Law Society of Scotland

Written Evidence

Assisted Dying for Terminally Ill Adults (Scotland) Bill

August 2024

Photo: Glencoe, Highlands

Law Society
of Scotland

Written Evidence

Assisted Dying for Terminally Ill Adults (Scotland) Bill

August 2024

Introduction

The Law Society of Scotland is the professional body for over 13,000 Scottish solicitors.

We are a regulator that sets and enforces standards for the solicitor profession which helps people in need and supports business in Scotland, the UK and overseas. We support solicitors and drive change to ensure Scotland has a strong, successful, and diverse legal profession. We represent our members and wider society when speaking out on human rights and the rule of law. We also seek to influence changes to legislation and the operation of our justice system as part of our work towards a fairer and more just society.

We welcome the opportunity to consider and respond to the call for views held by the Scottish Parliament's Health, Social Care and Sport Committee on the Assisted Dying for Terminally Ill Adults (Scotland) Bill ("the Bill").[1] We have the following comments to put forward for consideration.

Our approach to policy issues is directed by our statutory aims under the Solicitors (Scotland) Act 1980, namely to represent the interests of the solicitors' profession in Scotland and the interests of the public in relation to that profession, and by the regulatory objectives of the Legal Services (Scotland) Act 2010, namely:

- supporting the constitutional principle of the rule of law and the interests of justice
- protecting and promoting the interests of consumers and the public interest generally
- promoting access to justice and competition in the provision of legal services
- promoting an independent, strong, varied and effective legal profession
- encouraging equal opportunities within the legal profession
- and promoting and maintaining adherence to professional principles

Executive summary

We do not adopt a position on the moral and ethical issues of assisted dying.
We have specific concerns around the approach to capacity and mental disorder in the Bill.
We suggest a number of ways to strengthen the procedural safeguards set out in the Bill, should it proceed to Stage 2.
We have significant concerns about the proposed role of solicitors as proxies under section 12 of the Bill.
We request clarity on the interaction between the Bill and existing medico-legal principles, and specifically whether assisted dying could be considered a 'reasonable treatment option'.

1 Assisted Dying for Terminally Ill Adults (Scotland) Bill - Sharing your views - Scottish Parliament - Citizen Space

We have a number of comments on legislative competence.

General comments

We recognise that the subject matter of the Bill raises moral and ethical questions and will undoubtedly prompt much public and parliamentary discussion. We are not in a position, nor would it be appropriate for us, to comment on the ethical and moral aspects of the Bill. We therefore focus our comments on the practical and legal aspects and points, raising these to promote further consideration and debate on what is undoubtedly and understandably a recognised controversial subject. They include practical and legal matters that would, in our view, require to be addressed with clarity and careful consideration if the Parliament were to decide to proceed further with the Bill.

We note that the Bill seeks to allow terminally ill adults to be provided with assistance to end their own life. The Bill removes criminal[2] and civil liability[3] from the coordinating registered medical practitioner or an authorised health professional providing the provisions of the Bill are adhered to and the conditions fulfilled. Its plain effect is to allow people to assist others in taking their own lives.

Question 1 – Overarching question

The purpose of the Assisted Dying for Terminally Ill Adults (Scotland) Bill is to introduce a lawful form of assisted dying for people over the age of 16 with a terminal illness.

Which of the following best reflects your views on the Bill?

- Fully support
- Partially support
- Neutral/Don't know
- Partially oppose
- Strongly oppose

We are not in a position to comment on the general purpose of the Bill since this would involve the application of moral and ethical judgement. Our comments therefore are confined to the practical and legal application of the Bill.

Which of the following factors are most important to you when considering the issue of assisted dying?

- Impact on healthcare professionals and the doctor/patient relationship
- Personal autonomy
- Personal dignity
- Reducing suffering

2 Section 19
3 Section 20

- Risk of coercion of vulnerable people
- Risk of devaluing lives of vulnerable groups
- Sanctity of life
- Risk of eligibility being broadened and safeguards reduced over time
- Other, please specify

We are not in a position to comment on the general purpose of the Bill since this would involve the application of moral and ethical judgement. Our comments therefore are confined to the practical and legal application of the Bill.

Question 2 - Eligibility

The Bill proposes that assisted dying would be available only to terminally ill adults.

The Bill defines someone as terminally ill if they 'have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death'.

An adult is defined as someone aged 16 or over. To be eligible a person would also need to have been resident in Scotland for at least 12 months and be registered with a GP practice.

Eligibility – Terminal illness

Which of the following most closely matches your opinion on the terminal illness criterion for determining eligibility for assisted dying?

- No-one should be eligible for assisted dying
- Assisted dying should be available only to people who are terminally ill, and the definition of terminal illness should be narrower than in the Bill
- Assisted dying should be available only to people who are terminally ill, and the definition of terminal illness in the Bill is about right
- Assisted dying should be available only to people who are terminally ill, but the definition of terminal illness should be broader than in the Bill
- Assisted dying should be available to people who are terminally ill, and to people in some other categories.
- Other – please provide further detail

If you have further comments, please provide these

We have no specific comments at this stage, although we do note that the definition of terminal illness in the Bill is broadly drawn

Eligibility – minimum age

Which of the following most closely matches your opinion on the minimum age at which people should be eligible for assisted dying?

- No-one should be eligible for assisted dying.
- The minimum age should be lower than 16
- The minimum age should be 16
- The minimum age should be 18
- The minimum age should be higher than 18
- Other – please provide further detail

If you have further comments, please provide these

The provisions relating to eligibility to be provided with lawful assistance to voluntarily end one's life are set out in Sections 1-3 of the Bill as introduced.

In Scotland, the legal age of capacity is 16 years and a person of that age has the right to consent to, or decline, treatment (unless they lack the capacity to do so). A person under the age of 16 years can consent to, or refuse, medical treatment but only if they understand what treatment is being proposed[4]. It is up to the doctor to decide whether the person under 16 years of age has the maturity and intelligence to understand the nature of the treatment, the options, the risks involved and the benefits. The Bill would appear to abrogate section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 for the purposes of assisted dying.

Given the serious and irreversible consequences of the act in contemplation, careful consideration should be given to the age limit specified in the Bill. We note that proposals to date in the Isle of Man, Jersey and England & Wales state that the person seeking assistance must be 18 or over. In England and Wales, a 16 year old's refusal of medical treatment can be overridden if it is considered to be in his or her best interests to do so.[5] However, as the age of legal capacity is 16 years in Scotland the question of whether or not a 16 or 17 year old's refusal of treatment can be overridden, by parents for example, has not come before the Scottish courts.

We have concerns relating to the definition of capacity in Section 3(2) of the Bill.

Section 3(2)(a) proposes that a person has capacity to make a request if the person is not suffering from any mental disorder- defined as in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to include mental illness, learning disability and personality disorder- which "might affect the making of the request". This suggests that people with mental disorders may not have capacity

---

4 Age of Legal Capacity (Scotland) Act 1991: Section 2(4) A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.
5 NHS Trust v X [2020] EWHC 65 (Fam).

to request assisted dying. This is imprecise and could be taken to exclude all people with a mental disorder from being able to make a request, because it is a blanket approach to capacity with regard to mental disorder. We suggest that this may be discriminatory (although see our comments below on application of the Bill to those who are subject to compulsory treatment for mental disorder). We are also concerned that this may create a position where mental disorder is deemed to equate to incapacity, which is not the case.[6]

It is important to note that mental illness is extremely common, much more so than the type of chronic physical condition which we suspect that this Bill is intended to cover, and potentially there may be people with mental illness who would wish to request assisted dying should the Bill become law.

Section 3(2)(b) provides that a person has capacity to request lawfully provided assistance if they are capable of:

(i) understanding information and advice about making the request,

(ii) making a decision to make the request,

(iii) communicating the decision,

(iv) understanding the decision, and

(v) retaining the memory of the decision.

The Adults with Incapacity (Scotland) Act 2000 defines incapacity as being incapable of—

'(a) acting; or

(b) making decisions; or

(c) communicating decisions; or

(d) understanding decisions; or

(e) retaining the memory of decisions,

by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack 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)[7]

---

6 See the comments by the Lord Justice Clerk in the recent case of Chowdhury v General Medical Council (Inner House decision 14 March 2023): "There is a clear flaw at the centre of the appellant's approach in this case. That is that the primary focus has been on the mere diagnosis itself, rather than on the manner in which certain features of the condition affect the appellant in specific ways related to the subject matter, conduct and outcome of the proceedings. The diagnosis itself, and a recital of common characteristics which may be, or even are, found in the appellant does not advance the issue."
7 Adults with Incapacity (Scotland) Act 2000 Section 1(6) http://www.legislation.gov.uk/asp/2000/4/section/1

The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), when deciding if a person has the ability to make decisions about medical treatment, uses[8] the significant impairment of decision making ability ("SIDMA") test- *'...that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired...'*[9]

Section 3(2)(b) appears to use strands from the 2000 Act, in a converse fashion. Section 3(2)(a) makes no reference to the SIDMA test, although refers specifically to mental disorder. Any reference to capacity to make a request within the Bill must be consistent with both the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. The Bill must also be consistent with the state's obligation to ensure provision of support in Article 12.3 of UN CRPD.

We note that the Bill would not specifically exclude persons who are subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) or the Criminal Procedure (Scotland) Act 1995 from making a request for assistance. Before a person can be made subject to a compulsory treatment order, a compulsion order or a compulsion order with a restriction order, a tribunal or a court will have to be satisfied that the statutory tests have been met for the making of the order. A person who is subject to a compulsory treatment order would have to satisfy the significantly impaired decision making ("SIDMA") criterion (see above), whereas those subject to a compulsion order or a compulsion order with a restriction order would not. In either case, where a patient is subject to compulsory measures they will be receiving medical treatment for their mental disorder, the features and characteristics of which may include suicidal ideation. The medical treatment must fit the statutory criterion, *"that medical treatment which would be likely to (i) prevent the mental disorder from worsening; or (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the patient;"* [10]

The medical treatment may result in a reduction or removal of suicidal ideation. It is also noted that not all mental disorders where compulsory treatment is required result in a patient displaying symptoms of suicidal ideation. However, we are of the view that those subject to compulsory measures should be excluded from the definition of those who may make a request for assistance.

8...except where this involves a compulsion order or a compulsion order and restriction order, for which there is no SIDMA test
9 Section 64(5)(d)
10 Section 64(5)(b) of the 2003 Act and section 57A(3)(b) of the Criminal Procedure (Scotland) Act 1995

Question 3 – The Assisted Dying procedure and procedural safeguards

The Bill describes the procedure which would be in place for those wishing to have an assisted death.

It sets out various procedural safeguards, including:

- examination by two doctors
- test of capacity
- test of non-coercion
- two-stage process with period for reflection

Which of the following most closely matches your opinion on the Assisted Dying procedure and the procedural safeguards set out in the Bill?

- I do not agree with the procedure and procedural safeguards because I oppose assisted dying in principle
- The procedure should be strengthened to protect against abuse
- The procedure strikes an appropriate balance
- The procedure should be simplified to minimise delay and distress to those seeking an assisted death
- Other – please provide further detail

If you have further comments, please provide these

The assisted dying procedure and procedural safeguards are set out in Sections 4- 14 of the Bill as introduced, and the accompanying Schedules.

We have concerns regarding the eligibility and particularly exclusion criteria for the 'independent registered medical practitioner' outlined in section 6(6)(b)-(d). With time, there is a possibility that informal reciprocal arrangements may arise if the choice of approved 'independent medical practitioner' is left to the coordinating medical practitioner. A possible further safeguard might be provided for the 'independent medical practitioner' to be allocated at random from a list of these practitioners by a third party, for example, the Health Board to each individual case.

We note that it may be the aim of the Bill not to be too prescriptive in defining terms under the Bill to ensure flexibility in its application. We are concerned at the potential lack of clarity in section 7 around "close to" in relation to section 7(1)(c)(ii) which leaves uncertainty around any balance between family members and wider persons. Similarly in section 7(2)(c) it is not clear what weight is to be given to the opinions which the registered medical practitioner must "take account of".

We note that the schedule would require the relevant practitioners to sign and endorse the forms provided for if they are satisfied that the requirements within the statements have been met. The Bill does not provide for what happens if a

practitioner is not satisfied. Would a medical practitioner record that he or she is not satisfied that, for example, the person has sufficient capacity, or that the practitioner considers undue influence to have been applied - could an assessment of this nature trigger a process to ensure such individuals are protected or supported differently?

We also note that there is no requirement for the relevant practitioner to provide any reasoning or evidence on the form to justify their view that the requirements are met. It is accepted that there may be issues of patient confidentiality but there is no other way to be satisfied that the requirements are met if not included in the form, if there is any challenge to the process.

In dealing with who may witness a first or second declarations, Schedule 5 paragraph 2(g) states that it is a disqualifying relationship for a witness to be '*…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…'* This could create difficulty following the death of the terminally ill adult, where the person who acted as a qualified witness was not aware at the time of the assisted death that they would benefit financially, directly or indirectly, as a result of the assisted person's death but subsequently finds that they do so benefit.

Consideration could be given to safeguards on the face of the Bill to address this issue. For example, Schedule 1 and 3 could be amended to require the witness to acknowledge that they do not expect to be disqualified from acting as a witness in terms of schedule 5. Provision could also be made for the situation that a witness is, or becomes disqualified, a person relying on the document being properly executed is not denied its effect on account of the ignorance or malpractice of the witness or practitioner signing.

Consideration should also be given to whether it is appropriate for someone who will become the adult's executor to be disqualified from acting as a witness.

Section 11 describes the process by which a person may cancel a declaration. While there are schedules for all of the declarations, we note that there is no standard cancellation schedule and that notice to cancel may be given orally or in writing[11]. We suggest that the absence of a standardised schedule may make it more difficult to assess the validity of the cancellation, potentially making it more difficult for a person to ensure they provide the correct information and follow the appropriate process. A cancellation also comes without the safeguards attached to the declarations like an assessment by a practitioner or a witness. We suggest that the current provision may potentially permit a relative (who did not support a person's decision to ask for assistance) to coerce a vulnerable person who had signed declarations to submit a cancellation. We recognise, however, that the ability to give notice orally or in writing provides maximum flexibility and avoids

11 Section 11(2)

creating barriers to cancellation where the terminally ill adult decides that they no-longer wish to proceed.

We suggest, for consistency, clarity and certainty, that a cancellation also operates with a witness and medical practitioner present. Clearly the role of the practitioner would not be to prevent a person from cancelling the declaration just as it would not be to encourage a declaration to be made. However, it would allow for an assessment of capacity and judgment and perhaps indicate where other areas of support might be offered to the person.

We note that the Bill does not incorporate any mechanism for an interested person to seek review by a court of decisions by, for example, one of the medical professionals, similar to sections 3 or 52 of the Adults with Incapacity (Scotland) Act 2000. There may be merit in considering whether such a mechanism is appropriate.

We have specific concerns regarding the provisions of section 12 of the Bill as they relate to solicitors. Whilst solicitors would inevitably be asked to advise their clients on the law relating to assisted dying, the role of solicitors as currently described in the Bill gives rise to uncertainties. The inclusion of solicitors in the Bill may not be appropriate in the particular circumstances. Specifically, the provision in section 12 of the Bill providing for solicitors to act as proxies for a person may be better implemented by a medical practitioner. It would be useful to understand the intention behind section 12 of the Bill. Is there statistical evidence to indicate that the use of a proxy has been identified as a real need?

Section 12, identifies specific categories of individuals as proxies who may sign a document on behalf of a person by reason of physical impairment, being unable to read or for any other reason. Section 12(5) provides that a proxy means (amongst others) *'… a solicitor who has in force a practising certificate as defined in section 4(c) of the Solicitors (Scotland) Act 1980 (c.46)…'* We note that section 12 is derived in substantial form from section 9 of the Requirements of Writing Act 1995[12] (the "1995 Act"), which provides for subscription on behalf of a blind granter or a granter unable to write. However, our concern with section 12 of the Bill is that this requires a solicitor to perform more than a 'notarial' execution. This is because section 12(4) requires the proxy to reach a judgment about the person's understanding of the effect of the document.

A proxy is the authority to represent someone else. Of itself, this function does not give rise to any particular additional duties upon the proxy. The requirements under section 9 of the 1995 Act do not require (nor did it intend) that a proxy undertakes this additional responsibility of ensuring that a person understands the effect of a document to which the proxy is subscribing.

12 Requirements of Writing Act 1995 S9 Subscription on behalf of blind granter or granter unable to write http://www.legislation.gov.uk/ukpga/1995/7/section/9 The 1995 Act repealed in its entirety section 18 of the Conveyancing Scotland Act 1924 relating to notarial execution.

Given the nature of the provision in section 12 of the Bill, it is suggested that it is not appropriate to use the model in section 9 of the 1995 Act. Section 12 of the Bill is of a different character to the intention of section 9 of the 1995 Act which seeks to facilitate execution but does not require a test of understanding.

The introduction of the obligation at section 12(4) of the Bill is an understandable safeguard; however, it introduces additional responsibility upon a proxy to make assessments in relation a person's capacity and understanding. It is submitted that this changes what is primarily a 'notarial' function into something more. It also gives rise to a question as to whether a solicitor is an appropriate individual to perform this function in this context.

While section 12 envisages a physical or other limitation preventing a person from subscribing a document, in fact, the requirement of section 12(4) obliges a solicitor to make an assessment about mental capacity too. We question if all solicitors will be appropriately qualified or experienced to make this decision. We would also suggest that it is extremely likely that a solicitor acting as a proxy would give rise to a solicitor-client relationship between the solicitor and the person. In the event that acting in this capacity does establish a solicitor/client relationship a solicitor requires to exercise and give due regard to the rules of professional conduct and behaviour, recognising that his or her professional obligations are not only to their clients, but to the courts, the legal profession and the public. Amongst other things, these rules regulate:

confidentiality
- trust and personal integrity
- the interest of the client
- independence of the solicitor
- disclosure of interest
- relations with the Courts

conflict of interest

These distinct duties and roles that a solicitor performs are not reflected in the Bill. If the solicitor acting as a proxy gives rise to a solicitor/client relationship it would require clarity around terms of engagement and fees and whether the solicitor is in contract with the person. The Bill envisages the solicitor acting as proxy as performing a role akin to a public officer and not that of an advisor. However, given the requirement in section 12(4) it is not clear how or whether a solicitor can limit their role to that of a "public officer" and not give regard to the professional duties as a solicitor, especially if the person is also a "client". Making a decision about capacity also necessitates a consideration of vulnerability.

Law Society of Scotland Guidance provides that '*...The possibility of vulnerability should be considered whenever a solicitor is consulted or instructed in any matter. Often the solicitor will be able to decide quickly and confidently that there is no*

question of vulnerability; but solicitors should always be alert to any indications of possible vulnerability…'[13]

Furthermore, the Law Society of Scotland Practice Rules 2011 state that a solicitor *'…must only act in those matters where you are competent to do so…'* (Rule B 1.10)[14]. However, solicitors must not discriminate contrary to Rule B 1.15.1. They may accordingly require referring to another solicitor, whose particular skills are required in determining capacity, identifying vulnerability, or in advising and acting for a particular client.

Indications of possible vulnerability may arise from the normal process of ascertaining a client's wishes and intentions, exploring circumstances, and advising as to merits, risks, advantages and disadvantages of a proposed act or transaction, or of alternatives. However, on the one hand an apparently unwise act or transaction may represent a client's valid and competent choice; while conversely an apparently wise act or transaction could be invalid through lack of relevant capacity, or undue influence, or other vitiating factors.

We believe that the nature of assisted dying makes the considerations highlighted above relevant.

Society Guidance in relation to vulnerable clients also advises that a '…*solicitor should not simply rely upon the legal presumption of capacity.'* On the contrary, they *"must …. be satisfied when taking instructions, that the client has the capacity to give instructions in relation to that matter…'*[15]. In cases of doubt as to the extent to which, and circumstances in which, capacity can be exercised, or conversely as to the extent to which incapacity prevents a contemplated act or transaction, the advice of an appropriate professional should be sought. It may be necessary to approach someone with particular specialist expertise. The solicitor should not seek a generalised and simplistic verdict of "capable" or "incapable". The solicitor should explain the act or transaction contemplated and the legal requirements for it to be valid. The solicitor should explain any indications of relevant capacity or incapacity of which the solicitor is aware, and any steps which the solicitor proposes.

Solicitors have a duty to assess capacity in relation to all of their clients regardless of area of law or what the client is contemplating. If a solicitor is not experienced enough or is without the skill or knowledge to be able to assess a person's capacity properly then the solicitor should seek further advice. In normal circumstances, such advice would be sought from a medical practitioner. The guidance demonstrates that where a client with capacity instructs a solicitor to do something which the solicitor has advised against or considers to be unwise, then

---

13 B1.5: Vulnerable Clients Guidance | Law Society of Scotland (lawscot.org.uk), at para 11
14 B1.10: Competence, diligence and appropriate skills | Law Society of Scotland (lawscot.org.uk)

15 https://www.lawscot.org.uk/members/rules-and-guidance/rules-and-guidance/section-b/rule-b1/guidance/b1-5-capacity-generally/

it is not the responsibility of the solicitor to prevent the client from making bad decisions. For example, in a conveyancing transaction where a client instructs a solicitor to sell a house at a value considerably less than the asking price then, provided that he was satisfied the client was clear on what he wanted to do and had assessed the risks, it is not for the solicitor to protect the client from himself. This can be contrasted with the position of assisted dying where the outcome and impact of a decision is far more significant than money you would receive for selling a house. A decision in this context is terminal and irreversible. Conveyancing solicitors understand the property market and can give advice on what the range of options might have been for the client looking to sell the property. However, generally speaking, solicitors will not have experience or understanding of a person facing a terminal illness and seeking to die. The assessment of capacity required in a situation like that goes beyond what the ordinary solicitor might be expected to know and be able to assess. There is such a fundamental presumption for preserving life within our society that it may be very difficult for a solicitor to know or accept that a person has capacity to make such a choice and for a solicitor to be part of that process.

We note in section 12(4) the requirement which amounts to an obligation to certify that the person has relevant capacity, in terms substantially the same as part of the required certification of powers of attorney under Part 2 of the Adults with Incapacity (Scotland) Act 2000. As above, we have concerns around the additional certification needed for those unable to sign due to physical impairment. If there is to be certification equivalent to that for powers of attorney, that should be set out as a separate requirement, there would require to be a certificate in broadly similar form, and the obligation of solicitors regarding capacity would be to certify from their own knowledge or because they have consulted some other person, who is named – the present requirement for powers of attorney. We would recommend a consistent approach in all cases.

It may be more appropriate for the function provided for in section 12 to be performed by individuals other than the professionals identified in the Bill as introduced. With reference to comparative law, under Belgian legislation[16] a person who is permanently incapable of signing a directive can designate a person '…*who is of age and who has no material interest in the death of the person in question, to draft the request in writing…'* provided that there are two witnesses present (of age with no material interest) and the directive explains why the person is incompetent to sign together with a medical certificate. The Act therefore anticipates the possibility of requiring a proxy but does not require the proxy to be a lawyer. In the Netherlands' legislation[17] there is no comparative guidance regarding what can happen where a patient has capacity, but requires a proxy to physically sign a directive on their behalf.

---

16 Belgian Act of Euthanasia 2002, Chapter III, section 4 (1)
17 Termination of Life and Assisted Suicide Act 2002

On the face of it, we would suggest that the Belgian model appears to offer a more secure process by providing checks without the direction to employ a particular professional. Notably Belgium does not require an assessment that the person understands the effect of the document by the proxy. This approach would not preclude solicitors from acting as proxies, but this would not be on the basis of their solicitor status.

Given the above we suggest that the Bill provides for the referral to a medical practitioner or that medical practitioners are substituted as proxies given their position to be better able to assess the necessary capacity that a person requires in relation to assisted dying over solicitors.

We note acceptance by the Scott Review in its Final Report, and the apparent acceptance in principle by Scottish Government in response to the Scott Report, on the appropriateness of introducing a regime of advance choices, under which the competent decision contained in an advance choice document still in force at the time of the granter's subsequent incapacity/disablement would have the status of a competent decision then, unless disapplied in accordance with statutory criteria for disapplication. It seems that prior authorisation to sign as a proxy under section 12, or indeed to execute any document under section 9 of the 1995 Act, would be conferred by appropriate provisions in an advance choice.

We also note sections 12(1) and (2) go further than Section 9 of the 1995 Act with the words 'for any other reason' at the end of section 12(1)(a). Clarity is needed in whether this includes volitional impairment, potentially linked to a requirement for provision of support in terms of Article 12.3 of UN CRPD.

Question 4 – Method of dying

The Bill authorises a medical practitioner or authorised health professional to provide an eligible adult who meets certain conditions with a substance with which the adult can end their own life.

Which of the following most closely matches your opinion on this aspect of the Bill?

- It should remain unlawful to supply people with a substance for the purpose of ending their own life.
- It should become lawful to supply people with a substance for the purpose of ending their own life, as proposed in the Bill
- It should become lawful to supply people with a substance for the purpose of ending their own life, as proposed in the Bill, and it should also be possible for someone else to administer the substance to the adult, where the adult is unable to self-administer.
- Other – please provide further detail

If you have further comments, please provide these:

Sections 15-16 of the Bill provide for the lawful provision of assistance to end life and the final statement by the coordinating registered medical practitioner.

Section 15 implies, but does not expressly provide, that the death must have been as a result of the person's own deliberate act. The Explanatory Notes states at para 42 that "The person must self-administer the substance." If that is the policy intention, we would suggest that this must be made clear on the face of the Bill.

There is no indication as to where the assistance is to be provided under section 15. If this is to be NHS premises then issues may arise as to exercise of functions under the NHS Acts. There may also be concerns expressed should the patient be in a care home or a similar establishment.

We note that under section 15, the approved substance may be provided by an authorised health professional, as defined in section 15(8) as a registered medical practitioner or registered nurse authorised by the coordinating registered medical practitioner. Under section 15(3), the authorised health professional must be satisfied at the time that the substance is provided that the adult has capacity to request the provision of assistance to end their own life, and is requesting provision of that assistance voluntarily and has not been coerced or pressured by any other person into doing so. It appears that the authorised health professional conducting this final check need not have been previously involved in the process and we would question whether this provides a sufficient final safeguard in cases of fluctuating capacity.

Question 5 – Health professionals

The Bill requires the direct involvement of medical practitioners and authorised health professionals in the assisted dying process. It includes a provision allowing individuals to opt out as a matter of conscience.

Which of the following most closely matches your opinion on how the Bill may affect the medical profession? Tick all that apply.

- Medical professionals should not be involved in assisted dying, as their duty is to preserve life, not end it.
- The Bill strikes an appropriate balance by requiring that there are medical practitioners involved, but also allowing those with a conscientious objection to opt out.
- Assisting people to have a "good death" should be recognised as a legitimate role for medical professionals
- Legalising assisted dying risks undermining the doctor-patient relationship
- Other – please provide further detail

If you have further comments, please provide these

We note the provisions at section 18 on conscious objection and the provision as at sections 19 and 20 regarding potential civil and criminal liability. These provisions may be affected by the regulation of the professions reservation referred to at section 22, limiting the effect of these provisions.

Section 18, subsection (2) provides that in any resulting legal proceedings it is for the person claiming a conscientious objection to prove that they are lawfully able to object. The Bill does not mirror the same protection contained in section 4(3) of the Abortion Act 1967, which states that "*In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him."*

An alternative model may be for health professionals to actively opt in to providing lawful assistance under the Bill. This could also allow more effective training and monitoring.

One important issue about which we consider the Bill as it currently stands is not sufficiently clear is how the medication to be provided is to be understood by reference to current medico-legal principles.

Hunter v Hanley and *Bolam v Friern Hospital Management Committee* set out the legal test for establishing negligence by a doctor in diagnosis and treatment. This test is referred to as the "professional practice" test and is whether the doctor acted in accordance with a practice accepted as proper by a responsible body of opinion.

In *Montgomery v Lanarkshire Health Board*, the central issue was the distinction between the doctor exercising professional judgment to determine a patient's treatment options, risks and benefits and the patient's right to make an informed decision on which treatment they were willing to accept.

The UK Supreme Court decided that the professional practice test did not apply to a doctor's advisory role in "*discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved*". Doctors are *"under a duty to take reasonable care to ensure that a patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."*

In *McCulloch v Forth Valley Health Board*, the family of the deceased, who died after being treated in hospital for suspected pericarditis and pericardial effusion, appealed against the Inner House's decision upholding the Lord Ordinary's decision that the cardiologist's negligence hadn't caused the deceased's death.

The appellants alleged that the cardiologist should have advised the deceased of the treatment option of the non-steroidal anti-inflammatory drug (NSAID). If she had, the deceased would have taken the drug and survived. The cardiologist did

not prescribe the NSAID because she did not, in her professional opinion, regard it as appropriate to do so. The deceased was not in pain, and there was no clear diagnosis of pericarditis.

The appellants argued that the Health Board's duty to take reasonable care to ensure the patient was aware "of any reasonable alternative or variant treatments" meant all such treatments. It was for the court to determine what constituted a reasonable alternative or variant treatment option.

Lord Boyd had previously considered whether *Hunter v. Hanley* was the correct legal test for deciding what constituted a reasonable alternative treatment in *AH v Greater Glasgow Health Board* [2018] CSOH 57 and held that a doctor was under no duty to discuss a course of treatment they did not consider reasonable.

Meanwhile, south of the border, in *Duce v Worcestershire Acute Hospitals NHS Trust [2018*] *EWCA Civ 1307*, the court rejected the argument that allowing (*Bolam*) professional judgment to dictate what is (or is not) a reasonable alternative treatment undermined patient autonomy.

The BMA and GMC, as interveners in *McCulloch*, emphasised the importance of clinical judgment in determining a reasonable alternative treatment option to avoid doctors practising defensive medicine and overwhelming the patient.

The Supreme Court, endorsing Lord Boyd's approach, concluded that the correct legal test to be applied is the professional practice test found in *Hunter v Hanley* and *Bolam*. In explaining its reasoning, the court provided a hypothetical example where a patient may have ten possible treatment options, but their doctor thinks only four are reasonable. The doctor is not negligent by failing to inform the patient about the other six, even though they are possible alternative treatments. Narrowing the possible alternatives to reasonable alternatives is an exercise of clinical judgment.

That said, doctors are not entitled to narrow the reasonable alternative treatment options to their preferred treatments. Under *McCulloch*, a doctor who concludes that a particular treatment is reasonable is bound to discuss it with their patient even if they would advise taking a different approach. The doctor's duty of care, in line with *Montgomery*, is to inform the patient of all reasonable treatment options by applying the professional practice test (J.P.I. Law C223).

Under *McCulloch*, the doctor applies clinical judgment to diagnose and determine a patient's prognosis and then presents the patient with reasonable treatment options. This means that it becomes important to understand whether assisted dying is a ‘reasonable treatment option.’ Views may well vary upon this, and it would certainly not appear clear to us that the medical profession as a whole currently consider that this is the case. It is not immediately obvious whether by legalising assistance with dying the administration of lethal medication is:

- Being said as a matter of law to become a reasonable treatment option, a course of action which would be unusual in circumstances where the courts

have traditionally left it to the medical profession to identify what constitutes a reasonable option to respond to patients' needs.
- Simply being identified as something which is not unlawful.

Clarity on this matter is required, because it will make a considerable difference, inter alia as to:

- Whether the operation of *McCullloch* would **require** the doctor to bring up the question of the provision of assistance and, conversely, whether a failure to do so would render the doctor liable in negligence.
- The ability of the doctor to refuse to provide assistance with dying. If it is has been deemed by the state to be a reasonable treatment option, then the ability of a doctor not to provide it is limited (over and above the separate issue with conscientious objection provisions addressed below), because, by definition, they would be declining to put forward a reasonable treatment option.
- The obligation on the state to secure access to assistance with dying. If it has been deemed to be a reasonable treatment option, then the consequence is that the state should ensure it is available.

We consider that it is of considerable importance that the Bill is clear on all of these matters, rather than leaving them to be resolved in the courts.

Section 18 of the Bill provides that no one, including any individual health professional, is under any legal duty to play an active, participatory role in anything authorised. Since regulating the medical profession is reserved, the Scottish Parliament can only legislate for conscience rights with express authority under the 1998 Act, which (so far) does not appear to be granted (see our comments above in relation to legislative competence).

Therefore, in its current form, we would question whether section 18 would protect a healthcare provider against litigation for failing to advise a patient of the reasonable treatment option of assisted dying or, indeed, refusing to participate in providing a patient with the means to end their life.

Question 6 – Death certification

If a person underwent an assisted death, the Bill would require their underlying terminal illness to be recorded as the cause of death on their death certificate, rather than the substance that they took to end their life.

Which of the following most closely matches your opinion on recording the cause of death?

- I do not support this approach because it is important that the cause of death information is recorded accurately

- I support this approach because this will help to avoid potential stigma associated with assisted death
- Other – please provide further detail

If you have further comments, please provide these

Section 17 of the Bill as introduced makes provisions regarding death certification.

We have no specific comments.

Question 7 – Reporting and review requirements

The Bill proposes that data on first and second declarations, and cancellations, will be recorded and form part of the person's medical record.

It also proposes that Public Health Scotland should collect data on; requests for assisted dying, how many people requesting assisted dying were eligible, how many were refused and why, how many did not proceed and why, and how many assisted deaths took place.

Public Health Scotland would have to report on this anonymised data annually and a report would be laid before the Scottish Parliament.

The Scottish Government must review the operation of the legislation within five years and lay a report before the Scottish Parliament within six months of the end of the review period.

Which of the following most closely matches your opinion on the reporting and review requirements set out in the Bill?

- The reporting and review requirements should be extended to increase transparency
- The reporting and review requirements set out in the Bill are broadly appropriate
- The reporting and review requirements seem excessive and would place an undue burden on frontline services
- Other – please provide further detail

If you have further comments, please provide these

Sections 24-27 of the Bill as introduced make provision for reporting and review. Given the need for robust legal and institutional safeguards to ensure compliance with Article 2 ECHR (see our comments at question 8, below), we note that the Bill doesn't appear to provide oversight provisions beyond collection and reporting of data. We understand that some countries have review boards and review committee to provide oversight- especially when the death certificate will only record the terminal illness and won't disclose an assisted death. It may be appropriate for consideration to be given to strengthening oversight measures.

We note that section 27 makes provision for reviews of the operation of the Act. The Bill as introduced would require review after 5 years. We consider that this is quite a long period, and in light of the potential human rights implications a shorter review period may be appropriate. Bearing in mind the sensitivity of this legislation it may be appropriate to consider the application of a formal sunset clause to allow the Parliament to review the legislation in the future.

Question 8 - Any other comments on the Bill

Do you have any other comments in relation to the Bill?

Legislative competence

At the outset, consideration needs to be given as to whether the Bill itself is competent under the Scotland Act 1998 ("the 1998 Act"). The Presiding Officer and Liam McArthur MSP, the member in charge of the Bill, have given statements[18], that in their view, the Bill would be within the legislative competence of the Scottish Parliament. They have, however, not given reasons for their view.

Section 29 of the 1998 Act prevents any Act of the Scottish Parliament becoming law if it is outside of the legislative competence of the Parliament. An act will be outside of competence if, amongst other things, *'it is incompatible with any of the Convention rights ...'*[19].

The Bill may raise potential issues in relation to Article 2 of the *European Convention on Human Rights*, which protects the right to life[20]. The European Court of Human Rights has made clear that there is no right to assisted dying (see most recently *Karzai v Hungary* (application no. 32312/23, decision of 13 June 2024), albeit that member states of the Council of Europe are not prohibited by Article 2 ECHR for having legal systems within which assisted dying is legal. To be compatible with Article 2, the court has also held[21] any system must be accompanied by the provision of suitable and sufficient safeguards to prevent abuse and thus ensure respect for the right to life. There must be robust legal and institutional safeguards to ensure that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patient, with a view to protecting patients from pressure and abuse.[22]

Section 29 of the 1998 Act also provides that a provision is outside competence so far as it relates to reserved matters. There are concerns whether provisions in the Bill might be argued to be out with competence as they relate to reserved

---

18 https://www.parliament.scot/bills-and-laws/bills/assisted-dying-for-terminally-ill-adults-scotland-bill/introduced#topOfNav
19 Ibid Section 29(2)(d)
20 European Convention on Human Rights Article 2 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law'
21 Mortier v Belgium (application no. 78017/17, decision of 4 October 2022.
22 As per the safeguards in Article 12.4 of UN CRPD.

matters of the regulations of the professions, misuse of drugs or medicines, however, these matters would ultimately be for the court to decide. It is recognised in the Policy Memorandum of the Bill[23] that an order under Section 30 of the 1998 Act or similar would be required to achieve a truly comprehensive assisted dying scheme. In our view, the possibility of such an order should not be used as a basis for stating that the Bill is at present within legislative competence.

Section 22 of the Bill, which provides that provisions of the Bill which relate to reserved matters are of no effect, raises questions of whether this would be an acceptable way of ensuring that the provisions within the Bill are within the legislative competence of the Scottish Parliament. Section 22 does no more than re-state what section 29 of the Scotland Act already provides. It uses a similar drafting technique to the one used in the UNCRC case (2021 UKSC 42)[24] which criticised and disapproved of leaving it to the courts to interpret the provisions of a Bill in such a way as to bring them within legislative competence.

Whilst we do not seek to express a view on the legislative competence of the Bill, we would recommend that these issues are considered carefully during parliamentary scrutiny.

Professional Standards and Obligations

The Bill gives rise to a tension by overlooking the professional obligations and standards which have already been imposed on the medical and legal professionals being asked to help in this process. There is a challenge in treating the process as a dignified, but still primarily a process driven, procedure. This is because the nature of assisted dying and the acute impact of the proposed legislation also necessitates judgment, assessment, and in many cases an element of ethical analysis by the professionals involved in the process. While not accounted for specifically in the Bill, these additional elements cannot be removed from the process as long as these professionals are embedded in the process.

It is this juxtaposition between process and professional judgment that creates a tension in the Bill since the professional obligations and standards that medical practitioners and solicitors require to apply are not displaced by the requirements made of them in the Bill.

Delegated powers

We note the powers under section 31(2) which amount to Henry VIII powers[25] and it is not clear to us why such powers would be necessary in this legislation, beyond the expected amending powers found at section 31(1).

---

23 Policy Memorandum, paras 8-10
24 2021 UKSC 42, at paras 60-79
25 Henry VIII powers are delegated powers which allow Ministers to amend primary legislation.

For further information, please contact:

Terri Cairns
Policy Team
Law Society of Scotland
DD: 0131 476 8172
terricairns@lawscot.org.uk