, correspondence to Health, Social Care and Sport Committee. https://www.parliament.scot/-/media/files/committees/health-social-care-and-sport-committee/correspondence/2026/letter-from-several-organisations-in-regards-to-the-assisted-dying-bill.pdf

[84] Robson, Kathleen. Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 3 Proceedings. SPICe Briefing, Scottish Parliament. 15 March 2026

[85] Robson, Kathleen: 5, as above.

In relation to provision of assistance in dying, the final process was defined in more detail, with the inclusion of reference to a delivery device (where required). Powers to organise and integrate AD within NHS services were also covered. Both use of an approved substance and underlying condition were to be recorded.

In terms of civil and criminal liability, coercion again, along with public promotion or encouragement of AD, were identified as offences (in addition to coercive control already being a criminal offence in Scotland under the Domestic Abuse (Scotland) Act 2018).

While assistance up to self-administration would be legalised, direct administration (euthanasia) would remain illegal.

In terms of reporting, monitoring, and review, more specific requirements were added to each of these areas to ensure more detailed clarity, analysis, and transparency.

In terms of guidance and practice, more specific requirements were added to each of these areas to ensure more detailed clarity of process and provision of guidance.

The final Bill can be found on the Scottish Parliament website.[86]

The final vote on the Bill on 17th March 2026 resulted in the motion losing by 69 votes to 57 with one abstention. Continuing concerns over coercion were cited by a number of MSPs who moved from supporting the Bill initially to opposing it in the final vote, despite the conservative nature of the Bill and the reassurances and safeguards included.

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 have been naive. Certainly, it can be argued that reducing the scope of the legislation in comparison to previous attempts was a pragmatic compromise, as in previous attempts, the perfect (as perceived by many AD supporters) may well have proven to be the enemy of the good.

On perhaps a minor point, it can be noted that every successful Bill in Australia ensured that the word ‘voluntary’ was clearly applied, and indeed the process was referred to as Voluntary Assisted Dying (VAD). It was the first thing the public heard, and it was repeated in every report and debate thereafter. In New Zealand the word ‘choice’ was included in the title. How significant these inclusions were in setting the agenda and public perception of AD in the face of opposition claims around coercion is purely speculation, but it is fair to assume that however small or large an impact was achieved, overall it was a net positive for the proponents of AD.

Bache 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”.[87] It can be argued that such legal fora can be more disadvantageous to AD, as political arguments and indeed voting in parliaments can be more vulnerable to emotive responses and to lobbying, whereas a judge is more likely to decide on the basis of facts presented, and juries (or indeed citizen’s assemblies) may be more likely to come to conclusions that more closely reflect public opinion.

In countries where courts have proven reluctant to introduce changes to the law, the resulting legislation has tended towards the more conservative. In countries such as the Netherlands and Canada where the courts have enabled significant change, the resulting AD legislation has been more wide-ranging in terms of access. In the Netherlands and in Canada, a range of court-based

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[86] Assisted Dying for Terminally Ill Adults (Scotland) Bill, as above.

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

legal precedents operated in defining both the law and appropriate legal sanctions, subsequently enshrined in legislation.

Even within the context of the legislative process, the McArthur Bill was at a disadvantage. Bache notes the positive effect an actively committed government can have to such controversial issues both through publicly expressed support by party leaders[88] and by government agenda-setting where '[p]olicies develop through the accumulation of knowledge by experts and their subsequent proposals."[89] This would be in contrast to the perceived partisan claims and counter-claims that face politicians who do not have a detailed understanding of a subject when presented as a Member's Bill. It is not unreasonable to speculate that a number of MSPs were simply too busy with constituency business, other issues they were pursuing, other Parliamentary business (and of course focussing on an imminent election) to have the time to research the subject independently in the kind of depth that would allow a fully informed opinion on such a complex issue. As Preston and Ost note, as a Member's Bill - as compared to a manifesto commitment by the government - the McArthur Bill had "a far less exhaustive consultation process".[90] The two-year consultation for the successful government-led legislation in Jersey included a Citizen's Jury, "extensive public consultation and open meetings"[91], extensive consultation with experts, the General Medical Council, the British Medical Association and the Royal Colleges, and involved "more resources to explore international legal models, safeguards, ethical policy, and regulatory concerns."[92] This process had the advantage of actively and directly engaging with the public, medical organisations, and external experts, and to a much greater degree presenting findings and conclusions that could be regarded as independent, and intended to present fact, rather than one or other partial position. The debate was rational rather than emotional. Despite the Jersey law being broader (involving doctors administering the drugs where requested, and a waiver for requirement of future capacity), the proposals passed.

Bache[93], citing Burke, observes that in such 'votes of conscience', a number of other factors are relevant. Whilst voters may regard their representatives as 'delegates' who will vote in line with their wishes, most politicians regard themselves as 'trustees' who act on their own judgement. This latter position is, however, a grey area that can include voting along party lines, taking their lead from their leader's stated position (perhaps in the hope of advancement) and, simply in cases where they have been unable to become cognisant of the finer details of the debate, following the lead of others that they trust. Bache notes that the stated position of the party leader has particular significance, and it can be noted that in relation to the McArthur Bill, the Labour leader, Conservative leader, and SNP leaders (current and previous) had stated their clear opposition to the Bill. As things stand, the only party in Scotland committed to AD as policy are the Greens. Preston and Ost note that "the question remains whether, in the absence of government backing, any private

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[88] Bache, Ian. How (and when) does party matter? 2025, as above.

[89] Bache, I. The Multiple Streams Framework and Non-Politicized Issues: The Case of Assisted Dying/Assisted Suicide. Politics and Policy 53, 2025: 2. https://doi.org/10.1111/polp.70016

[90] Preston N, Ost S. The divergent fates of assisted dying in Scotland and Jersey offer lessons for future legislation BMJ 2026: 393 https://www.bmj.com/content/393/bmj.s636

[91] Preston N, Ost S. 2026 as above.

[92] Preston N, Ost S. 2026 as above.

[93] Bache, Ian. How (and when) does party matter? 2025: 3-5, as above.

members bill on assisted dying will be supported with sufficient time, consultative input, and resources to be approved."[94]

Despite its conservative approach, the McArthur Bill ultimately failed, by 69 for, 57 against, and 1 abstention. In terms of final votes, the result was Scottish Green Party: 7 for, 0 against; Scottish National Party: 41 for, 19 against plus 1 abstention; Scottish Liberal Democrats: 4 for, 1 against; Scottish Conservative and Unionist Party: 11 for, 19 against; Scottish Labour: 7 for, 15 against; Independent: 0 for, 1 against; and Alba Party: 0 for, 1 against.[95] It did, however, progress much further than any previous attempt, not least due to a number of external developments that can be seen to have played a part.

Changing Scottish demographics.

According to the Scottish government:

> The Scottish population is ageing, and in 2020, there were an estimated one million Scottish 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.[96]

Living with numerous and often complex health problems is becoming the norm for older people and those from disadvantaged communities in Scotland.[97] People are also living longer[98], but many of these additional years are spent with health problems, often multimorbidities[99] [100] [101]. In some cases, palliative care is simply insufficient and/or unpalatable to chronic sufferers.[102] [103] The Scottish government has stated that

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[94] Preston N, Ost S. 2026 as above.

[95] Scottish Parliament, Chambers and Committees: Votes and Motions. Assisted Dying for Terminally Ill Adults (Scotland) Bill, 06 May 2025. https://www.parliament.scot/chamber-and-committees/votes-and-motions/S6M-17416

[96] 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/

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

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

[99] 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

[100] 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/

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

[102] 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

[103] 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

> [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.[104]

Increasing numbers of Scots have already encountered, and may in the future directly or indirectly experience what they regard as the limitations of existing legal end-of-life provision for the intractably suffering. The number of AD cases will likely increase in parallel. Although some AD referrals will continue to be regarded as not in the public interest to pursue, others will continue to take up court time, traumatising those involved, and most likely result in non-custodial outcomes.

Institutional positions on AD in British medicine.

In terms of financing, the Westminster Impact Assessment for Assisted Dying estimated that while introducing AD would not save the NHS money, it would not necessarily add significantly to the overall health-care budget.[105]

As detailed in 'The Inescapable Truth About Dying in Scotland', "62% of Scottish healthcare professionals believe there are circumstances in which doctors or nurses have intentionally hastened death as a compassionate response to patients' requests to end their suffering at the end of life."[106] 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 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.[107] Professor Raymond Tallis notes that:

> In 2009, Clive Seale estimated that around 0.2% of deaths were the result of a doctor responding to an explicit request from their patient to end their life by taking direct action to do so. This equates to around 1000 deaths a year, a similar number of deaths that would be predicted under an assisted dying law.[108]

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[109]. The bargain struck by voting for the status quo is continued ambiguity and inconsistency, a 'devil's lottery', where, for example, a patient may find medical staff willing to listen to their pleas to hasten their death, but equally may find staff who are unwilling to do so. The

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[104] 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/

[105] 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

[106] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. 2019: 64, as above.

[107] 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

[108] Tallis, Prof R. Assisted dying: Why the RCP should be neutral. Royal College of Surgeons, Blog. 14/01/19. https://www.rcplondon.ac.uk/news-and-media/news-and-opinion/assisted-dying-why-the-rcp-should-be-neutral/

[109] 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

best interest of any patient and any medical practitioner is for all medical procedures to be clear and subject to the strictures of legislation, regulation, and professional administration[110].

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 took no position on AD,[111] Hospice UK presented a neutral tone of "no collective view"[112], Marie Curie maintained 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"[113], although they expressed concerns. The British Geriatrics Society continued to oppose AD, and the Royal College of Psychiatrists in Scotland (although remaining neutral on the principle of AD) and The Royal Pharmaceutical Society in Scotland moved from neutrality to opposing the McArthur Bill at Stage 3 due to the concerns about the removal from the Bill of protections for staff opting out of the process.

Meanwhile, even back in 2001, throughout the BMA/RC/RCN guidance, there was 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.[114]

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 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[115] 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[116].

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[110] 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

[111] 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

[112] Hospice UK. Our position on assisted dying. https://www.hospiceuk.org/assisted-dying

[113] 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

[114] 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

[115] 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

[116] Bache, Ian. How (and when) does party matter? 2025: 10, as above.

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 in support of AD 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%[117]. Bache cites the British Social Attitudes survey 2017, noting that "[s]ince the 1980s, UK public support for assisted dying/assisted suicide (AD/AS) undertaken by a doctor for people with a painful, incurable disease has consistently hovered around the 80% mark"[118]and quoting directly, ""[t]he most surprising aspect of this issue is, perhaps, how out of step UK law is with long-standing and significant majority public support""[119]. In the 2025 British Social Attitudes Survey, 79% of the British public supported AD. In the same survey, 81% of Scots supported AD.[120]

In 2005, the House of Lords First Report on the Assisted Dying for the Terminally Ill Bill 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".[121] The Autumn 2025 National Centre for Social Research British Social Attitudes survey found that 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%.[122] 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.[123]

In the July 2024 survey 'Rethinking the UK's approach to dying', 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 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.[124] In September 2024, a YouGov survey took an in-

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[117] 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

[118] Bache, Ian. How (and when) does party matter? 2025: 2, as above.

[119] Bache, Ian. How (and when) does party matter? 2025: 2, as above.

[120] National Centre for Social Research (NatCen). British Social Attitudes 43, 2026: 24 https://natcen.ac.uk/sites/default/files/2026-02/british-social-attitudes-43-1866.pdf

[121] 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

[122] National Centre for Social Research (NatCen). British Social Attitudes 43. 2026, as above.

[123] 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.

[124] 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

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 of those supporting AD - seven out of ten - also supported AD for those suffering intractably but not terminally.[125]

A YouGov poll in 2023 found that "58% of Scots have seen a loved one suffer at the end of life."[126] The most recent British Attitudes Survey (September and October 2025) 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.[127]

There continues to be strong and consistent support amongst the public for AD, in parallel with increasing instances of morbidities and chronic suffering within the population. The 2025 British Attitudes Study describes "a public that largely seems to have made its mind up in favour of change a long time ago."[128] 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 the practicalities of introducing AD have been studied and evaluated in detail. In addition, case law outcomes and associated rulings and guidance have incrementally clarified existing ambiguity in Scots law.

Only 6% of Scots think the current law in relation to AD in Scotland is working well.[129]

Scots Law.

Suicide is not illegal in Scotland. Assisting another person's death, in certain circumstances, is also not illegal in Scotland, although direct causation of a death remains a prosecutable offence as Scots law recognises "the inherent wrongfulness of killing"[130]. In Scotland, relevant court rulings on AD remain sparse, as does any explanation why some cases are simply not seen to be in the public interest. There also remains limited formal guidance from the Crown Office and Procurator Fiscal Service (COPFS), in comparison to 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 police or the Procurator Fiscal. The Scottish judiciary have remained adamant that substantive change must be codified by Holyrood.

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

[126] 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

[127] National Centre for Social Research (NatCen). British Social Attitudes 43. 2026: 24, as above.

[128] National Centre for Social Research (NatCen). British Social Attitudes 43. 2026: 27, as above.

[129] Dignity In Dying: The Inescapable Truth, 2019: 8, as above.

[130] McDiarmid, C. Examining Culpable Homicide in Scots Law in Reed, A et al (eds) Killings Short of Murder: A Research Companion London Routledge 2018: 6. https://strathprints.strath.ac.uk/66383/1/McDiarmid_2018_Killings_short_of_murder_culpable.pdf McDiarmid, C. Examining Culpable Homicide. 2018: 2, as above.

Nonetheless, how Scots law perceives AD cases continues to evolve, albeit incrementally, with each court verdict and each response to legal challenge.

It would therefore be useful to briefly examine the criteria of 'recklessness' and 'wickedness', along with the terms 'murder' and 'culpable homicide', and their relevance to AD cases. Under Scots law, murder is the wilful and deliberate taking of a life, with wicked/reckless intent. Wicked intent is established where the death of the victim was the outcome intended by the perpetrator. Reckless conduct is that which is carried out with insufficient thought as to outcome or consequences. Stark defines reckless as "unreasonable/unjustified risk-taking".[131] McDiarmid notes that in Scots law 'recklessness' is a "lack of caution, or rashness, or disregard for consequences"[132] in carrying out the act.

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"[133], i.e short of murder. As Ward notes, "the principle of actus non facit reum nisi mens sit rea[134] is generally applied in Scots Law."[135] In effect, it is separately labelled (from murder) and understood as: "blameworthy killing which is not murder".[136]

McDiarmid notes that "provocation and diminished responsibility are the only formal mechanisms available in Scots law for the reduction of murder to culpable homicide."[137]. The accused in such circumstances is seen to have acted from a type of weakness that could be understandable in any 'ordinary person'. 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"."[138] As Maher notes, "culpable homicide is an unlawful killing where the accused lacks intention to kill or such wicked recklessness."[139] There has, however, been an ambiguity that, while leaving significant discretion in sentencing, has also led to a degree of dissonance in interpretation.

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

[132] 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

[133] McDiarmid, C. Examining Culpable Homicide, 2018: 2, as above.

[134] The act does not make a person guilty unless the mind is guilty

[135] Ward, AJ. From Criminality, 2022: 74 , as above.

[136] 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

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

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

[139] 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

In Drury v HM Advocate[140] an appeal (controversially) reduced the conviction of murder to culpable homicide. Lord Justice-General (Rodger) stated that "just as the recklessness has to be wicked, so also must the intention be wicked"[141] and that provocation in this case meant that the action taken by the accused "though culpable, was not wicked".[142] McDiarmid notes that the subsequent cases of Elsherkisi[143] and Meikle[144] clarified that an intention to kill "absent either provocation or diminished responsibility will, generally, signify murder".[145] The judge in the original Elsherkis trial stated "intending to kill someone is obviously wicked". The Drury interpretation was also challenged in Gillon[146], where on appeal, the court reaffirmed the law's requirement that there existed a reasonable proportionality between the provocation and the responding actions. The ruling on Petto[147] was critical of such terms as wicked and depraved, describing them as limiting and anachronistic, meriting serious re-examination.

As a result of perceived ambiguity and controversy of interpretation, a discussion paper[148] was published in 2021. However, AD was excluded from the scope of the paper. McDiarmid argues that the definition of culpable homicide remains broad and vague and 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."[149]

Judging by the outcomes in trials relating to assisted deaths in recent decades, the actions taken by those who assisted in a death were perceived to be neither reckless nor 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. 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.[150]

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

[141] Drury v HM Advocate (2001) [11], as above.

[142] Drury v HM Advocate (2001) [18], as above.

[143] Elsherkis v HM Adv 2011 SCCR 735.

[144] Meikle v HMA 2014 SLT 1062

[145] McDiarmid, C. Between Accidental Killing, 2023: 7, as above.

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

[147] Petto v HMA, 2011 SCCR 519

[148] 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

[149] McDiarmid, C. Between Accidental Killing, 2023: 11, as above.

[150] Ward, AJ. From Criminality, 2022: 93, as above.

McDiarmid argues that cases such as Ross v Lord Advocate leave "culpable homicide as rather an amorphous category, lacking even a clear definition of *actus reus* and *mens rea*."[151] As Tickell notes, "in cases involving assisted dying, the causation analysis can be much more complex and uncertain."[152]

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 recklessness or wickedness. 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."[153] As McDiarmid notes, "[t]he Crown's discretion can allow for a compassionate, morally grounded response"[154], quoting Douglas Husak:

> 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.[155]

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 than later and with the absence of the main witness) would in large part remove these cases from the court docket. Any case that lay within the accepted parameters prescribed by law would also cause less trauma to relatives and loved ones.

Supply of a lethal substance.

Although the cases in this section are not directly related to AD, again they have bearing in terms of precedence to where supply and administration of a lethal substance stand currently in Scots law. The cases of Khaliq and Anor[156], and Ulhaq[157] 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[158], which reiterated that voluntary consumption by a victim did not (at that time) break the causal link of supply. A subsequent decision in the

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[151] McDiarmid, C. Examining Culpable Homicide, 2018: 5, as above.

[152] Tickell, A. Scots are stuck in legal limbo regarding assisted dying. The National, 22 March 2026.

[153] McDiarmid, C. Examining Culpable Homicide, 2018: 6, as above.

[154] McDiarmid, C. Examining Culpable Homicide, 2018: 10, as above.

[155] 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.

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

[157] Ulhaq v HMA 1991 SLT 614.

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

Westminster House of Lords[159] 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[160].

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*[161] which broke the causal link."[162] 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".[163]

In both cases, the intent and expectations of the accused, despite any awareness of the dangers associated with the illicit substances in question, were that a recreational and non-lethal experience would occur amongst friends. While there was also consent in the Kane case, the direct administration of the drug was regarded to more clearly resemble causation via culpable and reckless conduct. Emerging in the ruling was the notion that although 'culpably and recklessly' may be implied in all such cases, culpable homicide can apply in relation to supplying or administration of a controlled drug only if the prosecution offers to prove it was a reckless act. Citing Professor Glanville Williams, the ruling noted that a volitional act sets "a new "chain of causation" going, irrespective of what has happened before"[164], and that outside of those who lack capacity, the exercise of free will is assumed in criminal law. The ruling notes that "generally speaking, informed adults of sound mind are treated as autonomous beings able to make their own decisions"[165], but that "[s]ubject always to questions of immediacy and directness, the law may properly attribute responsibility for ingestion, and so for death, to the reckless offender."[166] The ruling noted that "a deliberate decision by the victim of the reckless conduct to ingest the drug will not necessarily break the chain of causation."[167]

As Chalmers observed:

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

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

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

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

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

[164] 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.

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

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

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

> The "not necessarily" conclusion reached by the High Court gives little concrete guidance on how the law would approach the facts of any future case. It at least leaves open the possibility that provision of the means of suicide would be regarded as the legal cause of death. If the provider knew the purpose for which the means were provided, they would almost certainly have the necessary mens rea for murder, or at least culpable homicide.[168]

McDiarmid 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."[169] However, Ward 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.[170]

Whilst the above cases are not directly related to AD, they had a significant bearing on potential AD rulings, to the subsequent Ross Appeal ruling, and to the choice to focus solely on self-administration in the McArthur Bill.

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

Around the same time as MacAngus, there were also two examples of medical practitioners providing advice, and— in the case of Kerr— prescriptions to facilitate death. In 2008, Dr Ian Kerr[171] 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 regarded as in the public interest to prosecute. In 2010, Surrey Police arrested Glasgow resident and retired family planning practitioner Elizabeth Wilson[172] 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.

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

In 1980, Robert Hunter[173] 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[174] [175] smothered his brother after administering alcohol and pills, and walked free with a charge of culpable homicide

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[168] Chalmers, J. Assisted Suicide (Scotland) Bill: Response to Question Paper: The Position Under Existing Scots Criminal Law. Scottish Parliament 2015. HS/S4/15/5/1

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

[170] Ward, AJ. From Criminality, 2022: 156, as above.

[171] Ward, AJ. From Criminality, 2022: 106, as above.

[172] Ward, AJ. From Criminality, 2022: 107, as above.

[173] Ward, AJ. From Criminality, 2022: 104, as above.

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

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

and an admonition. In a 1997 High Court case, David Hainsworth[176] was charged with the unsuccessful attempt to end the life of his father, who was dying of cancer. The charge was reduced to assault, with a two-year probation order. In HMA v Edge (2005)[177], 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[178] 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[179] 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 in 2017. He was convicted of culpable homicide and jailed for four years and three months[180]. The sentence was appealed[181] and - for an act described as a "final act of love"[182] while suffering a depressive episode - was quashed and an admonishment substituted.

The outcome in each case in the past forty years, in tandem with the consistent support for AD over the same period by Scots, has indicated a limited but clear pattern of likely non-custodial outcomes for any similar AD cases in the future in Scotland, regardless of a change in the law.

Gordon Ross seeks clarity on assisted deaths.

Gordon Ross challenged the Lord Advocate in court[183], 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.[184]

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

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[176] Ward, AJ. From Criminality, 2022: 105, as above.

[177] Ward, AJ. From Criminality, 2022: 106, as above.

[178] Ward, AJ. From Criminality, 2022: 155, as above.

[179] Ward, AJ. From Criminality, 2022: 108, as above.

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

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

[182] 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

[183] 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

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

> 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.[185]

Ross sought specific guidance, as had occurred in England after Purdy, on criteria applied and likely outcome of assessment of cases of AD, i.e. for a decision to prosecute or not prosecute where one individual provided assistance to another in dying. The Lord Advocate's response was that this was not appropriate, as while under the European Convention on Human Rights the right to respect for private life was recognised to encompass 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"[186], but also iterated 13 factors that could be taken into consideration in relation to a choice to prosecute: (i) The nature and gravity of the offence - The nature of the offence will be a major consideration in the assessment of the public interest. In general, the more serious the offence, the more likely it is that the public interest will require a prosecution; (ii) The impact of the offence on the victim and other witnesses; (iii) The age, background, and personal circumstances of the accused; (iv) The age and personal circumstances of the victim and other witnesses; (v) The attitude of the victim; (vi) The motive for the crime; (vii) The age of the offence; (viii) Mitigating circumstances; (ix) The effect of prosecution on the accused; (x) The risk of further offending; (xi) The availability of a more appropriate civil remedy; (xii) Powers of the court; and (xiii) Public concern.[187] The lack of specificity within the thirteen factors cited was clearly designed to allow a great deal of latitude in decisions to prosecute or otherwise, but was insufficient to reassure Ross.

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 lead to prosecution. As such, he and individuals in similar circumstances could feel pressurised to end their lives earlier than necessary by their own hands, before becoming 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 reactively after the attempt, not before, and on a case-by-case basis.

Ross petitioned for judicial review in the Court of Session seeking clarification. Ross's continuing concern was that at the time when he may find life unbearable, he would require assistance to take his own life. Ross died before the ruling was published, and the appeal was unsuccessful overall, although it elicited further clarification.

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[185] Ward, AJ. From Criminality, 2022: 140, as above.

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

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

The Ross Appeal.[188]

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

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"[189] 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".[190] 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".[191] 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."[192]

Lady Dorian notes that "[a]s 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."[193] She notes that, "there is in Scotland no offence of 'assisted suicide'."[194] 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.[195]

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."[196] He confirms the Lord Advocate's observation that neither taking one's own life nor attempting such is 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".[197] Clearly expressed and understood consent must, however, apply, and the degree of direct assistance

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188 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

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

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

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

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

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

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

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

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

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

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.[198]

Carloway concludes that "there is no need for the respondent to set these concepts out in offence-specific guidelines."[199] Dorrian concludes the same, 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".[200] While the above may not be self-evident or foreseeable to anybody other than legal scholars or professionals, it indicates a belief that the law, vis-à-vis AD, is now sufficiently clear for Scottish courts, and that codification is now a matter for the Scottish Parliament. 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".[201] Drummond Young confirmed a reluctance to engage in a change in the law led by the courts, noting that while

> assisted suicide is a subject that, on any view, raises profound moral issues. It also raises very strong feelings, both for and against. In such a case, it is in my opinion wholly inappropriate for the courts to attempt any major change in the law.[202]

It was his view that the law is "a matter for legislators".[203] Commenting on Ross v Lord Advocate, McDiarmid argues:

> [w]hile clearly the so-called right to die raises particularly fraught issues of law, ethics, morality, and compassion, it is precisely in such cases, and 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.[204]

Absent of successful AD legislation, Scottish medical and legal professionals will likely continue to interpret Scots law precedents as best they can. In Holland, "the courts had already provided de facto legalization"[205] before the Euthanasia Act of 2002. Similarly, "[a]s in the Netherlands, the

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[198] Gordon Ross (reclaimer) v Lord Advocate 2016: [30]

[199] Gordon Ross (reclaimer) v Lord Advocate 2016: [32]

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

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

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

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

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

[205] Bache, I. Assisted Dying/Assisted Suicide in the UK: An Idea Whose Time Has Come?. Politics & Policy53, no. 6, 2025: 4. https://doi.org/10.1111/polp.70090.

practice of AD/AS was happening in Canada before legalization"[206] and any court sentences tended to be somewhat symbolic and non-punitive before the Supreme Court ruled unanimously that the criminal prohibition of assisted dying was unconstitutional. As the Scottish public ages and becomes more prone to morbidities that cause great suffering, it is possible to foresee an increase in AD cases similar to those discussed earlier reaching court. While Scottish courts continue to publicly defer to Holyrood, their own rulings on cases suggest that reality has already bypassed Holyrood. It bears reiteration that no case relating to AD in the past forty years in Scotland has concluded ultimately in a custodial sentence. The Scottish judiciary has insisted that in relation to assisting deaths, they are "satisfied that the foreseeability requirement is met"[207] in terms of precedents and guidance provided. It is not unreasonable to speculate that in future cases where consent, competence, intractable suffering, and compassionate motive are evident and verifiable, a non-custodial outcome for assisted deaths in Scotland could become normative and prescriptive through further and repeated precedents. Without specific AD legislation, definition, clarification, interpretation and application of Scots law in relation to AD will continue to be limited to the choices of the Scottish judiciary in terms of which cases are pursued (if at all), the subsequent rulings, and any further challenges by members of the public.

Existing choices available to Scots seeking to end their life.

We do not live in a state of "decreed compulsory living"[208]. There exists a range of methods and current ethical rules that enable the ending of a life within a medical context to be legally justified. Clarke & Egan reiterate a common criticism of what many see as artificial distinctions between current practice and proposed AD practice:

> Passive euthanasia is accepted and in reality is widely practised. It is often called withdrawal of therapy. If further care is unlikely to be of any therapeutic benefit, a physician is not obliged to continue therapy. The current approach is for a physician to declare that future therapy is futile and then to withdraw therapy on the basis of futility.[209]

There are a good number of bioethicists, including Beauchamp and Childress themselves, who see little distinction between "killing" and "allowing to die"[210] [211] [212]. Non-treatment decisions, withdrawing/withholding treatment, heavy/terminal sedation that proves fatal, deep sedation/ induced comas and supported dehydration and starvation to death, can all be argued to bear strong similarity to assisted dying, and are already permissible and available within palliative care practice in Scotland. In terms of ending a life, the currently existing options below are all in evidence across Scotland as active choices made by Scottish individuals facing incurable and intractable suffering.

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[206] Bache, I. Assisted Dying 2025: 5, as above.

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

[208] Dankwort, Juergen. (2024). Voluntary Assisted Dying: The Impasse and a Way Forward. Canadian Journal of Bioethics / Revue canadienne de bioéthique, 7(4), 64–70. https://doi.org/10.7202/1114959ar

[209] Clarke, D L & Egan, A. Euthanasia – is there a case? https://www.academia.edu/117086765/Euthanasia_is_there_a_case?email_work_card=view-paper

[210] White, Lucie. Euthanasia, Assisted Suicide and the Professional Obligations of Physicians. https://philpapers.org/archive/WHIEAS-2.pdf

[211] Beauchamp, T & Childress, J 1983, Principles of Biomedical Ethics (2nd ed.), Oxford University Press, Oxford.

[212] Brock, D 1992, Voluntary and active euthanasia, Hastings Center Report, vol. 22, no. 2, pp.10-22.

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 end their lives earlier than they would otherwise have chosen.

Suicide with 'amateur' assistance (not assisted and monitored by medical professionals).

For those who choose to assist a suicide, assuming evidence can corroborate capacity and consent by the deceased and their own compassionate intent, those who provide assistance may be able to take comfort in that AD cases may never reached court as they have been regarded to be not in the public interest to pursue, and by the compassion and leniency demonstrated in sentencing in cases that have reached courts in recent decades. However, in the absence of medically supported assisted deaths, many of those in Scotland wishing or requiring support in ending their lives will be limited to 'citizen-assisted deaths', and all the attendant personal, legal and medical risks and problems.

Dignitas or a similar foreign facility.

This option is available for those who can afford it and remain in sufficiently good 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. While this concession may be welcome to those who can afford it, it remains prejudicial against the many Scots who cannot.

A continuation of suffering, with palliative care providing whatever support it can until death.

While some of the best palliative support in the world is available in Scotland, and the UK in general, palliative care provides insufficient relief from suffering for some. On average, 17 people a day in the UK experience painful deaths that cannot be relieved by the best palliative care[213]. 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.[214] According to the Office of Health Economics, 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."[215]

41% of Scots have witnessed a dying family member or friend suffer unbearably towards the end of their life.[216] 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.[217] 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:

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

[214] 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

[215] 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

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

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

> 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.[218]

Euthanasia/double effect.

Euthanasia— that is to say, a fatal dose administered by a medical practitioner— is technically illegal. However, sources cited in this document indicate that for compassionate and well-meaning reasons, medical professionals do curtail the unnecessary suffering of terminal patients. However, leaving such decisions to the vagaries and inconsistencies of individual opinion, even in response to patient requests, is a poor substitute for a consistent and well-regulated system.

While euthanasia is illegal, the application of the doctrine of double effect to such situations can make this somewhat moot. In such cases where unbearable suffering is occurring, 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, and remains a grey area of interpretation that provides medics latitude to euthanise. The claimed ethical distance between 'foreseeing death' and 'intending death' can appear very narrow in practice. It has been argued that double effect entails a degree of sophistry and can simply be convenient cover for euthanasia. 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."[219] According to Dignity in Dying "[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."[220] Amongst the evidence cited by Ward is the survey by Seale that indicated that "one sixth of all deaths in the UK were hastened by the use of 'double-effect'".[221] This is surely euthanasia by any other name, and there may be many for whom that is acceptable, but along with a lack of safeguards as proposed by McArthur, consistency remains an issue. Within the context of palliative care, some patients may be cared for by medical professionals who are willing to accelerate a terrible death, but others may be faced with staff that refuse to take such action. Unlike AD, the latter patient may experience unbearable suffering for some time without being able to autonomously choose to end that suffering.

Denial or withdrawal of treatment and sustenance by medical staff.

It is common practice for DNR/DNACPR/DNAR[222] notes to be placed by doctors in the files of patients, for whom they judge to be beyond effective treatment. Doctors in Scotland can also

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

[219] 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/

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

[221] Seale, C. National survey of end-of-life decisions made by UK practitioners. 20 (1) Palliative Medicine 3-10, 2006, as cited by Ward, AJ. From Criminality, as before, 2022: 260.

[222] Do Not Resuscitate/Do Not Attempt Cardiopulmonary Resuscitation/Do Not Attempt Resuscitation

withdraw, as well as withhold, 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. A 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 a statement saying that doctors who allowed patients to die with court approval would not be prosecuted.[223]

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.[224]

In relation to the Bland case[225] 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.[226]

Again, there is an indication that agreement of futility of treatment along with a patient's consent can be cited as legal justification in ending a life in Scotland.

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 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.[227]

Heavy dosage 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,

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

[224] 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

[225] 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.

[226] 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

[227] 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/

comprehend or engage[228] - some regard this loss of dignity as social death (the loss of any of the things that make life bearable) long before physical death. Heavy/terminal sedation can simply prolong an unpleasant dying process rather than extending any kind of beneficial life. 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 deeply traumatic for the dying person's loved ones.

Heavy dosage drug administration involving an induced coma (Continuous Deep Sedation (CDS)).

Regarded as the closest legal analogue (solely or in conjunction with VSED) to an assisted death[229], the process risks the patient experiencing physical discomfort and ICU delirium[230] - a common disorganised cognitive experience during an unconscious state under heavy sedation, where a person is apparently at peace but can actually be undergoing a deeply unpleasant and confused dream/nightmare state, although they remain unresponsive until death. As noted by Sheen & Oates, "[t]he absence of physical responses should not be misinterpreted to mean that cognitive processes are not occurring."[231] Bender et al 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."[232] O'Connor et al 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".[233] O'Connor et al recommend that based on available evidence of continued cognition, 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."[234] The process has also been criticised as an unnecessarily prolonged death. As Professor Stephen Duckworth argues:

> [b]eing unconscious for medication to treat intractable pain is the same as being dead, and Continuous Deep Sedation (CDS) induces unconsciousness just as

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

[229] 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/

[230] 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

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

[232] 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/

[233] 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

[234] 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

> Assisted Dying causes death. So, the "Doctrine of Double Effect" does not establish a moral difference between CDS and Assisted Dying.[235]

Voluntary Stopping of Eating and Drinking (VSED).

The law in Scotland already allows this particular analog of AD, enabled by the simple process of signing an advance directive form. VSED has been practised for decades. VSED is commonly accompanied by heavy-dose drug administration by medical staff (often but not always to induce a coma) until death.

VSED merits an examination as a counterpoint to - and as the closest legally practised 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 as part of the process of an individual successfully taking their own life. Jox et al argued that there is inconsistency in the support for VSED of palliative care societies, professional bodies of physicians, legal scholars, and ethicists while opposing AD:

> "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."[236]

Loewy refers to practice of Voluntary Stopping of Eating and Drinking as "physician stimulated starvation".[237]

Starvation and dehydration are a slow process. Bolt et al found that "in 8% of cases, dying was a prolonged process of more than 14 days"[238], while Quill et al found that "[t]he process of VSED until death may take up to 21 days"[239]. There is both anecdotal and research evidence that patients

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[235] Duckworth, S. Written evidence submitted. 2022, as above.

[236] 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

[237] https://www.academia.edu/113873484/Euthanasia_Physician_Assisted_Suicide_and_Other_Methods_of_Helping_Along_Death?email_work_card=view-paper

[238] 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

[239] 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

who have chosen VSED have been observed to experience delirium, pain, and anxiety[240] [241] [242] [243]. 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; the 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; the 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; the 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.[244]

As noted above, although a patient in an induced coma may remain unresponsive, this does not preclude the experience 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. A perceived peaceful stillness and inability to express need can belie a far from peaceful experience. In addition, the prolonged 'deathwatch' experienced by loved ones can be traumatic.

Summary and Conclusions.

On 17th March 2026, the Scottish Parliament voted down the McArthur Assisted Dying Bill.

Public support for the legalisation of AD has been consistent over the past four decades, currently with four out of five Scots in favour of legalising AD. It appears to be a matter that is already settled in Scotland, except in Holyrood.

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 significant amounts of real-life data and case studies with which to examine and test the claims of supporters and opponents to AD.

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 not make use of the option. It may also be possible to infer that two-thirds of that small minority do experience suffering that cannot be ameliorated by the best palliative care that modern medicine can provide.

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[240] 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

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

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

[243] 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

[244] 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

The Scottish population is living longer, but with increasing morbidities, co-morbidities and multi-morbidities. The number of 'bad deaths' for which palliative care cannot bring relief is likely to increase in coming years, along with a concomitant increase in more direct experiences and awareness of 'bad deaths' amongst the general Scottish 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 leniency of verdicts in AD cases that reached court in Scotland in the past four decades reflects the consistent support by Scots for AD over that period. While no comparative figures for Scotland exist, in England and Wales 173 out of 209 (82.8%) of AD cases referred were ultimately not pursued by the CPS or the police[245]. In the past forty years in Scotland every instance where an AD case was taken to court has ultimately seen those who assisted a death walk free. There has been an iterative (if cautious) move in Scottish courts towards clarification of Scots law in relation to AD.

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 nonetheless attempt to end their lives. Cases where loved ones assist in such deaths are likely to persist, even if that risks legal sanction. The ambiguity of the legal status quo, as it currently stands, has not and will not stop those who are determined to end their life, or indeed those determined to assist loved ones to do so. Scottish courts appear unlikely to impose a punitive sentence upon them where consent, capacity, and compassion are evident. Attempts by Scots to end their unbearable suffering alone or with others, in what Ward describes as "amateur citizen-assisted deaths"[246], run clear risks of the attempt being botched or causing unnecessarily unpleasant deaths. 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.

Where the law in relation to AD has changed democratically, opponents may represent this as a 'slippery slope'. The limitation in the McArthur proposals to only those persons already dying within six months, along with the bolstered protections in the Bill, were intended to counter broader concerns relating to coercion. Concerns about possible coercion were nonetheless cited as a key concern by MSPs who voted against the Bill. An abundance of research data exists countering arguments of coercion and targeting of the vulnerable within existing AD systems. However, most MSPs, while trying to form a view on the evidence and arguments presented by both sides may have been simultaneously focussing on constituency issues, personal campaigns on other issues, and, of course, the distraction of planning for the upcoming Scottish election. Within such a context, and without clearly and recognisably independent research on the subject, it would be challenging for non-experts to distinguish fact from partial information and propaganda. The final debate in Holyrood was described as emotional.[247] [248] [249] [250] Bache notes that in cases where politicians may

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[245] Crown Prosecution Service Operational Information: Assisted Suicide. As above.

[246] Ward, AJ. From Criminality,. 2022: 171, as above.

[247] Cochrane, A. BBC News. Scotland's assisted dying bill rejected after emotional debate. https://www.bbc.co.uk/news/articles/c33j3nd1kvko

[248] STV News. MSPs reject Assisted Dying Bill after emotionally charged Holyrood debate. https://news.stv.tv/politics/msps-reject-assisted-dying-bill-after-emotionally-charged-holyrood-debate

[249] Samson, K. 4 News. Scottish Parliament rejects Assisted Dying Bill after emotional debate. https://www.channel4.com/news/scottish-parliament-rejects-assisted-dying-bill-after-emotional-debate

[250] Scotsman. Assisted dying legislation rejected by MSPs following emotional debate. https://www.scotsman.com/news/politics/assisted-dying-legislation-rejected-by-msps-following-emotional-debate-6025857

be less acquainted with detail, or simply be ambitious, they may "stay on 'safe ground' and vote in line with the preferences of their leader".[251] In the Holyrood debate, SNP, Labour, and Conservative leaders clearly stated their opposition to the Bill.

Opposition to AD legislation often originates within religious belief. Tactics include 'astroturf organisations' and wilful misrepresentations. 'Lying for Jesus' is most likely regarded as a small sin that will be forgiven in service of stopping the greater 'sin' of legalising assisted dying. In opposing controversial change, opponents do not need to win the argument. They simply need to 'flood the zone' to create sufficient confusion and doubt as to discourage the undecided from supporting change and enable those who may simply feel it is politically more expedient to vote for the status quo to claim to have reasons to do so.

The Scottish judiciary have assiduously made a public point of insisting that legislative change in relation to AD is a matter for the Scottish Parliament to set policy. A response by Friends at the End to the Scottish Parliament Cross Party Group on End of Life Choices 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 sufficient. 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.[252]

The Ross Appeal ruling has indicated that the supply of a lethal substance alone does not qualify as causation of death where another individual, with capacity, chooses to ingest it. Lord Carloway's guidance establishes that supplying a lethal dosage to be self-administered in such circumstances breaks the causal link and is highly unlikely to lead to a successful prosecution. Scots law already permits the ending of a life by medical staff by denial or active withdrawal of life-maintaining treatment, with the Johnson ruling recognising that futility of treatment along with a patient's consent can be cited as legal justification in ending a life. It is undeniable that mercy-killings by medical staff have occurred in situations where patients are experiencing intractable suffering at the end of life, citing the doctrine of double-effect. It is clear that death by deliberate administration of an overdose does occur where medical staff are ethically comfortable to do so (but not in other instances where other medical staff may oppose accelerating death) in cases of intractable and unbearable suffering. Medical staff can also legally provide terminal sedation, inducing a coma until death. Any individual has the right to die by voluntarily stopping eating and drinking, and this process can and is supported by palliative care staff. VSED can be a prolonged and unpleasant death. The outcome of death in this case is both foreseeable and intended. VSED already operates beyond the restricted scope of the McArthur proposals as VSED is permissible to those unlikely to die within an arbitrary (six-month) period. Supporting medical staff understand the purpose is to cause a death. A majority of British medical organisations have now dropped their opposition to AD. Medical practitioners in Scotland who have provided advice and (in one case) the medication to facilitate death have not been prosecuted.

In the past four decades, decisions not to proceed with prosecution and court outcomes where prosecutions proceeded in Scotland have consistently reflected public consensus on AD. Each

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[251] Bache, Ian. How (and when) does party matter? 2025: 15, as above.

[252] 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

person who has assisted another person to die within the context of unbearable and intractable suffering has 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 regard as loving and compassionate.

Without the implementation of AD legislation with protections, advance investigation, and intervention in Scotland, any investigation of instances of AD will remain reactive, not preventative. If malfeasance is suspected in a directly assisted death, investigation will occur after the fact, once the main witness (the 'victim') is already deceased.

The proposals within the Assisted Dying for Terminally Ill Adults (Scotland) Bill did not appear to stray beyond already existing legal advice or precedents. The demand for clarification and confirmation of the legal position in Scotland has grown significantly over the years. The Scottish judiciary have sought to be as clear as they feel they can about what is legally permissible, insisting codification of law is the role of Holyrood. In the absence of such law, Scottish courts will continue to shoulder the burden of interpretation. As Tickell notes:

> Having once again decided not to legislate for assisted dying, there's every sign Scottish politicians will be content to ignore how incompatible their arguments are – not only with the proposals rejected last week – but with the compromised, uncertain, and often hypocritical status quo we're now left to live and die under.[253]

It is likely that there will continue to be Scots who will be willing to risk a jail sentence to stop the intractable suffering of somebody they love. Indeed, there may well emerge a greater awareness that others have walked free from court in the past forty years. Any belief that the voting down of the McArthur bill stops assisted deaths occurring some could argue is tantamount to (again) seeking to close the stable door long after that horse has bolted. Opponents of AD may simply have denied Scots proper safeguards and protections. As McArthur noted, defeat for the Bill would:

> "leave ever increasing numbers of dying Scots more at risk, isolated, and vulnerable. This issue isn't going away, but by refusing to take this opportunity to act, Parliament will simply force people to travel overseas, take decisions behind closed doors with no safeguards, no protections, no support, or condemn them to suffer."[254]

The failure to pass specific legislation risks continuing legal scenarios addressing inconsistencies and ambiguities, along with personal risks to individuals, rather than being able to follow definitive legislated guidance. Holyrood has effectively devolved the issue of AD within Scots law back to the public, the police, and the courts.

Citations and web addresses checked and confirmed 3rd April 2026.

No AI.

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[253] Tickell, A. 2026, as above.

[254] Carrell, S. Scottish parliament votes against legalising assisted dying. Guardian, 17 March 2026. https://www.theguardian.com/society/2026/mar/17/scottish-parliament-votes-against-legalising-assisted-dying