Scottish Police Federation

5 Woodside Place Glasgow G3 7QF

JCC Circular 11 of 2014

Ref: CS/LS

24 March 2014

Dear Colleague

Stage 1 consideration of the Assisted Suicide (Scotland) Bill – Consultation

I refer to the above and attach herewith the Bill and associated papers for your consideration.

Please submit any comments/observations you may have to Lesley.stevenson@spf.org.uk by **Friday 9th May 2014**.

Yours sincerely

Calum Steele
General Secretary

ASSISTED SUICIDE (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Assisted Suicide (Scotland) Bill introduced in the Scottish Parliament on 13 November 2013. It has been prepared by Non-Government Bills Unit on behalf of Margo MacDonald MSP, the member in charge of the Bill, to satisfy Rule 9.3.3A of the Parliament's Standing Orders. The contents are entirely the responsibility of the member and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 40–EN.

POLICY OBJECTIVES OF THE BILL

2. The Bill provides a means for certain people who are approaching the end of their lives to seek assistance to end their lives at a time of their own choosing, and to provide protection in law for those providing that assistance.

3. In this way, the Bill allows people who actively wish to retain control of their lives to secure a dignified death at a time of their own choosing, instead of having to endure a poor and declining quality of life until such time as they die as a result of their illness or condition.

4. The fear of a protracted, painful and undignified death is very real for many people, whether or not they have themselves been diagnosed with a terminal illness or condition. Despite all the advances in medical technology in recent years, and the high-quality palliative care that is available in many places, not everyone can be assured of a "good death" in which pain is kept at bay and a reasonable quality of life is maintained until the end. For some, their final months or years are dominated by pain or discomfort and the inability to experience or enjoy those things that previously gave their life meaning and which most of us take for granted. They may be paralysed or have limited mobility, they may need help with feeding and washing, everything they do may be painful, slow and frustrating.

5. The Bill is not just aimed at the small number of people whose quality of life is already so low that they would prefer not to go on living. It is also aimed at those whose diagnosis has allowed them to see such a situation in prospect, and even those who are currently healthy but fear for an uncertain future. For them, just knowing that there is a way out should they ever need it could be of great comfort and reassurance.

6. For the medical profession – which has always had to wrestle with the ethical dilemmas involved in end-of-life treatment – the Bill offers transparency and consistency. While it has long been accepted that the levels of medication necessary to manage pain effectively during the final stages of a terminal illness can have the effect of shortening life, some doctors have been prepared to go further, prescribing or administering deliberately higher doses than needed for pain-management in order to bring the patient's suffering to an earlier end. However, as this was necessarily a covert and unregulated process, there was no consistency in where and how it was done. It was also unfair on doctors to expect them to jeopardise their reputations and even risk imprisonment in order to do what they saw as being in the best interests of their patients. In any case, in the aftermath of the Harold Shipman scandal (in which a rogue GP was convicted in 2000 of murdering 15 of his elderly patients), it is now much more difficult for any GP, whatever their motivation, to exercise such discretion.

7. In recent years, much attention has focused on the availability of assistance with suicide through clinics overseas – the best-known example being Dignitas. Over 200 Britons have so far travelled to Switzerland to end their lives with the assistance of this organisation.[1] But this is an expensive option, in practice only available to the better-off. Even for those who can afford it, there are disadvantages – many prefer to die at home rather than in an unfamiliar place, and the friends or relatives who accompany them face the possibility of prosecution or other legal action on their return. Also, the demands of travelling to Switzerland sometimes make it necessary to go at an earlier stage in their illness than they might otherwise wish, to ensure they are strong enough to complete the process – thus denying them precious time with their families.

BACKGROUND

Legal context

8. Suicide and attempted suicide are not themselves illegal in Scotland, or in other parts of the UK. However, it is likely to be against the law to encourage or assist a suicide or an attempted suicide.

9. In England and Wales, assisting a suicide is a statutory offence (under section 2 of the Suicide Act 1961), with decisions on prosecution taken by the Director of Public Prosecutions (DPP). The law relating to the DPP's role has been clarified by two high-profile cases. In the case of Diane Pretty, the House of Lords upheld the DPP's refusal to give an advance undertaking not to prosecute Ms Pretty's husband should he assist her in ending her own life. (The European Court of Human Rights subsequently held that Ms Pretty's right to respect for her private life under Article 8 of ECHR had been interfered with, but it upheld the UK's right to continue to prohibit assisted suicide on the grounds of protecting the vulnerable.) In the case of Debbie Purdy, the House of Lords ruled that the DPP's refusal to issue guidance on whether Ms Purdy's husband would face prosecution for helping her travel to Switzerland to die contravened the European Convention on Human Rights (ECHR). Following this judgement, the DPP issued guidelines aimed at clarifying the approach to cases of encouraging or assisting a suicide.[2]

[1] Source: Dignitas response to consultation on the draft Assisted Dying Bill published by the All-Party Parliamentary Group on Choice at the End of Life, available at: http://www.dignitas.ch/index.php?option=com_content&view=article&id=60&Itemid=104&lang=en

[2] Available from: http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html

However, these guidelines do not have the force of law, and in any case have no direct bearing in Scottish cases.[3]

10. In Scotland, the decision whether to prosecute is one for the Crown Office and Procurator Fiscal Service (COPFS), taking account of all the circumstances of the case, including whether prosecution would be in the public interest. It is possible that a person who assists someone else to commit suicide would be prosecuted for homicide (i.e. murder or culpable homicide), or for some lesser offence (such as assault or culpable and reckless injury/behaviour), although the lack of relevant case-law makes it difficult to establish how likely this is to happen in any particular case.

The End of Life Assistance (Scotland) Bill

11. Margo MacDonald first attempted to persuade the Parliament to provide a statutory mechanism to enable people to secure assistance to end their lives in Session 3. She lodged a draft proposal in December 2008 and a final proposal in April 2009.[4] The End of Life Assistance (Scotland) Bill was then introduced in January 2010 and referred to an ad hoc committee. After extensive evidence-taking, the committee published its Stage 1 Report in November 2010, with a majority of its members recommending rejection of the Bill.[5] The Stage 1 debate took place in December 2010, on a free vote, and the Bill was defeated by votes to 85 votes to 16 (with 2 abstentions).

12. While the current Bill builds on the work done in relation to the previous one, the policy has also been substantially developed.

13. In particular, the current Bill limits eligibility to those with an illness that is, for them, terminal or life-shortening or a condition that is, for them, progressive and either terminal or life-shortening – but does not also include those who are permanently physically incapacitated, thus addressing concerns (disputed at the time by the member) that the previous Bill inappropriately targeted disabled people.

14. In addition, the current Bill is clear that the assistance it authorises does not include any form of euthanasia – thus addressing a specific concern that the previous Bill would have authorised some forms of voluntary euthanasia in addition to assisted suicide.

15. The process that a person must go through has also been amended, removing some overly-complex aspects, while at the same time enhancing overall the set of safeguards it provides. The main changes are the requirement for a preliminary declaration to be made before a first request, and provision for the training and licensing of facilitators, able to provide some of the practical assistance likely to be required.

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[3] Source: Law Society of Scotland: http://www.journalonline.co.uk/News/1007039.aspx
[4] The proposal may be viewed at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/17939.aspx
[5] End of Life Assistance (Scotland) Bill Committee, 1st Report, 2010, available at: http://www.scottish.parliament.uk/parliamentarybusiness/PreviousCommittees/19514.aspx.

16. In introducing this new Bill, despite the failure of her earlier attempt, the member is responding to a high level of support and encouragement she has received and continues to receive. She also believes that opinion among politicians, the medical profession and the public continues to move in the direction of assisted suicide – and she is confident that this new Bill will receive a higher degree of support than its predecessor, both from within the Parliament and across Scotland. She believes that it remains unacceptable to leave the law as it stands, given the impact this has on those people it condemns to an unnecessarily protracted and unpleasant death, and on the relatives and friends who have to watch them suffer.

DETAIL OF THE BILL

17. The Bill sets out a process that a person seeking an assisted suicide is to follow. This consists of three stages – a preliminary declaration, a first request and a second request. There are eligibility criteria at each stage, and disinterested third parties have a role in ensuring that these are met and that the steps in the process are correctly followed. Each stage in the process must be recorded, and there are minimum time-limits between the stages to provide a "cooling off" period, plus a maximum time-limit at the end as a further safeguard against the deterioration of capacity.

18. The aim is to provide a process that is practical, robust and clear – that is, one that provides a practical route towards an assisted suicide that is not unduly time-consuming or onerous, but at the same time has the checks and balances necessary to provide public confidence and to protect vulnerable people against abuse.

19. Where this process is correctly followed, the Bill provides legal protection to those involved in providing assistance to the person who commits suicide. The protection is both against criminal and civil liability (under sections 1 and 2 respectively), in each case subject to the "essential safeguards" set out in section 3 being complied with.

Preliminary declaration

20. A person cannot make a first request until certain conditions are satisfied – as explained below. In particular, the person must already have been diagnosed with a relevant illness or condition, and have concluded that their quality of life is unacceptable. However, the policy is not to allow anyone to go straight to a first request without having already indicated (by means of a preliminary declaration) a willingness to consider an assisted suicide. This is one of the safeguards that together should ensure that no-one opts for an assisted suicide without careful consideration over an appropriate period.

21. There is no limit on how far ahead of a first request a preliminary declaration can be made, and it is envisaged that some people who support the idea of assisted suicide as a valid end-of-life choice will make such a declaration when they are relatively young and in good health, simply to ensure that if they are later diagnosed with a relevant illness or condition, the first pre-condition of seeking an assisted suicide is already in place. At the same time, the Bill recognises that requiring the preliminary declaration to be made a long way in advance is not realistic – many people will not wish to face up to the reality of end-of-life choices until they are older or have been diagnosed with a relevant illness or condition. However, there must be a

minimum period of 7 days between the signing of the preliminary declaration and the first request – to provide a "cooling off period".

22. To make a preliminary declaration, the person must be at least 16 and registered with a medical practice in Scotland (see section 4). For the reason already explained, there is no requirement at this stage to have any particular diagnosis or to view one's quality of life as unacceptable. Nor is having capacity (defined in section 12) a pre-condition of making a preliminary declaration, in order to ensure it is a simple and non-burdensome process. (Capacity is, however, a key criterion at the first and second request stages.)

23. The preliminary declaration (set out in schedule 1) is worded in an open-ended way – that is, signing it in no way commits the person to taking the process any further – and the declaration includes an express recognition that there is a right to cancel it at any time. At the same time, anyone who is opposed in principle to the idea of assisted suicide can take reassurance from the fact that simply by never making a preliminary declaration they can disqualify themselves entirely from the process.

24. A further safeguard is provided by the requirement for the preliminary declaration to be signed in the presence of a witness, and then checked by a registered medical practitioner. The witness must be over 16 and may not be a close relative, someone who stands to gain financially from the person's death, or someone involved in their medical care (in relation to the relevant illness or condition); but they must have some prior acquaintance with the person. The aim is to ensure that the witness can make an informed but detached judgement as to whether the person is making the declaration voluntarily (recognising that a stranger would be less likely to notice if someone was acting out of character or was under inappropriate pressure). The registered medical practitioner's role is not, at this stage, to carry out any professional assessment, but simply to check that the terms of the declaration itself and the witness statement comply with the legislation and that nothing stated in either is (so far as the practitioner is aware) false.

25. After a preliminary declaration is completed, the fact it has been made must be recorded in the person's medical records (section 5), so that there is an objective basis for checking later that this step in the process has been carried out (and not subsequently cancelled under section 7).

First and second requests

26. Following a preliminary declaration, a person seeking an assisted suicide must make two requests for assistance, separated by a minimum period of 14 days. Each is in near-identical terms, and each requires to be endorsed by two registered medical practitioners (see sections 8 to 11).

27. As pre-conditions for each request, the person must be at least 16 and registered with a medical practice in Scotland. In addition, the person must have concluded that their quality of life is unacceptable – having reflected on the illness or condition that they have, and concluded that there is no prospect of any improvement in their quality of life. The illness or condition itself must also satisfy certain conditions – if it is an illness, it must be, for that person, either terminal or life-shortening; and if it is a condition, it must also be, for that person, progressive.

28. The aim here is to capture those diagnoses which involve an on-going deterioration in the person's ability to live a normal life, regardless of the medical treatment they receive. The way the Bill captures this recognises that some illnesses or conditions affect different patients in different ways; it also recognises that terms such as "illness", "condition" and "terminal", while generally understood, can be the subject of some disagreement within the medical profession. Therefore, although each medical practitioner must be clear that the person has a qualifying diagnosis, they need not be specific about whether it is an illness or a condition, or whether it is (for that person) terminal or life-shortening.

29. As a result of how qualifying illnesses and conditions are defined, it is not enough just to have a condition that involves physical constraints (however severe) and to have concluded on that basis that your quality of life is unacceptable. There was a perception among some critics of the previous Bill that certain people with disabilities would have been eligible for end-of-life assistance simply by virtue of being disabled, and that this stigmatised such people as having lives not worth living. The member strongly disputed that interpretation of the previous Bill, but has altered the policy for this Bill in order to ensure that no such perception is even inadvertently created.

30. Another difference from the previous Bill is that no time-limit is included as part of the definition of "terminal". The idea is that an illness or condition can qualify so long as it is recognised that the eventual outcome will be death, however far in advance of that outcome the diagnosis is made. This recognises that setting any particular time-limit (such as death being expected within six months) is arbitrary and may be inappropriate (quite apart from the practical difficulties of reliable prognosis). Not only do different patients with the same illness or condition decline in health at different rates, they may also have very different attitudes to how much of the time still left to them they wish to forego.

31. Key safeguards at both request stages are that two registered medical practitioners must separately confirm the person's diagnosis and satisfy themselves that the person has capacity to make the request. In addition, both practitioners must take a view on how consistent the person's conclusion about the unacceptability of their quality of life is with the medical facts known to the practitioner. The aim here is not to substitute the person's judgement about the quality of their own life with a medical opinion (i.e. the test is not whether the person's quality of life would be acceptable to the practitioner, or even whether the person's view of their quality of life is reasonable), but it does entitle each doctor to withhold their endorsement of the request if they feel that the person's own assessment of their quality of life is clearly at odds with the evidence.

32. The second medical practitioner must be identified by the first, rather than by the patient. This is a further safeguard to address any concern that a person whose eligibility is doubtful would be able to keep asking different doctors in the hope of finding two prepared to support their request.

33. The 14-day minimum interval between first request and second provides a further "cooling-off period". There is deliberately no upper time limit between the two requests. Just as the aim is to allow people to make a preliminary declaration well in advance of being eligible to make a first request, should they wish, so they may make a first request as soon as they become

eligible to do so, without then feeling under pressure to move to a second request until they are ready.

34. Each request must be in the form set out in the relevant schedule (2 or 3). These forms involve the person signing up to a sequence of clear statements, by which they make declarations about aspects of their eligibility and their understanding of the implications. Similarly, the form of the statements made by the two registered medical practitioners provides a checklist of the matters on which each must be satisfied. The forms have been designed to promote consistency and minimise the chance of any challenge to the process on procedural grounds (as might be the case if, for example, the Bill did not prescribe a form of words, and a judgement was therefore required as to whether the form of words used in a particular case matched the statutory requirements).

35. The making of each request must be recorded in the person's medical records (section 13) – so that there is certainty later that all the necessary steps have been taken (and not cancelled). Accordingly, while either request may be cancelled at any time, cancellation must also be recorded in the medical records (section 15). Cancelling either request does not itself cancel any earlier step in the process. This allows a person who has had second thoughts to go back a stage, without necessarily having to start the whole process anew. (A person whose second thoughts are more fundamental has, of course, the ability to cancel every step thus far taken, should they wish to do so.)

36. Section 14 provides for the three elements required at each request stage – the person's own request, and the statements by the two registered medical practitioners – to be contained in a single document (as set out in schedules 2 and 3). These documents must exist in hard-copy form. As a practical safeguard, a person may arrange for a certified copy to be made, so the copy can be used in the event of the accidental loss or destruction of the original.

Signature by proxy

37. Section 16 makes provision for a preliminary declaration, a first or second request or a cancellation to be signed by a proxy where the person is blind, unable to read, or unable to sign. Such provision is important in the context of this Bill, where the people eligible to request assistance are much more likely than would normally be expected to be unable to complete forms unaided. However, given the significance of what is involved in the declarations made at each stage of the process, section 16 includes important safeguards in relation to signature by proxy – the proxy must be a solicitor, advocate or justice of the peace (or, in other jurisdictions, a notary public or the equivalent) who does not have a disqualifying relationship with the person, and must be satisfied that the person understands the effect of the document being signed on their behalf.

The act of suicide

38. It is envisaged that, following completion of a second request, the person's GP will prescribe for them drugs suitable to enable them to end their life painlessly. The member understands that there are forms of barbiturates that are already included in the list of drugs that GPs are entitled to prescribe that will serve this purpose if an appropriate dose is taken. Pharmacists presented with such a prescription would be expected to dispense the medicine.

39. It is anticipated that the relevant professional organisations (the General Medical Council for GPs and the Royal Pharmaceutical Society for pharmacists) would amend their guidelines and codes of practice to reflect any change in the law. (Current guidelines would prevent their members from prescribing or dispensing drugs for the purpose of causing death.) Any such revised guidelines or codes might include recognition that some GPs and pharmacists will have ethical or faith-based objection to any involvement in assisted suicide, but it is anticipated that the large majority of GPs and pharmacists would not exercise any such opt-out, and that in most cases where they did, it would simply be a case of finding another local GP or pharmacy prepared to assist.

40. Although it is envisaged that prescribed drugs will be the normal method used, the Bill is drafted widely enough to allow for the use of other substances or means, should those be preferred or become available.

41. Section 17 requires the act of suicide (e.g. the taking of any drug) to take place within 14 days of the second request being recorded in the person's medical records. The purpose of this time-limit is to minimise the chances of the person's capacity deteriorating significantly in the interval between the second request (which is the last point when capacity is professionally assessed) and the act of suicide itself. As noted above, there is no upper time-limit on the interval between the first and second requests, thus allowing a person to move to second request stage only when they are nearly ready to bring their life to an end.

42. Section 18 makes explicit that it must be the person's own deliberate act that is the cause of death (or would have been, in the case of an attempt). In this way, the Bill ensures that the legal protection it affords to those involved in assisting a suicide does not extend to any instance of euthanasia – that is, any instance of killing a person, with or without his or her consent, to end their suffering (sometimes called "mercy killing").

Licensed facilitators

43. The Bill provides for a category of people who are trained and licensed to provide assistance to persons seeking to end their lives. Such "licensed facilitators" provide an additional safeguard against misuse through the direct attendance of someone with an informed and detached perspective. Facilitators must be over 16, and cannot provide assistance to anyone with whom they have a close family relationship, a financial relationship or a medical or nursing relationship (as defined in schedule 4). The attendance of a facilitator does not preclude the attendance of others, such as close family members, and there is also nothing to prevent such other persons from also providing assistance.

Licensing authorities and the role of Ministers

44. Facilitators must be licensed by an authority which has been appointed, by order, by the Scottish Ministers (under section 22). Any such order is subject to the affirmative procedure (that is, it would require approval by the Parliament). More than one licensing authority may be appointed (for example, if no candidate organisation operates throughout Scotland).

45. Ministers will no doubt wish to satisfy themselves that any organisation is appropriately qualified and resourced to take on the licensing role. They can also be expected to set out a general framework within which any authority is to work. In particular, Ministers may set out in regulations (subject to the negative procedure – that is, they could be annulled by resolution of the Parliament) how applicants for licences are to be checked and trained, how those who have been licensed are to have their training kept up-to-date and how they are to be supervised and inspected. Regulations may also include provision on a range of procedural matters (including the grounds on which a facilitator's licence may be suspended or revoked, and the facilitator's right of appeal against such a suspension or revocation).

46. Ministers may also issue directions to licensed facilitators – and licensing authorities must do what they can to ensure the facilitators they have licensed comply with any such directions. Ministers may also issue guidance to licensing authorities (something for which no provision in the Bill is needed), and those authorities must have regard to any such guidance. Any such directions or guidance must be published, in the interests of transparency, and to ensure easy access to them for those whom they affect.

47. In this way, the Bill gives Ministers high-level oversight of the licensing regime, thus providing a degree of political accountability, but without adding any significant new administrative burden at government level. That burden will instead be borne mainly by licensing authorities themselves, whose role is to check the suitability of applicants (for example, via Disclosure checks on previous convictions) and to train them in their role and responsibilities. It is envisaged that organisations generally supportive of assisted suicide (such as the Humanist Society Scotland) may be willing to take on this role.

The role of facilitators

48. The general functions of licensed facilitators are listed in section 19. All four are functions that a facilitator is "to use best endeavours" to carry out – recognising that a facilitator, however well-trained and conscientious, may not always be in a position to do all of them in full. In addition, the first two functions are described in very broad terms, recognising that the nature and extent of the assistance that each person will need or want will vary greatly according to their illness or condition (for example, whether they are physically capable of lifting a cup to their lips unaided), and their particular circumstances (for example, whether they also have family members supporting them at the end). The fourth general function, which is to remove, as soon as practicable after the 14-day time-limit expires, any drug (or other substance or means) dispensed or supplied for the person's suicide, should help to ensure that the time-limit is observed.

49. As well as these general functions, facilitators are obliged (under section 20) to report the person's death to the police as soon as practicable. Should the person attempt suicide but not die, that must also be reported. It would then be for the police to make any investigation they consider necessary. Should there be any reason for believing that the process set out in the Bill was not properly followed, the police would have the option to refer the matter to the procurator fiscal, to consider whether any prosecution is appropriate. In doing so, the procurator fiscal would take into account section 24, which is intended to ensure that errors and omissions made in good faith by people endeavouring to act in accordance with the Bill do not undermine the legal protection that it otherwise affords.

Commencement

50. Section 25 provides for certain provisions to come into force immediately, so that certain powers conferred by the Bill (such as Ministers' power to appoint licensing authorities) can be exercised in advance of anyone gaining the right to begin the process of making a preliminary declaration and then a first and second request. The rest of the Bill comes into force 6 months later. Such an interval will be necessary for the training and licensing of an initial tranche of facilitators, and to allow medical governing bodies (such as the General Medical Council) to consider the implications of the legislation and make any necessary changes to their guidance and codes of practice.

ALTERNATIVE APPROACHES

51. Given that the aim is to secure a substantial change in the law, it was considered that there was no credible alternative to primary legislation. Some greater clarity may come from case-law in due course, but no decision by the courts is likely to change the law substantially in such a sensitive area, as the courts quite properly see that as a matter for parliament to decide on.

52. The option of re-introducing the previous End of Life Assistance (Scotland) Bill was also considered, but quickly discounted. While disappointed with its rejection, the member recognised that the scrutiny process had demonstrated some problems with that Bill, and that a fresh approach was required. The current Bill therefore aims to learn lessons from the previous one, and also to reflect the member's on-going discussions with many people and organisations campaigning for change.

53. A number of specific issues arose during the development of the Bill, where policy choices were required.

54. For example, it was decided to limit the Bill to assisted suicide (where the person's death is the result of their own deliberate act, albeit with assistance), thus excluding any type of euthanasia; and to apply a relatively tight definition of the qualifying illnesses and conditions, thus excluding some conditions, however severe their impact on quality of life. Both decisions were taken in order to counter lines of objection to the previous Bill which, however much the member disputed their merits, undoubtedly contributed to its defeat. As a result, it is recognised that the form of assisted suicide the Bill authorises will not be available to all those that the member would ideally wish to include. While this is a matter of regret to the member, she considers this a price worth paying if it allows the Bill to secure majority support in the Parliament. She would be confident that, once it has been seen to operate effectively for a number of years, there may be an opportunity for further developments in the law that would offer hope to other categories of people seeking assistance to die.

55. Another policy decision was to require anyone seeking an assisted suicide to be registered with a medical practice in Scotland. This was considered a necessary condition to address any concerns that the Bill might lead to a cross-border traffic in people resident elsewhere travelling to Scotland to seek an assisted suicide (so-called "suicide tourism"), particularly if the law prevailing in the rest of the UK remains unchanged. However, unlike in the previous Bill, it is no longer considered necessary or appropriate to require a person to have been so registered for a continuous period of 18 months – as this would also deny access to the Bill's procedures to

people who have only recently taken up residence in Scotland for other reasons (and who may only be diagnosed with a relevant illness or condition after their arrival). In practice, GP practices require evidence of address before they will register new patients, and this makes it unlikely that anyone would succeed in registering in Scotland without relocating on a medium or long-term basis. There may be a small number of people who would be able to satisfy the test of being registered with a Scottish practice without actually being resident in Scotland by virtue of living just over the border in a location closer to the Scottish practice than the nearest one in England. (Even for such people, of course, the Bill only makes assisted suicide available in Scotland, and does not change the legal position in the rest of the UK.)

56. Various choices were needed in the framing of the various safeguards built into the process. In particular, the member was very conscious of the need to provide assurances to those who fear that the availability of assisted suicide will put vulnerable people at risk from inappropriate pressure (for example, from relatives seeking to relieve themselves of an onerous burden of care). She is confident that the Bill strikes an effective balance, with a range of robust safeguards included, but a process that can still deliver relatively quickly when required, and without unnecessary bureaucracy.

57. A key safeguard built into the process is the professional assessment of a person's capacity, to ensure that no-one can obtain an assisted suicide if there are doubts about their ability to understand the implications of that choice. In developing the Bill, consideration was given to whether a test of capacity needed to be included at or immediately before the act of suicide. However, the view was taken that this could be intrusive and that it would be more appropriate to assess capacity at each of the two request stages, as part of the endorsement role of the two registered medical practitioners. In addition, the Bill sets a 14-day time limit between the second request and the act of suicide (while setting no upper time-limit between first and second requests). This is to address concerns that a person might otherwise be able to go through the request process and obtain a prescription at a relatively early stage, when they still have capacity, and then hold off using the medication for an extended period, by which time their capacity to make informed decisions may have deteriorated substantially.

CONSULTATION

58. Margo MacDonald lodged the draft proposal for this Bill on 23 January 2012, accompanied by a consultation document. The consultation period ended on 30 April 2012, and a summary of the responses was then prepared by the Non-Government Bills Unit and published (with the member's commentary) on 30 September 2012, alongside the final proposal.[6]

59. The consultation document was sent to 149 organisations and individuals, and was widely publicised in the media. Responses were received from 55 organisations and 793 individuals. Nearly two-thirds (64%) of respondents opposed the proposal, while a third (33%) supported it and 3% were undecided or expressed no clear view. However, the responses included a large number of individual responses which either gave no reasons or merely endorsed the views of others. Among those respondents (organisations and individuals) who gave their own reasons in

[6] The proposal, consultation document and summary are available at: http://www.scottish.parliament.uk/parliamentarybusiness/Bills/46127.aspx

support of their view, the balance of opinion was very different – 59% in favour, 35% opposed and 6% neutral or undecided.

60. Margo MacDonald, in her commentary on the responses, noted that the level of opposition among consultation respondents was out of step with wider public attitudes as indicated by opinion-poll data. She has taken careful account of the information provided and arguments advanced by respondents in further developing the Bill.

61. Account has also been taken of the results of her 2008 proposal, and of the evidence taken by the End of Life Assistance (Scotland) Bill Committee on the previous Bill that resulted from that earlier proposal.

62. Margo MacDonald and her staff have continued to liaise closely with relevant organisations and individuals as the current Bill has been developed. This has included seeking comments on a draft version of schedules 1 to 3 from someone with direct experience of helping people facing up to end-of-life choices, and from a practising GP. Their thoughtful feedback has been reflected, where appropriate, in the final versions of these schedules.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

63. A right to an assisted suicide is likely to be used disproportionately by older people, as the people most likely to be diagnosed with a qualifying illness or condition. However, the Bill makes access to assisted suicide equally available to adults (over-16s) of any age.

64. Evidence from Oregon suggests that similar numbers of men and women obtain lethal medication, and use it to end their lives, under the Death With Dignity Act.

65. People from some ethnic groups or national origins, and people with certain religious faiths, are less likely to seek an assisted suicide on the grounds of incompatibility with their traditions or beliefs; but there is nothing in the Bill that would make it any more difficult for such a person to follow the process it lays down for any other reason. The Bill also respects the fact that some people may have faith-based or ethical objections to assisting another person's suicide – for example, if a person's own GP has such an objection, the Bill does not oblige them to act against their conscience, and any form of assistance that they might provide can equally well be provided by another GP in the same practice, or by a doctor from outside the practice. (The most that the person's own GP is obliged to do is to record certain factual information in the person's medical records – something that does not itself constitute assisting in the person's suicide.)

66. By providing a mechanism for assisted suicide in Scotland, at minimal cost to the individual, the Bill will particularly benefit those on lower incomes, given that the only current practical equivalent (travel to a clinic such as Dignitas in Switzerland) is relatively expensive and so affordable only to the better-off.

Human rights

67. The member is pursuing this Bill in the belief that the current law does not fully respect people's rights to control the timing and manner of their own deaths, and their right to a dignified death. To that extent, the Bill enhances human rights, in the member's view.

68. The Bill clearly has implications for human rights under ECHR – particularly Article 2 (right to life) and Article 8 (right to respect for private and family life). However, the member is confident that it is consistent with ECHR case-law, which suggests that states have some "margin of appreciation" in deciding whether and how to legislate for assisted suicide (as, indeed, a number of ECHR-signatory states have already done). Such legislation might be considered incompatible with ECHR if, for example, it failed to provide adequate safeguards against coercion, failed to exclude particularly vulnerable groups such as children or adults with incapacity, or required anyone to assist a suicide against their conscience. However, the member is confident that the robust safeguards in this Bill make a successful challenge on human rights grounds very unlikely.

Island communities

69. While the Bill applies in the same way throughout Scotland, an assisted suicide may in practice be harder to obtain for people living in small and remote communities, including island communities – particularly as travelling is likely to be particularly difficult for people who have the sort of illness or condition outlined in the Bill. The process requires the direct involvement of a number of other people to carry out certain functions, for example as a witness to a preliminary declaration. It may be harder for a person living in a small and remote community to identify someone who meets the various qualifying criteria and is able to attend at the relevant time and place to witness their declaration. It may also be more difficult for someone living in such a location to gain access to an alternative doctor if the only local GP declines to assist on grounds of conscience.

70. The member acknowledges these difficulties but considers them unavoidable. It would not be appropriate to weaken the safeguards provided in the Bill, and it would be impractical and unrealistic to differentiate in the way the process operates by reference to geography.

Local government

71. The Bill confers no powers or obligations on local authorities, and has no other direct impact on local government. There are implications for the NHS through the role conferred on registered medical practitioners, but it is not expected that the Bill will have any direct impact on Health Boards.

Sustainable development

72. The Bill has no direct environmental impact (for example, in terms of resource or energy use). There is no reason to suppose that the changes it makes could not be sustained indefinitely.

This document relates to the Assisted Suicide (Scotland) Bill (SP Bill 40) as introduced in the Scottish Parliament on 13 November 2013

ASSISTED SUICIDE (SCOTLAND) BILL

POLICY MEMORANDUM

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These documents relate to the Assisted Suicide (Scotland) Bill (SP Bill 40) as introduced in the Scottish Parliament on 13 November 2013

ASSISTED SUICIDE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

As required under Rule 9.3 of the Parliament's Standing Orders, the following documents are published to accompany the Assisted Suicide (Scotland) Bill introduced in the Scottish Parliament on 13 November 2013:

- Explanatory Notes;
- a Financial Memorandum;
- Margo MacDonald's statement on legislative competence; and
- the Presiding Officer's statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 40–PM.

EXPLANATORY NOTES

INTRODUCTION

1. These Explanatory Notes have been prepared by the Non-Government Bills Unit on behalf of Margo MacDonald MSP, the member in charge of the Bill. They have been prepared in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

2. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

SUMMARY AND BACKGROUND TO THE BILL

3. The Bill enables people with terminal or life-shortening illnesses or progressive conditions which are terminal or life-shortening and who wish to end their own lives to obtain assistance in doing so. It does this by removing criminal and civil liability from those who provide such assistance provided that the procedure set out in the Bill is followed. This procedure for accessing a lawful assisted suicide is designed to ensure that the individual seeking it meets the Bill's eligibility criteria, has made his or her own informed decision to end his or her life and has had the opportunity to reflect before moving forward at key stages.

4. In these Explanatory Notes, "the person" refers to an individual contemplating or seeking an assisted suicide under the Bill.

5. The Bill does not authorise any form of euthanasia, and its protections from liability apply only where the act of suicide (or attempted suicide) is carried out by the person him- or herself within 14 days beginning with the date of recording of the making of the second request in his or her medical records (see paragraphs 9, 33 and 34).

COMMENTARY ON SECTIONS AND SCHEDULES

Part 1: Lawfulness of assisting suicide

Section 1: No criminal liability for assisting suicide

6. Subsections (1) and (2) provide that it is not a crime (of any kind) to assist a person to commit suicide where the requirements contained in section 3 are complied with. Subsection (1) removes any criminal liability regardless of which offence an individual has been or may be charged with. (There is no case law holding that assisting a suicide is a specific offence in Scots law, and it is likely that in any prosecution the individual would be charged with one of a number of more general existing offences against the person. Murder, culpable homicide, assault and culpable and reckless injury or behaviour may all be possibilities, though in the absence of any modern prosecutions the likely outcome of such a trial is hard to assess.) However, subsection

(1) applies only where the substance of the case against the individual is (or would be) that they assisted a suicide. It does not apply to any incidental unlawful acts which an individual may have committed (e.g. where the means used to commit suicide were unlawfully supplied under legislation restricting the circulation of particular items, such as drugs).

7. Subsection (3) ensures that the courts will continue to be able to find that no offence has been committed for reasons which are separate from anything contained in the Bill (e.g. because the individual's conduct in the particular case never amounted to a crime under Scots law). Subsection (4) applies subsections (1) and (3) to attempts to commit suicide, as well as to completed suicides.

Section 2: No civil liability for assisting suicide

8. Section 2 makes provision for the removal of any civil liability which mirrors that made for criminal liability in section 1. It is doubtful whether assisting a suicide would ever give rise to civil liability in any case, but section 2 makes the position clear where the section 3 requirements are complied with.

Part 2: Safeguards

Section 3: Essential safeguards

9. Section 3 sets out the core provisions of the Bill which must be complied with if an individual assisting a suicide is to benefit from the removal of criminal and civil liability under sections 1 and 2. These include completion of the Bill's procedural steps (making, endorsement and recording of a preliminary declaration of willingness to consider assisted suicide and first and second requests for assistance). The other essential requirements are that the act of suicide (or attempted suicide) is carried out within 14 days beginning with the date of recording of the making of the endorsed second request in the person's medical records and that the cause of death is the person's own deliberate act (or in the case of an attempted suicide, would have been the person's own deliberate act).

10. Section 3 should be read alongside section 24, which provides protection for a person providing assistance under the Bill notwithstanding any breach of its provisions, where that person has acted in good faith and has not been at fault in respect of any breach which has occurred.

Section 4: Preliminary declaration, witness statement and medical practitioner's note

11. Section 4 contains further detail about the preliminary declaration which represents the first step in the process of seeking an assisted suicide under the Bill.

12. To be eligible to make a preliminary declaration, the person must be registered as a patient with a Scottish medical practice and aged at least 16 (subsection (1)(b)(i) and (ii)). At this stage, there is no requirement for the person to have a terminal or life-shortening illness or condition; a preliminary declaration may be made when the person is well.

13. The declaration must be in the form set out in schedule 1 (subsection (1)(a)). That form specifies that the person is declaring their willingness in principle to consider seeking assisted suicide under the Bill if they meet the necessary eligibility criteria either when the declaration is made or in future. It must be signed by the person in the presence of a witness who is aged at least 16 and is not disqualified from acting under schedule 4 (subsections (1)(c) and (2)(a) and (b)). Under subsection (1)(c), the witness must sign a witness statement, the form of which is also set out in schedule 1. Subsection (3) provides that endorsement (required under section 3(b)) consists of the signature by a registered medical practitioner of a note in the form set out in schedule 1. That form requires the practitioner to confirm that in his or her opinion the declaration and witness statement comply with the requirements of schedule 1, and that he or she has no reason to believe that they contain any false statements.

Section 5: Recording of making of preliminary declaration in medical records

14. Section 5 provides for the recording of the preliminary declaration in the person's medical records, as required by section 3(b). Subsection (2) requires the practitioner who endorsed the preliminary declaration to record the fact of its making and the date of its signature, where he or she works in the practice with which the person is registered. Where the person is the patient of another practice, subsection (3) requires the endorsing practitioner to notify a registered medical practitioner in that practice of the necessary details, while subsection (4) obliges that second practitioner to record them.

Section 6: Preliminary declaration, witness statement and medical practitioner's note to be in one conventional document

15. Subsection (1) requires the preliminary declaration, witness statement and medical practitioner's note to be in the form of one continuous document (prohibiting the breaking-up of schedule 1 by those using it in practice). Subsection (2) stipulates that this must be a hard copy document; legislation enabling electronic versions to act as equivalent is not to apply.

Section 7: Cancellation of preliminary declaration and record of cancellation

16. Section 7 provides for cancellation of an endorsed preliminary declaration by written, signed and dated notice (before it has been endorsed, the person can convey by any means that he or she does not wish to proceed further with it). Under subsection (1), cancellation does not take effect until notice of cancellation has been given to a registered medical practitioner in the practice with which the person is registered, but it is then backdated under subsection (3) to the date on which the notice was signed, giving full effect to the person's intention. Subsection (2) provides for the recording of the fact and date of cancellation in the person's medical records.

17. Under paragraph 3 of the medical practitioners' statements on the first request (see schedule 2), the doctors acting at that stage must confirm that the person has made a preliminary declaration which has not been cancelled. However, while a current preliminary declaration is necessary before the person can move on to complete the first request stage, cancellation of a preliminary declaration after this does not invalidate later stages in the process.

Section 8: First request for assistance

18. Section 8 contains further detail about the first request for assistance.

19. The criteria for eligibility to make a first request are set out in subsection (3). In addition to the two criteria which apply in relation to the preliminary declaration (registration with a medical practice in Scotland and being aged at least 16), the person must have an illness which, in his or her case, is terminal or life-shortening or a condition which, in his or her case, is progressive and either terminal or life-shortening. The person must see no prospect of improvement in his or her quality of life, and must have concluded on reflection that his or her quality of life is unacceptable in light of the consequences for him or her of this situation (subsections 3(d), (4) and (5)). The person must also have made a preliminary declaration which has been witnessed and not cancelled (subsection (3)(c), which also requires the completion of a 7 day "cooling off" period between the making of the preliminary declaration and the first request).

20. Subsection (2) requires the first request to be in the form set out in schedule 2. Subsection (6) provides that endorsement (which is required by section 3(b)) consists of the making of the medical statements referred to in section 9. The date of endorsement is the date of signature of the second statement.

Section 9: Endorsement of first request: medical practitioners' statements

21. Section 9 makes provision for the medical statements referred to in section 8(6). They must be in the form set out in schedule 2. Two statements are required, which must be made by different practitioners at different times (subsections (1) and (3)). The referral to the second practitioner must come from the first practitioner (subsection (4)).

22. Under subsection (2), the medical statements must include confirmation from both practitioners that in their opinions the person has capacity to make the request under section 12 (see paragraphs 27 and 28 below) and has an illness or condition of the type described in paragraph 19 above. Under subsection (5), the practitioners do not have to specify whether the person has an illness or a condition or whether it is terminal or life-shortening, so long as they can confirm in either case that it is one of the two. It does not matter for eligibility purposes which it is.

23. Subsection (2) also requires both practitioners to confirm that in their opinions the person's view of their quality of life arising from the factors set out in paragraph 19 above is not inconsistent with the facts known to them, for instance because the person currently has no significant symptoms arising from their diagnosis and prognosis.

Section 10: Second request for assistance

24. This section contains further detail about the second request for assistance. This substantially mirrors the provision in section 8 relating to first requests. There are some differences which are explained below.

25. A second request must be made in the form set out in schedule 3. The person must have made a first request which has been endorsed and has not been cancelled (subsection (3)(b)). Under subsection (6), the second request can be signed only after a "cooling off" period of 14 days beginning with the date of endorsement of the first request.

Section 11: Endorsement of second request: medical practitioners' statements

26. This section largely mirrors the provision made in section 9 for medical statements relating to the first request. The statements must be in the form set out in schedule 3. Under subsection (5), the practitioners making the medical statements on a second request need not be the same as those who made the equivalent statements on the first request.

Section 12: Capacity

27. Section 12 defines what is meant by the person having capacity to make a first or second request. The definition is based on that contained in section 1(6) of the Adults with Incapacity (Scotland) Act 2000 (asp 4), adapted to relate specifically to the context of making requests under the Bill.

28. Section 12 does not require specialist assessment of capacity by a psychiatrist. Assessment of capacity is not generally something which requires psychiatric expertise, in the absence of any reason to suspect that the person has any form of mental disorder. However, it is open to a medical practitioner dealing with a first or second request to seek any specialist input he or she feels is needed to inform his or her assessment.

Section 13: Recording in medical records of making of requests and associated statements

29. This section makes provision for recording of the first and second requests (required by section 3(b)) and the associated medical statements. Subsection (1) requires the medical practitioner who signed the second statement associated with a request to record the making of the request and the date of its endorsement in the person's medical notes, where he or she works in the practice with which the person is registered. The date of recording must also be given. Where the person is the patient of another practice, subsection (2) obliges that practitioner to notify a colleague in that practice of the relevant details. Subsection (3) requires that other practitioner to record them, together with the date of recording.

Section 14: Each request and associated statements to be in one conventional document; back-up copy)

30. Section 14 makes provision for each of the first and second requests and their associated medical statements equivalent to that made by section 6 for the preliminary declaration and associated items. In addition, subsection (4) provides a procedure for certifying a photocopy of the document containing the first or second request and its associated statements as a true copy, which will then have the same effect as the original. This will protect against the loss of this document. While the completion of a first or second request could be established from the person's medical records despite the disappearance of the document itself, the form containing the completed request remains the best evidence of this (and the most easily accessible, given the confidentiality of medical records).

Section 15: Cancellation of first or second request and record of cancellation

31. This section makes provision for cancellation of first and second requests mirroring that made by section 7 for preliminary declarations. In addition, subsections (2) and (4) specify that cancellation of a request has no effect on any prior stage of the process (preliminary declaration, and first request in the case of cancellation of a second request). A prior preliminary declaration

or first request must be cancelled separately if desired. Subsections (2) and (4) provide specific reassurance to the person where they may be concerned that cancellation of the latest stage in the process would force them back to the beginning if they subsequently decided they wanted to proceed. Cancellation of an earlier stage in the process once a later one has been completed equally does not invalidate that later stage under the Bill.

Section 16: Signing by proxy of preliminary declarations, first and second requests and cancellations

32. Section 16 enables a person who is blind or cannot read or sign his or her name to utilise the Bill's procedures by having a proxy sign the relevant document in his or her presence and on his or her behalf. Under subsection (4), the proxy must be satisfied that the person understands the effect of the document the proxy is signing. Subsection (6) lists the occupational groups whose members may act as proxies. Subsection (5) prohibits an individual who is disqualified under schedule 4 on the basis of their relationship with the person from acting as a proxy.

Section 17: The act of suicide: time limit

33. Subsection (2) requires the person to ensure that any act of suicide (or attempted suicide) which follows a second request is carried out within the period of 14 days beginning with the date of recording of the making of that request in his or her medical records. (This time limit is not breached if the person dies after 14 days, so long as the act of suicide – e.g. the taking of drugs – has been completed within this time limit). The time limit ensures so far as possible that the person retains capacity when the act of suicide takes place. It also ensures that assisting a premature act of suicide (before the making of the second request is recorded) is not permitted. Observance of this time limit is an essential requirement under section 3(c), so non-compliance would potentially lead to removal of the Bill's protections for those assisting the person (subject to section 24).

Section 18: Nature of assistance: no euthanasia etc.

34. Subsection (1) provides that neither euthanasia nor any other form of direct killing is authorised by the Bill. Under subsections (2) and (3), the cause of death must be the person's own deliberate act (in the case of an attempted suicide, the attempt must be constituted by the person's own deliberate act). This is an essential requirement under section 3(d), with the consequences outlined in paragraph 33 above.

Section 19: General functions of licensed facilitators

35. Section 19 sets out the general role of a facilitator licensed under section 22. This is largely focused on providing assistance to the person. Paragraph (a) deals with practical assistance before, during and after the act of suicide (or attempted suicide) – including in the interval between the act of suicide (e.g. the ingesting of drugs) and the person's death. Section 19(d) obliges a facilitator to use best endeavours to remove as soon as practicable anything dispensed or supplied for use in the act of suicide which remains in the person's possession if the 14 day period referred to in section 17(2) has expired and the person is still alive, thus reinforcing this time limit.

Section 20: Reporting to police

36. Section 20 sets out the circumstances in which a facilitator is under a duty to report the person's death or attempted suicide to the police.

Section 21: Licensed facilitators: disqualifying relationships and minimum age

37. Subsection (1) prohibits an individual from acting as a licensed facilitator if they are disqualified under schedule 4 on the basis of their relationship with the person. Subsection (2) provides that a facilitator must be aged at least 16.

Section 22: Licensing of facilitators

38. This section confers broad enabling powers on the Scottish Ministers to establish a licensing regime for facilitators.

39. Under subsection (1), the Scottish Ministers may by order appoint one or more licensing authorities. Such an order is subject to the affirmative procedure (subsection (3)). Individual facilitators are to be licensed by those authorities rather than by the Scottish Ministers themselves.

40. Subsection (2) lists the aspects of the licensing regime for which the Scottish Ministers may make provision by regulations. Under subsection (2)(e), regulations may enable the suspension or revocation of individual licences by the Scottish Ministers or the relevant licensing authority or both. Suspension or revocation of an appointment as licensing authority is for the Scottish Ministers, and under subsection (2)(a) regulations may provide for this to be done by executive act. Subsection (2)(d) deals with provision to ensure the suitability of people recruited to be facilitators and the maintenance of standards amongst facilitators. Other matters which may be covered in regulations include grounds for revocation and suspension and procedural matters including appeals (subsection (2)(b), (f) and (g)). Regulations under subsection (2) are subject to the negative procedure (subsection (4)).

Section 23: Directions and guidance

41. Section 23(1) provides for the issuing of directions by the Scottish Ministers about the way in which licensed facilitators are to perform their functions. Under subsection (2), a licensing authority has the responsibility for seeking to ensure compliance by its facilitators with those directions. Under subsection (3), a licensing authority must take into account any non-binding guidance which the Scottish Ministers may issue. Subsection (4) requires the publication of directions and guidance.

Section 24: Savings for certain mistakes and things done in good faith

42. Subsection (1) applies where a person has unintentionally (but not carelessly) made an incorrect statement or done something else which is inconsistent with the Bill while acting in good faith and in intended pursuance of the Bill's provisions. Although this would involve non-compliance with some aspect of these provisions, protection from criminal and civil liability under sections 1 and 2 would be preserved – hence the term "savings".

43. Subsection (2) applies where a person has acted in good faith in pursuance of the Bill's provisions, but the requirements of section 3 have not been fully complied with owing to the conduct of someone else. Protection from civil and criminal liability is preserved for the former individual. The latter individual may be protected under subsection (1) if his or her conduct falls within that subsection.

44. Subsection (3) ensures the continuing validity of any act carried out by a person acting in good faith and in intended pursuance of the Bill's provisions even though these provisions have been breached by someone acting in bad faith or carelessly before or after the first person has acted.

Part 3: Commencement and short title

Section 25: Commencement

45. Section 25 provides for the commencement of the Bill. This section, section 26 (short title) and the sections relating to subordinate legislation, directions and guidance come into force the day after Royal Assent, enabling the Scottish Ministers to put any provision under the latter sections in place before commencement of the remainder of the Bill 6 months later.

Schedules

Schedule 1: Form of preliminary declaration, witness statement and medical practitioner's note

46. Schedule 1, introduced by section 4, sets out the form of the document comprising the preliminary declaration, witness statement and medical practitioner's note. It reflects the substantive and procedural requirements of that section, which are explained in paragraphs 11 to 13 above. The preliminary declaration includes a statement by the person that he or she is making the declaration voluntarily and has not been persuaded or similarly influenced (e.g. non-verbally) to make it by someone else. It also includes confirmation that to the best of the person's knowledge the witness is at least 16 and is not and will not become disqualified from acting as such in relation to the person under schedule 4.

47. The witness statement includes similar statements to be made by the witness, and also includes confirmation that the witness knows the person, and has not just met him or her in connection with the signing of the preliminary declaration.

Schedule 2: Form of first request and medical practitioners' statements

48. Schedule 2, introduced by sections 8 and 9, sets out the form of the document comprising the first request for assistance and the associated medical statements. The form of the medical statement is given twice to enable the schedule to be printed off or copied and used for its intended purpose without the need to add a duplicate form for the second statement.

49. The schedule reflects the requirements of sections 8 and 9, which are explained at paragraphs 18 to 23 above. The first request includes a statement by the person that he or she is making the request voluntarily and has not been persuaded or similarly influenced to make it by another person. The form of medical statement also requires each medical practitioner to confirm that to the best of his or her knowledge the person is making the request voluntarily etc.

50. Under paragraph 1 of the medical statement, the practitioner must confirm that he or she has discussed with the person the nature and effect of the request. Paragraph 3 of the statement will require the practitioner to check the existence and status of the person's preliminary declaration (which must have been endorsed and recorded), and that the "cooling off" period provided for in section 8(3)(c) has been observed.

Schedule 3: Form of second request and medical practitioners' statements

51. Schedule 3, introduced by sections 10 and 11, sets out the form of the document comprising the second request for assistance and associated medical statements. It reflects the requirements of those sections, which are explained at paragraphs 24 to 26. It also largely mirrors the form for the first request and associated medical statements contained in schedule 2. Significant differences are outlined below.

52. Paragraph 5 of the second request requires the person to confirm they understand that the second request is the final step in the procedure for obtaining a lawful assisted suicide. Under paragraph 6, the person must confirm that he or she is aware of the 14 day time limit for carrying out the act of suicide (or attempted suicide) under section 17(2). Under paragraph 7, the person must declare that he or she has arranged for a facilitator to be in place when the act of suicide is carried out.

53. Under paragraph 3 of the medical statement, the practitioner will need to check the existence and status of the person's first request (which must have been endorsed and recorded), and that the "cooling off" period set out in section 10(6) has been complied with.

Schedule 4: Disqualifying relationships: witnesses, proxies and licensed facilitators

54. Schedule 4, introduced by sections 4, 16 and 21, lists those relationships between the person and another individual which disqualify that other individual from acting as a witness to a preliminary declaration by the person or as a proxy for or facilitator to the person. The excluded categories cover both family and financial relationships. In relation to the former, the excluded relationships are those one or two "steps" away in the person's family tree, but not those further away – so for example children and grandchildren are excluded, but not great-grandchildren. Paragraph 4 ensures that, for example, an adopted child or step-child is treated in the same way as a biological child, and that a half-sister is treated identically to a sister who shares both parents. Doctors or nurses who have cared for the person in connection with their terminal or life-shortening illness or condition are also excluded under paragraph 2(h).

FINANCIAL MEMORANDUM

INTRODUCTION

1. This Financial Memorandum has been prepared by the Non-Government Bills Unit on behalf of Margo MacDonald MSP, the member in charge of the Bill, to satisfy Rule 9.3.2 of the Parliament's Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

2. The purpose of the Bill is to give effect to Margo MacDonald's final proposal, for a Bill to "enable a competent adult with a terminal illness or condition to request assistance to end their own life, and to decriminalise certain actions taken by others to provide such assistance".

3. To deliver this, the Bill sets out a process to be followed by a person seeking an assisted suicide, involving the following stages:

- a preliminary declaration, which requires to be witnessed and endorsed by a registered medical practitioner
- a first request, which must be endorsed by two registered medical practitioners
- a second request, which must be similarly endorsed.

4. It is then envisaged (although this is not provided for directly in the Bill) that a registered medical practitioner will prescribe drugs suitable for the person's assisted suicide, and these will be dispensed by a pharmacist.

5. The Bill also provides for individuals to be licensed as facilitators, with the function of assisting the person in various ways. Licensing authorities are to be appointed by Scottish Ministers, who also have powers to define, in subordinate legislation and in other ways, how these authorities are to operate. Facilitators also have the function of reporting successful or unsuccessful assisted suicides to the police, and it is anticipated the police will wish to carry out some checks to ensure the legislation has been complied with (failing which the circumstances may be reported to the procurator fiscal).

6. The anticipated cost implications of the Bill are as follows:

- costs on the Scottish Ministers in carrying out checks prior to appointing licensing authorities and in preparing subordinate legislation and other material to govern how they and individual facilitators operate
- costs on licensing authorities and/or individual facilitators relating to training and licensing, and in acting as a facilitator in particular cases
- some costs associated with the role of registered medical practitioners, particularly in assessing diagnosis and capacity at first and second request stages
- costs on governing bodies for registered medical practitioners and pharmacists in revising codes of conduct etc.

- cost implications for the police and, in any case where there is reason to believe that the new law has not been properly followed, for the Crown Office and Procurator Fiscal Service (COPFS).

7. The costs on the Scottish Ministers (described in the first bullet above) will be start-up costs, liable to arise in financial years 2014-15 or 2015-16 (depending on when the Bill is enacted) – although further costs may be incurred on later occasions (e.g. if there is a need to appoint a new licensing authority, or to issue revised directions). The other costs will be recurring costs, arising in each financial year, probably starting from 2015-16 (again depending on when the Bill is enacted).

Number of likely cases of assisted suicide

8. The population of Scotland is around 5.3 million (2011 Census). In 1997, the Death with Dignity Act (DWDA) was enacted in Oregon, a US state with a population of around 3.9 million in 2012.[1] During the period for which data is available (1998-2012), a total of 1,050 people were prescribed lethal doses of medication under the DWDA, of which 673 (64%) died as a result of taking that medication.[2] The number of deaths each year has ranged from 16 in 1998 to 77 in 2012, with a general trend of increasing numbers over the period. Taking a mid-range point as the average number of deaths per year – say 50 – and taking account of Oregon's growing population[3], this amounts to approximately 14 deaths per million people each year.

9. On a pro-rata basis, the average number of deaths per year in Scotland from assisted suicide, during the first decade or so after a change in the law, could be around 79 per year.[4] If the pattern of uptake broadly replicates the Oregon experience, this number could rise to around 100 per year in the longer term.[5]

10. As noted above, deaths in Oregon result in around 64% of cases where people are prescribed medication under the DWDA. Applying the same proportion in a Scottish context, it is reasonable to assume that, on average, around 120 people per year in Scotland will (during the first decade or so after the law is changed) get as far as being eligible to make a second request. (This is roughly equivalent to the stage of having medication prescribed under the DWDA – given that, under the DWDA, there is no upper limit on the period between medication being prescribed and used; whereas, under the Bill, it is the interval between first and second requests that has no upper limit.)

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[1] Oregon is a useful comparator as it is a jurisdiction that has enacted legislation comparable to that proposed in the Bill for long enough to enable meaningful lessons to be drawn from its experience. The DWDA is available here: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx

[2] Data on the application of the DWDA is available here: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[3] Oregon's population was around 3.4 million in 2000, so its average population during the 1998-2012 period was presumably around 3.6 million.

[4] This takes into account that Scotland's population grew by around 5% between the 2001 and 2011 censuses, and so could reach around 6 million by 2025.

[5] The actual number of deaths per year could of course be higher or lower than these estimates, given the number of variables involved.

COSTS ON THE SCOTTISH ADMINISTRATION

Appointment of licensing authority

11. Section 22 of the Bill anticipates the Scottish Government appointing one or more licensing organisations that will train and license facilitators. In addition, the Scottish Government may make regulations which regulate the procedure for licensing facilitators. The Bill also enables the Scottish Government to issue directions and guidance in connection with the role of licensing authorities and facilitators.

12. Scottish Government officials would need to identify potential licensing authorities and undertake enquiries to establish their suitability. Some official and solicitor time would be needed to prepare the necessary subordinate legislation, directions and guidance.

13. Scottish Government sources have been unable to provide indicative figures for the amount of staff time likely to be involved or the costs of that time. This may be on the basis that, as such work is a normal part of the operation of Scottish Government departments, the costs involved cannot easily be separated out from general running costs.

14. However, some numerical data has been provided by the Scottish Parliament staff who manage the process of appointing individuals to fill posts (e.g. as commissioners) for which the SPCB is responsible under statute. This is only a loose analogy to the appointment of an organisation to fulfil a licensing authority function, but may serve to give a general indication of what is involved. The SPCB process is estimated to account for around 31 hours of the time of a staff member on a pay-scale ranging from approximately £40-48K per annum (i.e. £25-30/hour) – suggesting a mid-range cost of around £850.[6]

15. It is not envisaged that a licensing authority, once appointed, would be funded by the Scottish Government for carrying out its functions. However, it may be that those organisations prepared to carry out this role would seek such funding to offset the costs they would incur. Subject to the Scottish Government having an appropriate legal basis to provide funding, it would of course be for Ministers to decide whether to provide such funding, or whether to appoint only organisations that were prepared either to absorb the costs or recoup it from other sources (e.g. donations, fundraising or fees).

COSTS ON LOCAL AUTHORITIES

16. The Bill does not impose any new obligations on local authorities. It is possible that some local authorities may wish to become licensing authorities, but that is not a requirement of the Bill; and it would be for any such authority, in reaching a decision, to take account of any additional costs that this would involve.

[6] Actual costs to the SPCB for a commissioner-type appointment would include advertising costs (typically £6,000), plus the time involved for 3 MSPs and an independent assessor (whose costs were not disclosed) to sift the applications received. It is not envisaged that equivalent costs would arise in the context of the Bill.

17. Local authorities may also incur costs in providing social care to people who would be eligible for assisted suicide, and the period for which such care needs to be provided is likely to be reduced in cases which result in such a person ending their own life under the Bill.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSESS

NHS/Health Boards

18. As noted above, the Bill requires registered medical practitioners (RMPs) to play a part at preliminary declaration stage and at first and second request stages.

19. The preliminary declaration can be made by a person at any time, whether or not they have been diagnosed with a relevant illness or condition. The numbers of preliminary declarations is likely to be substantially greater than the numbers of first or second requests, as many of those who make a preliminary declaration on a precautionary basis will never face the circumstances in which they become eligible to make a request. It is expected that the RMP's role in endorsing the declaration will normally be done during a regular GP appointment. Any additional burden on the GP practice is expected to be minimal and would be absorbed within the practice's normal running costs.

20. A first request must be endorsed by two RMPs (either GPs or hospital-based specialists), each of whom must assess the individual's capacity to make the request and confirm a diagnosis/prognosis of the individual's illness/condition. It is envisaged this will require a face-to-face discussion with the individual, and would take longer than a standard appointment, thus involving some additional costs to the GP practice or hospital. Nevertheless, it is reasonable to assume that any such cost can be absorbed within normal running costs.

21. In most cases, it is likely that one of the two RMPs will be the person's own GP or consultant, who will already be familiar with the person's general circumstances and state of health. However, the other RMP will not be so familiar, and may therefore require more time to satisfy him or herself about the issues in question.

22. A second request must also be endorsed by two RMPs. While these do not need to be the same as the two involved at first request stage, it is expected that they normally will be, and this should mean that the time required at second request stage is less than at the first request stage, as both doctors will by this point be familiar with the person and their circumstances.

23. It is also worth noting that any additional time required for the procedures under the Bill may be offset (in relation to those cases that lead to an assisted suicide) by reduced demand on RMP time as a result of the person's earlier death.

24. The Bill will make it necessary for the NHS to update guidance and other sources of information for staff and the public. NHS Education for Scotland (NES) may also wish to consider developing appropriate training materials for GPs. As there is an ongoing need to update such materials to reflect new legislation, changes in practice and emerging new

treatments and medication, it is reasonable to assume that any additional cost arising from the Bill will be minimal and capable of being met from within existing budgets.

25. Where the making of a second request is followed by the issuing and dispensing of a prescription for medication suitable for an assisted suicide, there will be a cost involved to the NHS (under the current policy of prescriptions that are free to the patient). However, the drugs most likely to be considered suitable are relatively inexpensive, and certainly unlikely to exceed in cost other medication that the same person might otherwise require (were assisted suicide not available).

26. Where the person seeking an assisted suicide would otherwise require care in an NHS hospital or other NHS facility, or would otherwise receive NHS-funded healthcare support at home, the assisted suicide is likely to shorten the period for which such care is required.

27. It is difficult to estimate how much shorter this period is likely to be in a typical case. Some illnesses or conditions are such that, by the time a person is eligible to make a first request death is in any case likely to follow in a relatively short time (weeks or months). In such cases, and allowing for the time required to complete the process set out in the Bill, the amount by which the person's life is shortened by an assisted suicide may only be a few weeks. However, people with other illnesses or conditions may become eligible for an assisted suicide even when an unassisted death is still years away. Again, some illnesses and conditions involve a final stage during which the person is likely to be unable to meet the requirements of section 18(3) (that the cause of death must the person's own deliberate act) – so in such cases, any assisted suicide under the Bill is bound to shorten the person's life by at least the typical duration of that final stage. But this, too, is not true in all cases. For all these reasons, it is not really possible to estimate with any confidence the amount by which a person's life is likely to be shortened in assisted suicide cases.

28. The other factor is that end-of-life care varies greatly in cost, and people approaching the end of life vary greatly in their need for, and attitude towards, such care. Many, whatever their attitude to assisted suicide, will no doubt wish to reduce their dependence on medical intervention and treatments as far as possible – for example, to spend as much as possible of the time remaining to them at home with family, rather than in a hospital environment.[7] In this context, estimating the cost implications is very difficult, and any figures could be misleading. Given the small numbers likely to seek an assisted suicide each year, any resulting reduction in demand for end-of-life care is likely to represent a very small proportion of the care provided. Also, given the overall level of demand for such care, it is unlikely that a small number of assisted suicides would lead to any overall reduction in expenditure – the expenditure would simply be distributed slightly differently.

29. It is also important to emphasise that, while providing assisted suicide as an option may lead to some cost savings in specific instances, this is not part of the aim of the Bill, which is instead about preserving dignity and choice to the individual.

[7] In Oregon, the vast majority of DWDA cases involve the person dying at home – e.g. 97.4% in 2012. (Source: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx.)

Police Scotland and Crown Office and Procurator Fiscal Service (COPFS)

30. Every assisted suicide (or attempt) must be reported to the police. It will be for the police to decide whether the Bill has been properly complied with. In most cases, this should be a straightforward matter, as there will be a clear set of documented evidence (signed and endorsed preliminary declaration, first and second requests etc.), and there should normally be a facilitator who can provide any further information that may be required (including about the circumstances of the death itself). Only if there is reason to believe that the new law has been breached would it be necessary for the police to carry out more extensive investigations and, where appropriate, refer the case to the procurator fiscal.

31. Where a case is so referred, it would be for the relevant procurator fiscal, taking account in particular of the safeguards provided by section 24, to consider whether there was sufficient evidence of an offence having been committed, and whether prosecution would be in the public interest.

32. A key aim of the Bill is to provide a process that those involved can follow clearly and straightforwardly, and which is aimed at ensuring that any assistance they provide is lawful. As all those involved have a clear incentive to act in accordance with the law, there is no reason to suppose that evidence of a breach will be found in the vast majority of cases. Detailed investigations by the police, and referrals by the police to COPFS, can therefore be expected to happen only rarely, and the additional cost implications for both organisations are therefore likely to be minimal.

33. In Oregon, the Public Health Division reports any non-compliance by a doctor with the requirements of the Death With Dignity Act to the Oregon Medical Board. During the last seven years (2006-2012) a total of 14 instances of non-compliance have been so reported, but none resulted in a finding that the doctors involved did not act in good faith, and none led to disciplinary action.[8]

Licensing authorities and facilitators

34. The Bill gives Scottish Ministers power to appoint one or more licensing authorities. It is envisaged that this role is most likely to be taken up by an existing non-governmental organisation that is sympathetic to the aim of the Bill and has the capacity to take on the licensing role.

35. The cost implications for any such organisation are difficult to estimate. For one thing, it will be up to the organisation itself to decide how many facilitators it thinks it necessary and appropriate to train and license (which will also depend on how many people apply to become facilitators). A licensing authority will also need to decide whether to seek to recoup the training and licensing costs from facilitators (e.g. by charging fees for licences), or whether to seek to

[8] Source: annual reports on the DWDA Act, available at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx. The format of these reports changed in 2006, and only reports from this date refer to the outcomes of reports of non-compliance.

cover these costs in other ways (e.g. by using existing resources, by seeking donations, or by seeking funding from the Scottish Government – as discussed above).

36. A point of comparison for what might be involved in training someone to become a facilitator is the role of the Humanist Society of Scotland (HSS) in training people to become "registered celebrants". The initial training for this (which qualifies someone to officiate at non-religious funerals) costs £500, subject to the trainee meeting certain criteria. This pays for a two-day residential training course and one day's training and assessment at a crematorium, followed by an extensive period of mentoring. Such celebrants can go on to do further training for other roles, such as weddings.

Organisations providing palliative care

37. Much of the palliative care provided in Scotland, for example in hospices, is delivered by charities rather than through the NHS. Many of these organisations are opposed in principle to assisted suicide (for example, on religious grounds) and it is unlikely that people receiving their care would be receptive to assisted suicide in the first place. The Bill is therefore unlikely to have any significant cost implications for such organisations.

Persons seeking an assisted suicide, and their relatives

38. There should be no direct costs for the person seeking an assisted suicide in respect of most elements of the process set out in the Bill. In particular, they will not be charged by registered medical practitioners for carrying out the assessments required at first or second request stage, nor will they be charged for any drugs dispensed by a pharmacist.

39. However, the Bill also requires the person to declare, at second request stage, that they have arranged to have the services of a licensed facilitator. While it is not a requirement of the Bill, it is possible that facilitators will charge for their services. This may involve an amount aimed simply at recouping the costs directly associated with assisting a particular person on a particular occasion, or it may also be aimed at recouping for that facilitator the costs they have incurred in obtaining their licence.

40. Again, the Humanist Society Scotland may offer a point of comparison. Their registered celebrants currently charge £135 to conduct a funeral for an adult or a naming ceremony for a child, and £175 for an "extended funeral". Charges for weddings are currently £350 (rising to £375 in 2014). (Celebrants are in turn required to pay a 10% commission to HSS.)[9]

41. Against this, the Bill is intended to provide a direct alternative to the current best option for securing an assisted suicide, namely travel to Dignitas in Switzerland. Estimated costs for going to Dignitas are from £5,000 – £10,000, depending on whether, for example, the person has specific travel needs, such as a vehicle adapted to someone using a ventilator, or whether the person needs to be accompanied by medically-trained support personnel. Where a spouse, partner or other relative wishes to accompany the person, this will clearly add further cost.

[9] Source: Humanist Society Scotland website – http://www.humanism-scotland.org.uk/content/ceremonies/ (for fees, click on the links to Weddings, Funerals and Namings).

42. In some cases, an assisted suicide will reduce the period for which a person's family will have to pay for certain care costs, where these are funded privately rather than by the NHS.

Professional bodies

43. It is anticipated that both the General Medical Council and the Royal Pharmaceutical Society would revise their codes of practice and other guidance material to reflect the changes made by the Bill. These bodies already have established systems and processes for updating such documentation to reflect changes of legislation or other developments, including where the changes raise complex issues or impinge on matters of conscience. As such, it seems reasonable to assume that any additional costs can be absorbed within existing budgets.

MEMBER'S STATEMENT ON LEGISLATIVE COMPETENCE

On 12 November 2013, the member in charge of the Bill (Margo MacDonald MSP) made the following statement:

> "In my view, the provisions of the Assisted Suicide (Scotland) Bill would be within the legislative competence of the Scottish Parliament."

PRESIDING OFFICER'S STATEMENT ON LEGISLATIVE COMPETENCE

On 13 November 2013, the Presiding Officer (Rt Hon Tricia Marwick MSP) made the following statement:

> "In my view, the provisions of the Assisted Suicide (Scotland) Bill would be within the legislative competence of the Scottish Parliament."

These documents relate to the Assisted Suicide (Scotland) Bill (SP Bill 40) as introduced in the Scottish Parliament on 13 November 2013

ASSISTED SUICIDE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

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This document relates to the Assisted Suicide (Scotland) Bill (SP Bill 40) as introduced in the Scottish Parliament on 13 November 2013

ASSISTED SUICIDE (SCOTLAND) BILL

DELEGATED POWERS MEMORANDUM

PURPOSE

1. This memorandum has been prepared by the Non-Government Bills Unit on behalf of Margo MacDonald MSP. Its purpose is to assist consideration by the Delegated Powers and Law Reform Committee, in accordance with Rule 9.6.2 of the Parliament's Standing Orders, of provisions in the Assisted Suicide (Scotland) Bill conferring powers to make subordinate legislation. It describes the purpose of each of the subordinate legislation provisions in the Bill and outlines the reasons for seeking the proposed powers. This memorandum should be read in conjunction with the Explanatory Notes and Policy Memorandum for the Bill.

Outline of Bill provisions

2. The Bill makes provision to enable persons suffering from terminal or life-shortening illnesses or progressive conditions which are terminal or life-shortening to request assistance in ending their own lives, subject to certain conditions. It does this by setting out a procedure which requires to be followed in order to access assistance to commit suicide, and by removing criminal and civil liability from those providing such assistance where this procedure has been followed.

3. Sections 19 to 23 of the Bill create the role of "facilitator". A facilitator is an individual licensed by a licensing authority (licensing authorities in turn are to be appointed by the Scottish Ministers) to act as such, and whose role is to provide the person seeking an assisted suicide with practical assistance, comfort and reassurance at the end of life and to report any suicide or attempted suicide at which they assisted to the police, enabling monitoring and investigation (where appropriate) of such deaths. The assistance which the facilitator provides will often include help which is directly required to enable the act of suicide to take place, for example holding a cup for someone who might otherwise be unable to drink the necessary drugs from it.

Rationale for subordinate legislation

4. The Bill contains two powers to make subordinate legislation which are delegated to the Scottish Ministers. These powers are new, and no existing powers are amended or repealed. The powers are explained in detail in the following paragraphs, but in considering if and how provision should be set out in subordinate legislation rather than on the face of the Bill the member has had regard to-

- the need to strike a balance between the importance of ensuring full Parliamentary scrutiny of the core provisions of the Bill and making proper use of Parliamentary time;
- the relatively better position of the Scottish Ministers when compared with an individual member in making decisions on the best use of public resources to meet objectives;
- enabling a flexible and responsive approach on matters of detail, which do not relate to eligibility to access assisted suicide;
- the possible need to change provisions relating to such matters in a manner which responds to experience of their operation.

Delegated powers

Section 22(1) – Appointment of licensing authority

Power conferred on: **Scottish Ministers**
Power exercisable by: **order made by statutory instrument**
Parliamentary procedure: **affirmative resolution of the Scottish Parliament**

Provision

5. Section 22(1) enables the Scottish Ministers to appoint a person or a body, association or group of persons to be the licensing authority for facilitators, or two or more persons or bodies, associations or groups of persons to be licensing authorities.

Reason for taking power

6. Bodies which may be interested in taking on the role of licensing authority may need time during the passage of the Bill and immediately after its enactment to consider whether they wish to put themselves forward to do so. The changing nature of the organisational landscape in sectors such as the voluntary sector may require the authority or authorities appointed originally to be replaced over time. Appointment on the face of the Bill would therefore not be desirable.

Choice of procedure

7. The importance of ensuring that those appointed as licensing authorities are suitable to undertake this sensitive role means that the affirmative procedure is considered appropriate for the exercise of this power. Potential licensing authorities should be individually scrutinised by both Ministers and the Parliament prior to being given this important role.

Section 22(2) - Maintenance of standards amongst licensing authorities and facilitators and procedural matters

Power conferred on: **Scottish Ministers**
Power exercisable by: **order made by statutory instrument**
Parliamentary procedure: **negative resolution of the Scottish Parliament**

Provision

8. Section 22(2) empowers the Scottish Ministers to make provision in regulations for the suspension or revocation by them of an appointment as licensing authority; for the suspension or revocation of individual licences by them or by licensing authorities; for the grounds of suspension or revocation in either case; for the checking and training of those applying to become licensed facilitators and the training, supervision and inspection of existing facilitators; for the procedure for obtaining a licence; for appeals and for such other matters (within the context of the subsection) as the Scottish Ministers consider appropriate.

Reason for taking power

9. While the eligibility criteria and procedure for accessing assisted suicide are likely to be key points of debate and controversy during the passage of the Bill, it is considered that ancillary matters such as the detail of the licensing scheme for facilitators are substantially less sensitive. If they were on the face of the Bill, scrutiny of these aspects would be likely to be overshadowed by the ethical arguments about its core provisions. Including a detailed licensing scheme would also be likely to alter the balance of the Bill, which should be predominantly concerned with the issues of eligibility and core procedure and not skewed towards administrative matters.

10. Constructing an appropriate licensing scheme is likely to require the bringing together of different strands of expertise, for example from those with experience of running other licensing schemes, organisations such as Disclosure Scotland and court and tribunal interests. Decisions will require to be made about matters such as the extent of background checks to be required for individual facilitators, what training is or can be made available and would be appropriate and the right procedure and forum for any appeals. It is submitted that decisions of this type are best taken by Ministers following appropriate consultations.

11. The system for licensing facilitators should be sufficiently flexible to respond to both changing circumstances and experience of its operation. For example, experience may suggest that some aspect of procedure needs to be modified because it has turned out to be too onerous, or training requirements may need to be altered or extended as the role of facilitators becomes better-established.

Choice of procedure

12. The licensing scheme to be contained in regulations will require to be detailed, to contain administrative provisions and to have drawn on a range of expertise. The need to adjust details of the scheme in future without undue difficulty will also be important. We consider that given this context and the fact that exercise of the power will not involve amendment of primary legislation, the negative procedure is the most appropriate.

This document relates to the Assisted Suicide (Scotland) Bill (SP Bill 40) as introduced in the Scottish Parliament on 13 November 2013

ASSISTED SUICIDE (SCOTLAND) BILL

DELEGATED POWERS MEMORANDUM

Assisted Suicide (Scotland) Bill

[AS INTRODUCED]

CONTENTS

ACCOMPANYING DOCUMENTS
Explanatory Notes, together with other accompanying documents, are printed separately as SP Bill 40-EN. A Policy Memorandum is printed separately as SP Bill 40-PM.

Assisted Suicide (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to make it lawful, in certain circumstances, to assist another to commit suicide; and for connected purposes.

PART 1

LAWFULNESS OF ASSISTING SUICIDE

1 No criminal liability for assisting suicide

(1) It is not a crime (of any kind) to assist a person to commit suicide.

(2) Subsection (1) applies only if the requirements of section 3 are complied with.

(3) Subsection (2) does not limit the circumstances in which, apart from this Act, a court can find that a person who has assisted another to commit suicide has not committed a crime.

(4) The references in subsections (1) and (3) to assisting a person to commit suicide include references to assisting the person in an attempt to do so.

2 No civil liability for assisting suicide

(1) Assisting a person to commit suicide does not give rise to civil liability.

(2) Subsection (1) applies only if the requirements of section 3 are complied with.

(3) Subsection (2) does not limit the circumstances in which, apart from this Act, a court can find that a person who has assisted another to commit suicide is not subject to civil liability.

(4) The references in subsections (1) and (3) to assisting a person to commit suicide include references to assisting the person in an attempt to do so.

PART 2

SAFEGUARDS

Essential safeguards

3 Essential safeguards

The requirements of this section are that—

(a) the person who is to be assisted—

(i) has made a preliminary declaration under section 4, and

(ii) has made a first request for assistance under section 8 and a second under section 10,

(b) the preliminary declaration and both requests have been endorsed in accordance with those sections and the facts that the declaration and requests have been made have been recorded in the person's medical records under sections 5 and 13 respectively,

(c) the person complies with the 14 day time limit stipulated in section 17 for the act of suicide (or attempted suicide), and

(d) the assistance meets the requirement in section 18 that the cause of death is (or, in the case of an attempt, would have been) the person's own deliberate act.

Preliminary declaration

4 Preliminary declaration, witness statement and medical practitioner's note

(1) A preliminary declaration—

(a) must be in the form set out in schedule 1,

(b) may be made only by a person who—

(i) is registered as a patient with a medical practice in Scotland, and

(ii) is at least 16 years old, and

(c) must be signed by that person in the presence of a qualified witness who then signs a witness statement in the form set out in schedule 1.

(2) A "qualified witness" is anyone who—

(a) is at least 16 years old, and

(b) is not disqualified under schedule 4 from being the witness.

(3) A preliminary declaration is "endorsed" when a registered medical practitioner signs a note in the form set out in schedule 1.

5 Recording of making of preliminary declaration in medical records

(1) This section applies in relation to an endorsed preliminary declaration.

(2) If the practitioner who endorsed the declaration is in the medical practice with which the person who made the declaration is registered as a patient, then that practitioner is to record in the person's medical records that the person has made the declaration and the date when the person signed it.

(3) If the practitioner is not in that medical practice, then that practitioner is to notify a registered medical practitioner in that practice of those facts.

(4) The practitioner so notified is to record those facts in the person's medical records.

6 Preliminary declaration, witness statement and medical practitioner's note to be in one conventional document

(1) A person's preliminary declaration and the associated witness statement and medical practitioner's note are to be contained in a single document.

(2) Enactments authorising documents in electronic form do not apply to that document.

7 Cancellation of preliminary declaration and record of cancellation

(1) A person who has made a preliminary declaration which has been endorsed may cancel it by written, signed and dated notice given to a registered medical practitioner in the practice with which the person is registered as a patient.

(2) That practitioner is to record in the person's medical records the fact that the declaration has been cancelled and the date the notice was signed.

(3) A cancellation under subsection (1) has effect as from the date the notice is signed.

First and second requests and endorsement

8 First request for assistance

(1) This section applies in relation to a first request for assistance.

(2) It must be in the form set out in schedule 2.

(3) It may be made only by a person who—

(a) is registered as a patient with a medical practice in Scotland,

(b) is at least 16 years old,

(c) has, at least 7 days before signing the request, signed a preliminary declaration which has been witnessed and has not been cancelled, and

(d) has, after reflecting on the consequences for the person of the considerations set out in subsection (4) and in the light of that reflection, concluded that the quality of the person's life is unacceptable.

(4) Those considerations are that the person—

(a) has an illness or condition of the kind described in subsection (5), and

(b) sees no prospect of any improvement in the person's quality of life.

(5) The kind of illness or condition referred to in subsection (4)(a) is—

(a) an illness that is, for the person, either terminal or life-shortening, or

(b) a condition that is, for the person, progressive and either terminal or life-shortening.

(6) A first request is "endorsed" when both the statements referred to in section 9 have been made; and the date of endorsement is the date on which the second of them is signed.

9 Endorsement of first request: medical practitioners' statements

(1) The statements mentioned in section 8(6) are two statements each made by a different registered medical practitioner.

(2) A statement must be in the form set out in schedule 2 and, in particular, the practitioner making it may do so only if, in the opinion of the practitioner—

(a) the person making the request has capacity within the meaning of section 12 to make it,

(b) the person has—

(i) an illness that is, for the person, either terminal or life-shortening, or

(ii) a condition that is, for the person, progressive and either terminal or life-shortening, and

(c) the person's conclusion under section 8(3)(d) that the person's quality of life is unacceptable is not inconsistent with the facts then known to the practitioner.

(3) The statements must be made at different times.

(4) It is for the practitioner who makes the first of them to refer the matter of the making of a second to another practitioner; and the second statement may be made only on such a reference.

(5) For the purposes of subsection (2)(b), it is enough to state an opinion—

(a) that the person has an illness or condition of the kind described there,

(b) that the illness or condition is terminal or life-shortening,

without further identification, in either case, of which of the two it is.

10 Second request for assistance

(1) This section applies in relation to a second request for assistance.

(2) It must be in the form set out in schedule 3.

(3) It may be made only by a person who—

(a) is registered as a patient with a medical practice in Scotland,

(b) has made a first request which has been endorsed and has not been cancelled, and

(c) has, after reflecting on the consequences for the person of the considerations set out in subsection (4) and in the light of that reflection, concluded that the quality of the person's life is unacceptable.

(4) Those considerations are that the person—

(a) has an illness or condition of the kind described in subsection (5), and

(b) sees no prospect of any improvement in the person's quality of life.

(5) The kind of illness or condition referred to in subsection (4)(a) is—

(a) an illness that is, for the person, either terminal or life-shortening, or

(b) a condition that is, for the person, progressive and either terminal or life-shortening.

(6) The request may be signed by the person only after the expiry of 14 days beginning with the date of endorsement of the person's first request.

(7) A second request is "endorsed" when both the statements referred to in section 11 have been made; and the date of endorsement is the date on which the second of them is signed.

11 Endorsement of second request: medical practitioners' statements

(1) The statements mentioned in section 10(7) are two statements each made by a different registered medical practitioner.

(2) A statement must be in the form set out in schedule 3 and, in particular, the practitioner making it may do so only if, in the opinion of the practitioner—

(a) the person making the request has capacity within the meaning of section 12 to make it,

(b) the person has—

(i) an illness that is, for the person, either terminal or life-shortening, or

(ii) a condition that is, for the person, progressive and either terminal or life-shortening, and

(c) the person's conclusion under section 10(3)(c) that the person's quality of life is unacceptable is not inconsistent with the facts then known to the practitioner.

(3) The statements must be made at different times.

(4) It is for the practitioner who makes the first of them to refer the matter of the making of a second to another practitioner; and the second statement may be made only on such a reference.

(5) Neither of the statements relating to a person's second request need be made by a medical practitioner who made a statement in relation to the person's first request.

(6) For the purposes of subsection (2)(b), it is enough to state an opinion—

(a) that the person has an illness or condition of the kind described there,

(b) that the illness or condition is terminal or life-shortening,

without further identification, in either case, of which of the two it is.

12 Capacity

(1) For the purposes of sections 9(2)(a) and 11(2)(a), a person has capacity to make a request if the person—

(a) is not suffering from any mental disorder (within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)) which might affect the making of the request, and

(b) is capable of—

(i) making a decision to make the request,

(ii) communicating the decision,

(iii) understanding the decision, and

(iv) retaining the memory of the decision.

(2) However, a person is not to be regarded as lacking capacity by reason only of a lack of or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise).

Procedural matters

13 Recording in medical records of making of requests and associated statements

(1) If the practitioner who made the second statement in relation to a first or second request is in the medical practice with which the person who made the request is registered as a patient, then that practitioner is to record the following facts in the person's medical records—

(a) that the person has signed the request,

(b) the date it was endorsed,

(c) the date the facts referred to in paragraphs (a) and (b) are recorded in the person's medical records.

(2) If that practitioner is not in that medical practice, then that practitioner is to notify a registered medical practitioner in that medical practice of the facts set out in subsection (1)(a) and (b).

(3) The practitioner so notified is to record in the person's medical records those facts and the date they are recorded.

14 Each request and associated statements to be in one conventional document; back-up copy

(1) A person's first request and the associated statements are to be contained in a single document.

(2) A person's second request and the associated statements are to be contained in a single document.

(3) Enactments authorising documents in electronic form do not apply to those documents.

(4) A photocopy of such a document bearing to be certified as a true copy by either of the practitioners who made a statement contained in it or by a notary public and signed and dated by the practitioner or notary has the same effect as the original.

Cancellation of requests

15 Cancellation of first or second request and record of cancellation

(1) A person who has made a first request which has been endorsed may cancel it by written, signed and dated notice given to a registered medical practitioner in the practice with which the person is registered as a patient.

(2) Cancelling a first request has no effect on a preliminary declaration.

(3) A person who has made a second request which has been endorsed may cancel it by written, signed and dated notice given to a registered medical practitioner in the medical practice with which the person is registered as a patient.

(4) Cancelling a second request has no effect on a preliminary declaration or a first request.

(5) The practitioner to whom a notice of cancellation is given is to record in the person's medical records the fact that the request to which it relates has been cancelled and the date the notice was signed.

(6) A cancellation under subsection (1) or (3) has effect as from the date the notice is signed.

Signature by proxy

16 Signing by proxy of preliminary declarations, first and second requests and cancellations

(1) This section applies where a person intending to make or cancel a preliminary declaration or a first or second request—

(a) declares to a proxy that the person is blind or unable to read, or unable to sign the person's name, and

(b) authorises the proxy to sign the declaration, request or notice of cancellation (the "document") on the person's behalf.

(2) A document signed by the proxy—

(a) in the presence of the person, and

(b) in accordance with subsection (3),

has the same effect as if signed by the person.

(3) The proxy is to add, after the proxy's signature, the proxy's full name, address and qualification to sign, and a statement that the proxy has signed in that capacity (for example, John George Smith, 2 Ivy Street, Edinburgh, EH00 1AA, Solicitor, signing as proxy).

(4) A proxy may not sign a document unless satisfied that the person understands its effect.

(5) A proxy may not sign a document on behalf of a person in relation to whom the proxy is disqualified under schedule 4.

(6) A "proxy" means—

(a) a solicitor who has in force a practising certificate as defined in section 4(c) of the Solicitors (Scotland) Act 1980 (c.46),

(b) a member of the Faculty of Advocates,

(c) a justice of the peace in Scotland,

(d) in relation to a document to be signed in a place outwith Scotland, a notary public or other person with authority under the law of that place to sign or otherwise execute documents on behalf of persons who are blind or unable to read or to sign.

The act of suicide

17 The act of suicide: time limit

(1) This section applies in relation to a person who has made a second request the making of which has been recorded in the person's medical records under section 13.

(2) The person must ensure that, if any act of suicide (or attempted suicide) follows on that request, it takes place within the period of 14 days beginning with the day when the making of the request was so recorded.

Nature of assistance

18 Nature of assistance: no euthanasia etc.

(1) Nothing in this Act authorises anyone to do anything that itself causes another person's death.

(2) Accordingly, assistance must not be such as to infringe the requirement in subsection (3).

(3) That requirement is that the cause of the other person's death must be (or, in the case of an attempt, would have been) that person's own deliberate act.

Licensed facilitators

19 General functions of licensed facilitators

A licensed facilitator is to use best endeavours—

(a) to provide, before, during and after the act of suicide (or attempted suicide) by the person for whom the facilitator is acting, such practical assistance as the person reasonably requests,

(b) to provide the person with comfort and reassurance,

(c) to be with the person when any drug or other substance or means dispensed or otherwise supplied for the suicide of the person is taken or used by the person,

(d) as soon as practicable after the expiry of the period of 14 days referred to in section 17(2), to remove from the person any such drug or other substance or means still in the person's possession.

20 Reporting to police

Where a licensed facilitator knows or believes—

(a) that the person for whom the facilitator has been acting has died as a result of taking or using any drug, substance or other means dispensed or otherwise supplied for the person's suicide, or

(b) that the person has attempted to commit suicide in that way but has not died,

the facilitator must report that fact or belief to a constable as soon as practicable.

21 Licensed facilitators: disqualifying relationships and minimum age

(1) A licensed facilitator may not act as such for a person in relation to whom the facilitator is disqualified under schedule 4.

(2) A person under 16 years old may not be a licensed facilitator.

22 Licensing of facilitators

(1) The Scottish Ministers may, by order, appoint—

(a) a person or a body, association or group of persons to be the licensing authority, or

(b) persons or bodies, associations or groups of persons to be licensing authorities,

for facilitators.

(2) The Scottish Ministers may, by regulations, provide for—

(a) the suspension or revocation by the Scottish Ministers of an appointment,

(b) the grounds on which an appointment may be suspended or revoked,

(c) the procedure for granting licences,

(d) the checking and training of applicants for licences and the training, supervision and inspection of licensed facilitators,

(e) the suspension and revocation of licences, whether by the Scottish Ministers or a licensing authority,

(f) the grounds on which licences may be suspended or revoked,

(g) appeals and the grounds and procedure for appeals or different appeals or classes of appeal, and

(h) such other matters as the Scottish Ministers think appropriate.

(3) An order under subsection (1) is subject to the affirmative procedure.

(4) Regulations under subsection (2) are subject to the negative procedure.

23 Directions and guidance

(1) The Scottish Ministers may issue directions about how licensed facilitators are to act in pursuance of this Act.

(2) A licensing authority must use its best endeavours to ensure that those directions are complied with by the facilitators to whom it has granted licences.

(3) A licensing authority must have regard to any guidance issued by the Scottish Ministers.

(4) The Scottish Ministers must publish any such directions or guidance.

Savings

24 Savings for certain mistakes and things done in good faith

(1) If a person, when acting in good faith and in intended pursuance of this Act, makes an incorrect statement or otherwise does anything inconsistent with the Act (including an omission) but has not been shown to have been careless in doing so, then—

(a) the person does not, in that respect, commit a crime (of any kind) or incur any civil liability, and

(b) the statement, act (or omission), and anything done or omitted to be done on the basis of it, is to be treated as in conformity with the Act.

(2) If—

(a) a person, when acting in good faith and in intended pursuance of this Act, provides any assistance (the "assisting" person), and

(b) another person makes or has made an inaccurate statement or does or has done anything inconsistent with this Act (including an omission),

the assisting person does not, in respect of that assistance, commit a crime (of any kind) or incur any civil liability.

(3) Nothing done by a person when acting in good faith and in intended pursuance of this Act is affected by—

(a) any incorrect statement carelessly or knowingly made, or

(b) any other thing carelessly or knowingly done that is inconsistent with this Act (including an omission).

PART 3

COMMENCEMENT AND SHORT TITLE

25 Commencement

(1) This section and sections 22, 23 and 26 come into force on the day after Royal Assent.

(2) The rest of this Act comes into force at the end of the period of 6 months beginning with that day.

26 Short title

The short title of this Act is the Assisted Suicide (Scotland) Act 2014.

SCHEDULE 1
(introduced by section 4)

FORM OF PRELIMINARY DECLARATION, WITNESS STATEMENT AND MEDICAL PRACTITIONER'S NOTE

"PRELIMINARY DECLARATION OF WILLINGNESS TO CONSIDER ASSISTED SUICIDE

Full name.....

Address.....

.....

.....

Postcode.....

Date of birth.....

Medical practice (name and address).....

.....

.....

1. I declare that if I become/am* eligible to seek the assistance to commit suicide that is made lawful by the Assisted Suicide (Scotland) Act 2014, I am willing to consider whether to request it.
2. I make this declaration voluntarily and, in particular, I have not been persuaded or similarly influenced by another person to make it.
3. I understand that I can cancel this declaration at any time.
4. I am registered as a patient with the above medical practice.
5. I am at least 16 years old.
6. To the best of my knowledge, ..., the witness to my signature of this declaration is at least 16 years old.
7. To the best of my knowledge, he/she* is not disqualified from being my witness under schedule 4 to the Assisted Suicide (Scotland) Act 2014 (disqualification of relatives, persons standing to gain and certain doctors and nurses), nor do I expect him/her* to become so disqualified.
8. I understand that the assistance to commit suicide that is made lawful by that Act can be obtained by me under that Act only if I have started off by making this declaration.

*Delete as appropriate

Signed.....date of signature.....

WITNESS STATEMENT

Full name of witness.....

Address.....

.....

.....

Postcode.....

Date of birth.....

1. ..... signed the above preliminary declaration in my presence.
2. I am acquainted with him/her* and I have been for a period longer than that associated with the signing of the declaration.
3. I am at least 16 years old.
4. To the best of my knowledge, I am not nor do I expect to become disqualified from acting as his/her* witness under schedule 4 to the Assisted Suicide (Scotland) Act 2014 (relatives, persons standing to gain and certain doctors and nurses).
5. To the best of my knowledge, he/she* has made the declaration voluntarily and, in particular, has not been persuaded or similarly influenced by another person to make it.
6. To the best of my knowledge he/she* understands that he/she* can cancel the declaration at any time.

*Delete as appropriate

Witness's signature.....date of witness's signature.....

NOTE BY REGISTERED MEDICAL PRACTITIONER

Full name of medical practitioner.....

Address of medical practice.....

.....

.....

Postcode.....

1. I am satisfied that the above preliminary declaration and witness statement conform with schedule 1 to the Assisted Suicide (Scotland) Act 2014.
2. On the basis of the facts known to me, I have no reason to believe that anything stated in the above preliminary declaration or witness statement is false.

Signed.....date of signature.....

SCHEDULE 2
(introduced by sections 8 and 9)

FORM OF FIRST REQUEST AND MEDICAL PRACTITIONERS' STATEMENTS

"FIRST REQUEST FOR ASSISTANCE IN COMMITTING SUICIDE

Full name.....

Address.....

.....

.....

Postcode.....

Date of birth.....

Medical practice (name and address).....

.....

.....

1. I ask for the assistance to commit suicide that is made lawful by the Assisted Suicide (Scotland) Act 2014.
2. I make this request voluntarily and, in particular, I have not been persuaded or similarly influenced by another person to make it.
3. I understand that I can cancel this request at any time.
4. I understand that the assistance I am asking for can be obtained by me under the Assisted Suicide (Scotland) Act 2014 only if I have made a preliminary declaration and this first request, and then followed them up with a second request.
5. I have reflected on the consequences for me of the considerations set out in paragraph 6 below and, in the light of having done so, I have concluded that my quality of life is unacceptable.
6. Those considerations are that—
   (a) I have an illness or condition of the kind set out in paragraph 7 below, and
   (b) I see no prospect of any improvement in my quality of life.
7. The kind of illness or condition I have is—
   (a) an illness that is, for me, either terminal or life-shortening, or
   (b) a condition that is, for me, progressive and either terminal or life-shortening.

Signed.....date of signature.....

FIRST REGISTERED MEDICAL PRACTITIONER'S STATEMENT ON FIRST REQUEST

Full name of medical practitioner.....

Address of medical practice.....

.....

.....

Postcode.....

1. I have discussed with ..... the nature and effect of the above request.
2. To the best of my knowledge, he/she* is making the request voluntarily and, in particular, has not been persuaded or similarly influenced by any other person to make it.
3. I am satisfied that—
   (a) he/she* has signed a preliminary declaration which has been endorsed,
   (b) it was signed at least seven days before he/she* signed the above request,
   (c) the fact that the declaration has been made and the date when it was signed have been recorded in his/her* medical records, and
   (d) he/she* has not cancelled it.
4. I am of the opinion that he/she* has capacity (within the meaning of section 12 of the Assisted Suicide (Scotland) Act 2014) to make the above request.
5. I am satisfied that he/she* is registered as a patient with a medical practice in Scotland.
6. I am satisfied that he/she* is at least 16 years old.
7. I am of the opinion that he/she* has an illness that, for him/her*, is either terminal or life-shortening or a condition that, for him/her*, is progressive and either terminal or life shortening.
8. I am of the opinion that his/her* conclusion (as set out in the above request) that his/her* quality of life is unacceptable is not inconsistent with the facts currently known to me.

*Delete as appropriate

Signed.....date of signature.....

Note: under section 9(5) of the Assisted Suicide (Scotland) Act 2014, it is enough to state an opinion that the person has an illness or condition of the kind mentioned above and to state that it is terminal or life-shortening without, in either case, identifying which of the two it is.

SECOND REGISTERED MEDICAL PRACTITIONER'S STATEMENT ON FIRST REQUEST

Full name of medical practitioner.....

Address of medical practice.....

.....

.....

Postcode.....

1. I have discussed with ..... the nature and effect of the above request.
2. To the best of my knowledge, he/she* is making the request voluntarily and, in particular, has not been persuaded or similarly influenced by any other person to make it.
3. I am satisfied that—
   (a) he/she* has signed a preliminary declaration which has been endorsed,
   (b) it was signed at least seven days before he/she* signed the above request,
   (c) the fact that the declaration has been made and the date when it was signed have been recorded in his/her* medical records, and
   (d) he/she* has not cancelled it.
4. I am of the opinion that he/she* has capacity (within the meaning of section 12 of the Assisted Suicide (Scotland) Act 2014) to make the above request.
5. I am satisfied that he/she* is registered as a patient with a medical practice in Scotland.
6. I am satisfied that he/she* is at least 16 years old.
7. I am of the opinion that he/she* has an illness that, for him/her*, is either terminal or life-shortening or a condition that, for him/her*, is progressive and either terminal or life shortening.
8. I am of the opinion that his/her* conclusion (as set out in the above request) that his/her* quality of life is unacceptable is not inconsistent with the facts currently known to me.

* Delete as appropriate

Signed.....date of signature.....

Note: under section 9(5) of the Assisted Suicide (Scotland) Act 2014, it is enough to state an opinion that the person has an illness or condition of the kind mentioned above and to state that it is terminal or life-shortening without, in either case, identifying which of the two it is."

SCHEDULE 3
(introduced by sections 10 and 11)

FORM OF SECOND REQUEST AND MEDICAL PRACTITIONERS' STATEMENTS

"SECOND REQUEST FOR ASSISTANCE IN COMMITTING SUICIDE

Full name.....

Address.....

.....

.....

Postcode.....

Date of birth.....

Medical practice (name and address).....

.....

.....

1. I ask again for the assistance to commit suicide that is made lawful by the Assisted Suicide (Scotland) Act 2014.
2. I make this second request voluntarily and, in particular, I have not been persuaded or similarly influenced by another person to make it.
3. I understand that I can cancel this second request at any time.
4. I understand that the assistance I am asking for can be obtained by me under the Assisted Suicide (Scotland) Act 2014 only if I have made a preliminary declaration, a first request and this second request.
5. I understand that this second request is the final step in the procedure for obtaining that assistance.
6. I understand that the assistance I am asking for will be lawful under that Act only if any act of suicide (or attempted suicide) following this second request takes place within the period of 14 days beginning with the day the making of this request is recorded in my medical records.
7. I have arranged to have the services of a licensed facilitator.
8. I have reflected on the consequences for me of the considerations set out in paragraph 9 below and, in the light of having done so, I have concluded that my quality of life is unacceptable.
9. Those considerations are that—
   (a) I have an illness or condition of the kind set out in paragraph 10 below, and
   (b) I see no prospect of any improvement in my quality of life.
10. The kind of illness or condition I have is—
   (a) an illness that is, for me, either terminal or life-shortening, or
   (b) a condition that is, for me, progressive and either terminal or life-shortening.

Signed.....date of signature.....

FIRST MEDICAL PRACTITIONER'S STATEMENT ON SECOND REQUEST

Full name of medical practitioner.....

Address of medical practice.....

.....

.....

Postcode.....

1. I have discussed with ..... the nature and effect of the above request.
2. To the best of my knowledge, he/she* is making the request voluntarily and, in particular, has not been persuaded or similarly influenced by any other person to make it.
3. I am satisfied that—
   (a) he/she* has made a first request,
   (b) the fact that the first request has been made and the date when it was endorsed have been recorded in his/her* medical records,
   (c) he/she* has not cancelled it, and
   (d) the above request was signed by him/her* at least 14 days after his/her* first request was endorsed.
4. I am of the opinion that he/she* has capacity (within the meaning of section 12 of the Assisted Suicide (Scotland) Act 2014) to make the above request.
5. I am satisfied that he/she* is registered as a patient with a medical practice in Scotland.
6. I am satisfied that he/she* is at least 16 years old.
7. I am of the opinion that he/she* has an illness that, for him/her*, is either terminal or life-shortening or a condition that, for him/her*, is progressive and either terminal or life-shortening.
8. I am of the opinion that his/her* conclusion (as set out in the above request) that his/her* quality of life is unacceptable is not inconsistent with the facts currently known to me.

*Delete as appropriate

Signed.....date of signature.....

Note: under section 11(6) of the Assisted Suicide (Scotland) Act 2014, it is enough to state an opinion that the person has an illness or condition of the kind mentioned above and to state that it is terminal or life-shortening without, in either case, identifying which of the two it is.

SECOND MEDICAL PRACTITIONER'S STATEMENT ON SECOND REQUEST

Full name of medical practitioner.....

Address of medical practice.....

.....

.....

Postcode.....

1. I have discussed with ..... the nature and effect of the above request.
2. To the best of my knowledge, he/she* is making the request voluntarily and, in particular, has not been persuaded or similarly influenced by any other person to make it.
3. I am satisfied that—
   (a) he/she* has made a first request,
   (b) the fact that the first request has been made and the date when it was endorsed have been recorded in his/her* medical records,
   (c) he/she* has not cancelled it, and
   (d) the above request was signed by him/her* at least 14 days after his/her* first request was endorsed.
4. I am of the opinion that he/she* has capacity (within the meaning of section 12 of the Assisted Suicide (Scotland) Act 2014) to make the above request.
5. I am satisfied that he/she* is registered as a patient with a medical practice in Scotland.
6. I am satisfied that he/she* is at least 16 years old.
7. I am of the opinion that he/she* has an illness that, for him/her*, is either terminal or life-shortening or a condition that, for him/her*, is progressive and either terminal or life-shortening.
8. I am of the opinion that his/her* conclusion (as set out in the above request) that his/her* quality of life is unacceptable is not inconsistent with the facts currently known to me.

*Delete as appropriate

Signed.....date of signature.....

Note: under section 11(6) of the Assisted Suicide (Scotland) Act 2014, it is enough to state an opinion that the person has an illness or condition of the kind mentioned above and to state that it is terminal or life-shortening without, in either case, identifying which of the two it is."

SCHEDULE 4
(introduced by sections 4, 16 and 21)

DISQUALIFYING RELATIONSHIPS: WITNESSES, PROXIES AND LICENSED FACILITATORS

1 As respects—

(a) a person signing a preliminary declaration under section 4(1),

(b) a person who has made a second request under section 10,

(c) a person intending to have a document signed by proxy under section 16,

the individuals specified in paragraph 2 are disqualified from being the witness, a licensed facilitator or, as the case may be, the proxy.

2 Those individuals are as follows—

Family relationships

(a) the person's spouse, civil partner or cohabitee,

(b) the person's parent or grandparent and any spouse, civil partner or cohabitee of that parent or grandparent,

(c) the parent of the person's spouse, civil partner or cohabitee and any spouse, civil partner or cohabitee of that parent,

(d) the person's child or grandchild and the spouse, civil partner or cohabitee of that child or grandchild,

(e) the person's brother, sister, nephew or niece and the spouse, civil partner or cohabitee of that brother, sister, nephew or niece,

(f) the person's aunt, uncle or cousin, the child of that cousin and any spouse, civil partner or cohabitee of that aunt, uncle, cousin or cousin's child,

Financial etc. relationships

(g) anyone who will gain financially in the event of the person's death whether directly or indirectly and whether in money or money's worth,

Medical and nursing relationships

(h) where the person has an illness or condition such as is described in section 8(5), any registered medical practitioner or registered nurse who has provided treatment or care for the person in relation to that illness or condition.

3 In paragraph 2, "cohabitee", in relation to a person, means another person who is living with the person as if married to, or in civil partnership with, the person.

4 The family relationships set out in paragraph 2(b) to (f) include—

(a) relationships created by adoption or by marriage,

(b) relationships of the half-blood, and

(c) step-family relationships (step-children, step-brothers, step-sisters, step-cousins and so on).

Assisted Suicide (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make it lawful, in certain circumstances, to assist another to commit suicide; and for connected purposes.

Introduced by: Margo MacDonald
Supported by: Patrick Harvie
On: 13 November 2013
Bill type: Member's Bill

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