

## **Correspondence 01 (email + letter)**

### ***Email***

From: **[redacted S.38(1)(b)]**  
Sent: 29 August 2025 15:17  
To: Cabinet Secretary for Health & Social Care 2024  
Cc: Alison Strath  
Subject: Letter from Royal Pharmaceutical Society on Assisted Dying for Terminally Ill Adults (Scotland) Bill

Dear Cabinet Secretary

Attached is a letter on the Assisted Dying for Terminally Ill Adults (Scotland) Bill, from **[redacted S.38(1)(b)]** Royal Pharmaceutical Society.

Yours sincerely

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**  
Royal Pharmaceutical Society  
Direct: **[redacted S.38(1)(b)]** | Email: **[redacted S.38(1)(b)]**  
44 Melville Street, Edinburgh, EH3 7HF  
www.rpharms.com

### ***Letter***

29 August 2025  
Sent via email to: CabSecHSC@gov.scot  
Dear Cabinet Secretary

## **RE: Assisted Dying for Terminally Ill Adults (Scotland) Bill**

As the professional leadership body for pharmacists in Scotland and the rest of Great Britain, Royal Pharmaceutical Society (RPS) in Scotland is taking a very active interest in the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

RPS has supported the Bill development process by providing written evidence to the Scottish Government consultation on assisted dying, providing oral evidence to the Health, Social Care and Sport Committee and engaging with key stakeholders, including lawyers, to understand what the Bill as drafted may mean for pharmacists and other healthcare professionals if implemented into practice.

RPS is neutral on the principle of assisted dying, however, we are not neutral on the process. Our priority throughout the Bill's development process has been to ensure that every pharmacist can either take part, or not take part, in the process, according to their individual moral, religious and/or ethical considerations.

As our written evidence to Scottish Government, and oral evidence to the Health Committee made clear, we are of the view that the Bill as drafted would not provide

pharmacists with the protections necessary to allow them to conscientiously object to providing assisted dying care.

This is the case because:

- The conscientious objection clause in the Bill as drafted is limited to the activities described within the Bill. Many of the processes which pharmacy teams would be expected to be involved in such as assembly and dispensing of medication are not explicitly covered within the Bill, meaning that there would be no automatic right for pharmacists to object to these tasks.
- There is a reference in the draft Bill to the 'burden of proof' resting on the individual. We do not understand why there would be any need for a burden of proof if the right to conscientious objection for all healthcare professionals exists in the first place.

There is legal ambiguity about whether The Scottish Parliament has the authority under the Scotland Act 1998 to legislate for conscientious objection for healthcare professionals. Some legal experts, such as Dr Mary Neal, have argued that this is reserved to Westminster as this constitutes 'Professional Regulation'.  
[<https://www.strath.ac.uk/humanities/lawschool/blog/protectionforconscienceintheassisteddyingforterminallyilladultsscotlandbill/>]

We are also very concerned that the Bill makes no reference to the substance which would be used in any process, nor the processes which would surround this to ensure the best patient care, safety and experience.

As experts in medicines, pharmacists would have a critical role to play in such a process, but without this being noted in the Bill, it is difficult for us to be able to advocate for this effectively.

Again, we believe that the omission here is because the Medicines Act 1968, which provides the framework for a discussion on this issue, is reserved to Westminster. This means that, unlike in the Westminster Bill, there can be no references to medicine in the Holyrood legislation, which is highly problematic and prevents the necessary robust discussion on this during the Bill's development process.

In order that the Bill is comprehensive, allowing for detailed discussion and debate on both conscientious objection and the substance which would be used in the process, together with the process which would govern this, RPS is of the view that it is essential that a Section 30 order is sought by Scottish Government. This would provide Holyrood with the necessary powers to include these aspects in the Bill and debate them properly. Without this, there is a clear risk that pharmacists and other healthcare professionals will not be able to exercise their intended rights to conscientious objection, and that the legislative framework surrounding the substance and intended process is not specified enough in the legislation to support any implementation in a clear, safe and effective manner.

Our understanding of the Section 30 process is that only Scottish Government can make this request to Westminster. We are extremely concerned that we have not heard anything about this happening. Furthermore, with this legislation needing to

have passed third reading by May 2026, time for this request to be made and enacted is quickly running out.

I would be extremely grateful if you could let me know:

- Is it the Scottish Government's intention to ask Westminster for a Section 30 order, or has one already been sought?
- If this is the intention, would this Section 30
  - Include professional regulation for healthcare professionals as detailed in the Scotland Act 1998, to allow legislation to be created in the area of conscientious objection?
  - Include necessary powers under the Medicines Act 1968, to allow legislation to be created covering the substance and process around this?
- What are the timescales, both for a formal request being made, and when can we expect a response?

I would also be very interested to hear, if a Section 30 is not being sought, why this is the case, and what, in the Scottish Government's view will be the impact of this legislation being debated and voted on without a Section 30 being in place particularly as Scottish Government have previously advised that the Bill is out with the scope of the Scottish Parliament.

Yours sincerely

**[redacted S.38(1)(b)]**

**[redacted S.38(1)(b)]**

Royal Pharmaceutical Society

CC: Alison Strath, Chief Pharmaceutical Officer, Scottish Government

---

## Correspondence 02 (email + 2 attachments)

### Email

From: [redacted S.38(1)(b)]

Sent: 02 September 2025 16:56

To: Minto J (Jenni), MSP <Jenni.Minto.MSP@Parliament.scot>

Subject: Legal Advice on Assisted Dying for Terminally Ill Adults (Scotland) Bill

CAUTION: *This e-mail originated from outside of The Scottish Parliament. Do not click links or open attachments unless you recognise the sender and know the content is safe.*

Dear Mrs Minto,

Legal advice on the Assisted Dying for Terminally Ill Adults (Scotland) Bill

I want to share with you [redacted S.38(1)(b)] and [redacted S.38(1)(b)] legal assessment of whether the Assisted Dying for Terminally Ill Adults (Scotland) Bill is compatible with the European Convention on Human Rights (ECHR).

In their legal opinion for The Christian Institute, they conclude that “because, without justification, it contains no adequate safeguard protecting the position of those with disabilities where suicidal ideation is more likely, and who are, because of that feature of their disability, more likely to express a wish to die”, the Bill “would not be compatible” with the ECHR. In particular, they believe it would be a breach of Article 14, which prohibits discrimination.

Please find attached:

1. The full legal opinion
2. Summary extracts from the opinion

Yours sincerely,

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]



[redacted S.38(1)(b)]

### Attachment 1

IN THE MATTER OF THE ASSISTED DYING FOR TERMINALLY ILL ADULTS  
(SCOTLAND) BILL

## OPINION

---

### 25. A. INTRODUCTION AND SUMMARY

1. We are asked to advise on whether, if it were enacted in its present form, the Assisted Dying for Terminally Ill Adults (Scotland) Bill (“the **Bill**”) would be compatible with the European Convention on Human Rights (“the **ECHR**”).

2. In summary, our view is that it would not be compatible. That is because, without justification, it contains no adequate safeguard protecting the position of those with disabilities where suicidal ideation is more likely, and who are, because of that feature of their disability, more likely to express a wish to die. By virtue of Article 14 of the ECHR, disabled persons enjoy special protection from discrimination, including in the enjoyment of the right to life under Article 2 of the ECHR. In law, “*very weighty reasons*” may be required to justify the same. Persons with disabilities of the above sort are in a significantly different situation from persons who do not have such disabilities, because they are - all else being equal - more likely to express the wish to die required under the legislation to be eligible to be assisted to die. They are on that basis more vulnerable both than persons whose disabilities are not of that sort and than persons who are not disabled at all. Accordingly, they are on well-established principles required to be treated differently under Article 14 unless there is justification not to do so. However, without justification, the legislation fails to provide any adequate safeguard to address that greater vulnerability.

3. In our opinion, this failure to treat these different cases differently in the enjoyment of the right to life is in breach of the ECHR. We consider that, on that basis, an application for judicial review in respect of the legislation once enacted could result in a declaration that it is “*not law*” for the purposes of section 29(1) of the Scotland Act 1998 (“the **Scotland Act**”).

4. We explain the reasons for this view in more detail below, structuring matters as follows. In section B, we explain the significance of the ECHR in relation to legislation of the present sort. In section C, we identify the relevant principles concerning the right to life as they have been identified in the case law of the ECtHR. In section D, we explain

Article 14, and its relationship to Article 2. In section E, we apply those principles to the legislation at issue and set out why we consider that, if enacted, it would not be Convention-compliant. At Section F, we make concluding remarks.

## 26. **B. THE SIGNIFICANCE OF THE ECHR**

5. The ECHR guarantees rights and freedoms to citizens who live in one of the States that is a party to it. For present purposes, the three most important rights are as follows.

6. First, Article 2 (the right to life). This provides: “*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 the penalty is provided by law*”. Article 2 is an absolute right; that is to say it can never be interfered with by the State even if the State considers such interference justified.

7. Secondly, Article 8 (the right to respect for private and family life). The basic right is that “*Everyone has the right to respect for his private and family life, his home and his correspondence.*” This right is not absolute and can be interfered with in certain circumstances. It is this right, broadly characterised by reference to personal autonomy, upon which proponents of assisted suicide principally rely.

8. Thirdly, Article 14 (the prohibition on discrimination in the enjoyment of rights). This provides: “*The enjoyment of the rights and freedoms set forth in the European Convention on Human Rights and the Human Rights Act shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*”. Article 14 is ‘parasitic’ on other Convention rights: it arises only in connection with the enjoyment of such other rights. It is important to understand that, for Article 14 to be applicable, it is not necessary for a State measure to interfere with, far less breach, a Convention right. We explain this as it relates more particularly to Article 2 below.

9. The ECHR has been made a part of UK domestic law by way of the Human Rights Act 1998 (“the HRA”). Where an Act of the Westminster Parliament is incompatible with the ECHR the UK courts are able to issue a “*declaration of incompatibility*” under section 4 of

the HRA. A court may do so where the “*court is satisfied that the provision is incompatible with [an ECHR] right.*”<sup>1</sup>

---

However, when legislation is passed by the Scottish Parliament a court is able to go further, and declare it “*not law*” if it is incompatible with any of the ECHR rights.<sup>2</sup> In effect this means that, unlike in the case of a Westminster Act, the courts have the ability to “*strike down*” a Scottish Act if it does not comply with the ECHR.

10. We understand that the Bill is currently at Stage 2 of the legislative process, and that Members of the Scottish Parliament (“**MSPs**”) are able to table amendments to the Bill. At the end of the Stage 1 process, the Health, Social Care and Sport Committee produced a report on the Bill and highlighted some potential legal and human rights risks:<sup>3</sup>

(a) The Law Society expressed concerns over the Bill’s compliance with the ECHR, in particular the lack of oversight provisions: “*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 committees 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.*”<sup>4</sup>

(b) Those witnesses representing disabled people’s organisations who gave oral evidence to the Committee were “*strongly of the view that the provisions in the Bill as introduced represented a direct threat to disabled people’s rights.*”<sup>5</sup>

11. We go on to address the lack of substantive safeguards in respect of specific categories of disabled persons further below.

---

1 Section 4(2) of the HRA.

2 Section 29(2)(d) of the Scotland Act. As was the case in *The Christian Institute and others v The Lord Advocate (Scotland)* [2016] UKSC 51.

3 Paragraphs 117 to 144 of Stage 1 Report: Assisted Dying for Terminally Ill Adults (Scotland) Bill, Published 30 April 2025, SP Paper 770, 2<sup>nd</sup> Report, 2025 (Session 6)

<sup>4</sup> *Ibid.* at paragraph 136. <sup>5</sup>

*Ibid.* at paragraph 126.

## 27. C. THE RIGHT TO LIFE

12. Over the last twenty years, cases concerning the compatibility of assisted suicide with the ECHR have received judicial consideration to some extent. Some have concerned blanket bans on assisted suicide (including in the UK<sup>4</sup>). Others have concerned challenges to regimes in which some form of assisted suicide is lawful. The following central principles emerge:

---

(a) The right to life under Article 2 does not include a right to death: *Pretty v United Kingdom* ((2002) 35 E.H.R.R. 1) at para 40.<sup>5</sup>

(b) The State is required to protect vulnerable individuals, including against actions by which they endanger their own lives: *Haas v Switzerland* (2011) 53 E.H.R.R. 33 at para 54. The applicant in *Haas* was a man who suffered from a chronic bipolar disorder and who wanted to use particular drugs to end his own life in the way he wanted. He had been denied access to those drugs because he did not have a prescription. In finding that there had been no violation of Mr Haas' Article 8 rights, at para 54 the Court held: "*In the Court's view, that last provision obliges the national authorities to prevent an individual from ending his life if his decision is not freely made in full knowledge of the facts.*" It further held at para 56: "the requirement of a medical prescription *and to prevent abuse, in particular, to prevent a patient incapable of making up his own mind from obtaining a fatal dose...*".

(c) Article 2 does not prohibit, in general, the conditional decriminalisation of euthanasia. However, where assisted suicide has been decriminalised, it must be accompanied by appropriate and sufficient safeguards to secure respect for the right to life as well as to prevent abuse: *Mortier v Belgium* (Application no. 78017/17) dated 4 October 2022 ("*Mortier*") at paras 137 – 139.

13. In *Mortier*, the ECtHR was concerned with assessing whether adequate safeguards had been put in place for the purpose of an allegation of breach of Article 2 on the facts of a specific case of euthanasia. It made clear that, among other matters, there must exist in domestic law and practice a legislative framework concerning acts prior to euthanasia, as well as controls based on experience offering all the guarantees required by Article 2: see para 141.

14. Referring to the United Nations Human Rights Committee<sup>6</sup>, the ECtHR observed at para 139:

*“euthanasia does not in itself constitute an interference with the right to life if it is accompanied by robust legal and institutional safeguards to ensure that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patient...”*

---

15. Certain further features of the cases to date should be noted:

(a) Whilst relatively detailed consideration has been given over the years to the permissibility of a blanket ban on assisted suicide, the legalisation of assisted suicide, and the question of what is required by way of safeguards including to protect the most vulnerable, have received much less detailed judicial consideration. This no doubt reflects in part that very few Council of Europe States have legalised assisted suicide. As noted in Haas at para 55 *“the Benelux countries in particular have decriminalised the act of assisting suicide, but only in well-defined circumstances. Certain other countries only allow “passive” acts of assistance. The vast majority of Member States, however, appear to place more weight on the protection of an individual’s life than on the right to end one’s life”*.

(b) There has been no decided case concerning whether a State’s legalisation of assisted suicide has been discriminatory under Article 14 ECHR<sup>7</sup>.

---

4 Where there is a prohibition on assisting suicide, the State is required to provide sufficient guidance as to when such an individual will be prosecuted in order to ensure that there is no unjustified interference with the right to respect for private life (under Article 8): see esp. *R (Purdy) v Director of Public Prosecutions* [2009] UKHL 45.

5 That application was brought by a person suffering from motor neurone disease who wanted her husband to assist her to die. She sought an undertaking from the Director of Public Prosecutions (“the DPP”) in England and Wales that her husband would not be prosecuted for his assistance. She argued, unsuccessfully, that the DPP’s refusal was an infringement of her rights under the ECHR.

6 The United Nations Human Rights Committee (HRC) General Comment No. 36 (2019) on right to life (3 September 2019, CCPR/C/GC/36)

7 In *Pretty and Karsai v Hungary* (Application no. 32312) dated 13 June 2024 the ECtHR briefly considered Article 14 (see paras 87-90 and paras 173-177 respectively), but in neither case did it address the question of the appropriate approach to discrimination cases. Each of those cases concerned alleged discrimination in the applicants’ inability to access assisted suicide, rather than a challenge to the legalisation of assisted suicide.

(c) It follows that the ECtHR has not addressed the proper approach to the concept of “margin of appreciation” in a discrimination case. It has certainly observed that issues involving medically assisted suicide involve sensitive moral and ethical questions on which opinions in democratic countries profoundly differ, leading it to permit States a wide margin of appreciation in a number of the cases before it: see e.g. *Nicklinson and Lamb v UK* (2015) 61 E.H.R.R. SE7 at para 84; *Haas v France* at para 55; *Karsai v Hungary* (Application no. 32312) dated 13 June 2024 at para 144. Discrimination cases, however, raise a particular problem. In such cases, where there is prima facie discrimination, the State must account for its differential treatment of certain groups (or, as in a case such as the present, its failure to treat groups in different situations differently). It is in that context that, for present purposes, the applicable margin of appreciation falls to be understood and applied.

## 28. D. NON-DISCRIMINATION (ARTICLE 14)

16. As set out above, Article 14 imposes an obligation on States to ensure that the rights and freedoms guaranteed by the ECHR are “*secured without discrimination.*” As a result, Article 14 is parasitic upon the rights and freedoms established in the ECHR.

---

17. It is engaged when the discrimination comes within the “*ambit*” of one of the substantive Articles, including Article 2. The scope of whether something comes within the “*ambit*” of the substantive rights has been construed very broadly. Anything that touches upon the rights enshrined in the ECHR can be within its ambit. In *EB v France* (2008) 47 EHRR 21 at para 48 the ECtHR held:

*“The prohibition of discrimination enshrined in article 14 thus extends beyond the enjoyment of the rights and freedoms which the Convention and the Protocols thereto require each state to guarantee. It applies also to those additional rights, falling within the general scope of any Convention article, for which the state has voluntarily decided to provide.”*

18. Article 14 lists a series of ‘statuses’ on the ground of which unjustified discrimination is forbidden. The ECtHR has interpreted the concept of ‘status’ broadly. The Courts have consistently held that a “status” includes having a disability (see *Çam v*

*Turkey* (Application no. 51500/08), 23 February 2016 at para 55: “*The Court reiterates that it has already held that the scope of Article 14 includes discrimination based on disability*”).

19. Discrimination under Article 14 does not only relate to a failure to treat everyone in the same way. The ECtHR has also made clear that there will be occasions where the State is obliged to treat different groups differently because of “*factual inequalities*” between them. In *DH v Czech Republic* (2008) 47 E.H.R.R. 3 at para 175 the Grand Chamber of the ECtHR held:

*“Art.14 does not prohibit a Member State from treating groups differently in order to correct “factual inequalities” between them; indeed in certain circumstances a failure to attempt to correct inequality through different treatment may in itself give rise to a breach of the Article. The Court has also accepted that a general policy or measure that has disproportionately prejudicial effects on a particular group may be considered discriminatory notwithstanding that it is not specifically aimed at that group, and that discrimination potentially contrary to the Convention may result from a de facto situation.”*

20. Discrimination by way of failure to attempt to correct inequality is often referred to as “*Thlimmenos*” discrimination, after the case *Thlimmenos v Greece* (2001) 31 E.H.R.R. 15. In *Thlimmenos*, the applicant was a Jehovah’s witness who was prohibited from being appointed as an accountant because of a criminal conviction. His conviction was for refusing to enlist in the army for religious reasons. Greece’s laws did not distinguish between those who had a criminal conviction on the basis of their religious beliefs, and those who had convictions on other grounds. As a result of this failure to treat these situations differently the ECtHR held that there had been a violation of Article 14 read with Article 9 (the right to religious freedom).

21. Where there is a prima facie case of discrimination, the burden of proof then shifts to the State to justify its actions. It is necessary to ask whether there is an “*objective and reasonable justification*” for a difference in treatment, judged by whether the measure pursues a “*legitimate aim*” and there is a “*reasonable relationship of proportionality*” between the aim and the means employed to realise it: (*see Ramussen v Denmark* (1984) 7 EHRR 371 at para 38; *X v Austria* (2013) 57 EHRR 14 at para 98). In relation to the HRA, Lord Reed for the UK Supreme Court in *Bank Mellat v HM Treasury (No 2)* [2014] AC 700 framed this exercise by reference to four questions, at para 74:

*“(1) whether the objective of the measure is sufficiently important to justify the limitation of a protected right,*

*(2) whether the measure is rationally connected to the objective,*

*(3) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective, and*

*(4) whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter.”*

22. In performing this exercise, the Courts afford the State a form of leeway which is conceptualised in slightly different ways. The ECtHR affords a “*margin of appreciation*” (see for example *Glor v Switzerland* (Application no. 13444/04), 30 April 2009, at para 74). In domestic law, the Courts afford what is usually called “*latitude*” to Parliament in assessing whether its actions are justified (see for example Lord Reed in *R (SC) v Secretary of State for Work and Pensions* [2022] AC 223 (“**SC**”) at paras 97 to 117).

23. In cases of disability discrimination, the latitude afforded or the margin of appreciation allowed is comparatively limited. Disability has been categorised as a “*suspect ground*” which requires “*very weighty reasons*” to justify a difference in treatment. As the ECtHR observed in *Kiss v Hungary* (2013) 56 E.H.R.R. 38 at para 42 where the discrimination relates to a “*particularly vulnerable group in society ... such as the mentally disabled, then the state's margin of appreciation is substantially narrower and it must have very weighty reasons*” for that treatment.

24. Further, the latitude or margin to be afforded to Parliament is narrowed where Parliament has not specifically considered the matter in question. Parliament's consideration of a particular issue may be a relevant factor in assessing compatibility. In *SC*, Lord Reed said at para 182:

*“It is of course true that the relevant question, when considering the compatibility of legislation with Convention rights, is not whether Parliament considered that issue before making the legislation in question, but whether the legislation actually results in a violation of Convention rights. In order to decide that question, however, the courts usually need to decide whether the legislation strikes a reasonable balance between competing interests, or, where the legislation is challenged as discriminatory, whether the difference in treatment has a reasonable justification.*

*If it can be inferred that Parliament formed a judgment that the legislation was appropriate notwithstanding its potential impact upon interests protected by Convention rights, then that may be a relevant factor in the court's assessment, because of the respect which the court will accord to the view of the legislature. If, on the other hand, there is no indication that the issue was considered by Parliament, then that factor will be absent. That absence will not count against upholding the compatibility of the measure: the courts will simply have to consider the issue without that factor being present, but nevertheless paying appropriate respect to the will of Parliament as expressed in the legislation.”*

## 29. E. APPLICATION TO THE BILL

30. In simple terms, the Bill provides for a person to be eligible for assisted suicide<sup>8</sup> through following the steps set out in Clauses 4 to 15. Expressed shortly, those steps principally include (1) a request for assistance and making of a first declaration (Clauses 4 and 5); (2) a first doctors’ assessment (Clauses 6 to 9); (3) the making of a second declaration (Clause 10); and (4) the provision of assistance to end life by the coordinating doctor by provision of an approved substance where the conditions of Clause 15(2) and (3) are met.

31. The core conditions that must be met in order for a person to qualify are:

(a) **Terminal illness** – which is drawn in broad terms under Clause 2: *“For the purposes of this Act, a person is terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death.”*<sup>9</sup>

(b) **Connection to Scotland** – the person must have been registered at a medical practice in Scotland and have been resident in Scotland for at least 12 months before the first declaration was made (Clause 3(1)(a) and (b)).

---

8 Unlike in England and Wales, there is no specific criminalisation of assisted suicide in Scotland. However, as highlighted by the Stage 1 report at paragraph 39, someone assisting in another’s suicide can be prosecuted for other offences such as murder or culpable homicide.

9 This contrasts with the equivalent Bill in Westminster which requires a prognosis of less than 6 months to live.

(c) **Voluntary request** – the coordinating doctor must be satisfied that the wish to end one’s own life has not been made as a result of coercion or pressure by another person (as ascertained at the various stages and as a condition for administering the approved substance:

see Clause 15(3)).

(d) **Capacity** – the person must have mental capacity to make the request for assistance in that

- (i) they are not suffering from a mental disorder which might affect the making of the request (Clause 3(2)(a)); and (ii) they are able to understand, make, communicate and remember the making of the request (Clause 3(2)(b)).

(together, (a), (b), (c) and (d) are the “**Core Conditions**”)

32. In terms of safeguards:

(a) **Further specialist medical help.** The Bill enables a doctor engaging in an assessment under Clause 6 to refer the person to a specialist in respect of (i) whether they are terminally ill (Clause 7(2)(a)); or (ii) whether they have capacity to request assistance to end their own life (assessed by a registered psychiatrist, Clause 7(2)(b)).

(b) **Reporting obligations.** The Bill contains various reporting obligations to monitor the process and effect of the Bill:

- (i) **Provision of information by Public Health Scotland to Scottish Ministers.** Under Clause 24 Public Health Scotland is to provide information about those who have sought assistance to die to Scottish Ministers.<sup>10</sup> This is to be done on a yearly basis (Clause 24(6)). This information is to be broken down by characteristics under Clause 24(3). This list includes post code, age group, gender, ethnicity, nationality and type of terminal illness. At the moment the Bill does not require reference to disability, but it is possible for this to be added under Clause 24(5).

---

<sup>10</sup> Regulations are to be made for the purpose of gathering that information under Clause 25.

(ii) **Annual report.** The Scottish Ministers are to publish a yearly report on the provision of assisted dying, which is to be laid before Parliament (Clause 26).

(iii) **Review of operation of the Bill.** Five years after the passing of the Bill, the Scottish Ministers are to write a report on the operation of the Bill (Clause 27).

---

33. As highlighted by the Law Society above, the vast majority of safeguards in this Bill are monitoring and reporting obligations.

34. We consider that the Bill contains a major omission in relation to the position of the very most vulnerable persons included within the eligibility for assisted suicide for which it provides. As set out further below, the issue is not concerned with capacity or coercion, but the failure to ensure that people who have certain disabilities are adequately protected.

35. We turn to apply Article 14 in relation to the Bill.

(i) *“Significantly different situation”*

36. There is clear and cogent evidence that particular disabilities are more likely to manifest in the sufferer expressing a wish to die, because they are more likely, by virtue of the disability, to experience suicidal ideation. While the precise scope of those disabilities is a factual matter lying beyond the scope of this Advice, we observe that there is well-documented medical evidence that, for example, those who have been diagnosed with the following conditions have greater rates of suicide and attempted suicide than the general population:

(a) **Bipolar disorder**, in respect of which the latest research suggests 15–20% of people with bipolar disorder die by suicide and 30–60% will make at least one attempt to end their own life;<sup>11</sup>

---

11 See for example, KR Jamison, *Suicide and bipolar disorder*, J Clin Psychiatry 2000:61 Suppl 9:47-51 and the latest research from T Gergel, F Adiukwu and M McInnis, *Suicide and bipolar disorder: opportunities to change the agenda*, The Lancet Psychiatry, Volume 11, Issue 10, p. 781, October 2024.

(b) **Depression**,<sup>12</sup> and

(c) **Autism**, as to which the latest research suggests that 35% of autistic adults had planned or attempted suicide in their lifetime with 72% reporting suicidal ideation.<sup>13</sup>

37. The Bill fails to treat those suffering with these disabilities in a way that reflects their significantly different situation. The Core Conditions apply equally to all:

---

(a) **Clause 15(2) and (3)** – these provisions set out the conditions that must be satisfied before the coordinating doctor may provide a terminally ill adult with an approved substance. Aside from ensuring the procedural obligations in respect of the declarations are met, the doctor is only required to satisfy him or herself (i) of capacity; and (ii) that it is a voluntary request.

(b) **Clause 3(2)** – while Clause 3(2)(a) does refer to “*any mental disorder which might affect the making of the request*” this is in respect of deciding whether the person has the capacity to make the request for assistance. It does not provide a safeguard for those who have capacity but who are more likely to experience suicidal ideation on account of their disability. Where someone is assessed to have capacity to request assistance, they are then treated as being fully capable of making their own decisions.

38. Against that background we have no hesitation in concluding that persons whose disabilities manifest as above are in a significantly different situation for *Thlimmenos* purposes than those who have no such disability. That cohort of disabled persons, who undoubtedly possess a “status” for Article 14 purposes, are *particularly* vulnerable under an assisted suicide regime eligibility for which depends *inter alia* on expressing a wish to die. In order to avoid the risk arising from that comparatively greater vulnerability, they are in need of a safeguard requiring it to be determined (by a person able - and thus appropriately qualified - to do so) whether they are expressing a wish to die *in consequence of their disability* or otherwise. Absent such a safeguard, the State cannot know if it is treating them as eligible for assisted suicide because they have a disability manifesting in the expression of suicidal ideation.

---

12 B Harmer, S Lee, A Rizvi and A Saadabadi, *Suicidal Ideation*, StatPearls, April 2024.

13 D Hedley and M Uljarević, *Systematic Review of Suicide in Autism Spectrum Disorder: Current Trends and Implications*, Current Developmental Disorder Reports, Volume 5, p. 65 (2018)

39. A study conducted in the Netherlands considered whether “*any particular difficulties arise when the EAS [euthanasia and assisted suicide] due care criteria are applied to patients with an intellectual disability and/or autism spectrum disorder*”. In this study the authors searched 416 case summaries on the RTE (the Dutch authority monitoring euthanasia practice) between 2012–2016, looking for intellectual disability and autism spectrum disorder. Professor Tuffrey-Wijne, alongside coauthors (including Baroness Finlay and Baroness Hollins) concluded:

*“Autonomy and decisional capacity are highly complex for patients with intellectual disabilities and difficult to assess; capacity tests in these cases did not appear sufficiently stringent. Assessment of suffering is particularly difficult for patients who have experienced life-long disability. The sometimes brief time frames and limited number of physician-patient meetings may not be sufficient to make a decision as serious as EAS. The Dutch EAS due care criteria are not easily applied to people with intellectual disabilities and/or autism spectrum disorder, and do not appear to act as adequate safeguards.”<sup>14</sup> (underlining added)*

40. We have asked ourselves whether, on a close analysis of the Bill, it provides for a safeguard of the sort we have identified above. In order to be treated as eligible for assisted suicide, must it first be assessed by a suitably qualified person whether a person expressing a voluntary wish to die is, in doing so, manifesting their disability? The answer, in our view, is no. In fact, there is no requirement for such an assessment by any person, far less one qualified to make it.

41. In our view, none of the safeguards in the Bill meet this hurdle. We highlight two.

42. First, the provision for reporting and monitoring obligations does not amount to a safeguard. At the moment, the Bill does not even require information to be provided in respect of disability as a characteristic (Clause 24(3)). But even if disability was added as a characteristic, it is no more than monitoring, with no guarantee, or even indication, that a safeguard addressing the problem will ever eventuate. The time for ensuring that the Bill protects the most vulnerable is during its passage through Parliament. In our view, it is

---

14 I Tuffrey-Wijne, L Curfs, I Finlay, S Hollins *Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012–2016)*. *BMC Med Ethics*. (2018)

inadequate, on analysis, to adopt a “wait and see” approach, by which the State may come to learn in due course whether rights of its citizens have been violated. By that time the Bill will be law, and the horse will have bolted.

43. Second, the ability to make a referral to a psychiatrist under Clause 7(2)(b) does not amount to a safeguard of the nature required. The purpose of that referral, which the coordinating doctor “may” make, is where “*they have doubt as to the capacity of the person.*” It is not made in order for a suitably qualified person to assess whether the individual is manifesting their disability by requesting to die. As soon as the person is assessed as having capacity, they are treated the same as anyone else who has capacity.

44. In our view, for the reasons above, those individuals with disabilities manifesting in suicidal ideation are in a significantly different situation from those who have no such disability.

45. That the legislation would have particularly prejudicial impact on the disabled cohort at issue is *a fortiori* given the evidence available in respect of other jurisdictions who have legalised assisted suicide. In short, the number of individuals who express the wish to die is ever increasing:

---

(a) In **Canada** one in twenty deaths is now as a result of assisted suicide.<sup>15</sup>

(b) Similarly, in the **Netherlands** 5.4% of all registered deaths were with assisted suicide. The uptake increases by 8% every year.<sup>16</sup>

46. We have no basis to suppose that a similar trend will not broadly be seen in Scotland should the Bill in its current form be enacted. If it is, the volume of cases in which the risk we have identified will arise will increase, correspondingly, over time. The prejudicial impact on the particularly vulnerable cohort will, over time, become greater.

(ii) *Justification*

---

15 See O. Dyer, *Assisted dying now accounts for one in 20 deaths in Canada, but rate of growth slows*, *British Medical Journal*, 2024, 387.

16 *Ibid.*

47. We have explained that it is possible, in principle, for a State to justify a failure to treat differently situated groups differently. Could the Scottish Ministers justify failing to make different provision for the more vulnerable cohort of disabled people here? Here, the State has not sought to justify the discrimination at all, because it has failed to engage with the discrimination which we have explained. In any event, we do not see what justification could sensibly be advanced. We do not consider that it could be sufficient to assert that the State does not have the resources to incorporate the further safeguard required. To do so would be to accept that because of resourcing constraints some of the most vulnerable in society will be placed at greater risk of ending their lives through a manifestation of their disability.

48. In our view, the latitude or margin of appreciation that is afforded to the Scottish Parliament will not enable the State to successfully defend the Bill if it is passed into law. As set out above, very weighty reasons will be required to justify discrimination against the vulnerable groups of disabled individuals at issue. Since there has been no decided case in Strasbourg on the issue of whether the provision of assisted suicide may be discriminatory,<sup>17</sup> the matter falls to be addressed on first principles, as we have done above.

---

49. **F. CONCLUSION**

44. We have explained why we consider that the Bill unjustifiably discriminates against those persons whose disabilities manifest in the expression of suicidal ideation. In order to avoid an Article 14 violation, it would be necessary to include within its safeguards an assessment by a suitably qualified person of whether a person's expression of a clear and settled wish to die is in manifestation of a disability.

**[redacted S.38(1)(b)]**

---

<sup>17</sup> We note that a leading text for human rights practitioners has noted more generally the relative lack of cases concerning discrimination on the basis of disability before the ECtHR: "*The dearth of cases may be that the problems facing those with disabilities concern more social and economic issues than civil and political ones, and would often involve the imposition of a positive obligation on authorities to act, rather than the negative obligation to refrain from acting. Or it may be that the voice of those with disabilities is still struggling to be heard*": Reid and others, *A Practitioner's Guide to the European Convention on Human Rights*, 7th Ed. 2023 (Sweet & Maxwell) 46-003.

20 August 2025

**Attachment 2**

**ASSISTED DYING FOR TERMINALLY ILL ADULTS (SCOTLAND) BILL  
EXTRACTS FROM THE ADVICE OF [redacted S.38(1)(b)], 20 AUGUST 2025**

SUMMARY

“2. In summary, our view is that it would not be compatible. That is because, without justification, it contains no adequate safeguard protecting the position of those with disabilities where suicidal ideation is more likely, and who are, because of that feature of their disability, more likely to express a wish to die... Persons with disabilities of the above sort are in a significantly different situation from persons who do not have such disabilities, because they are - all else being equal - more likely to express the wish to die required under the legislation to be eligible to be assisted to die. They are on that basis more vulnerable both than persons whose disabilities are not of that sort and than persons who are not disabled at all. Accordingly, they are on well-established principles required to be treated differently under Article 14 unless there is justification not to do so. However, without justification, the legislation fails to provide any adequate safeguard to address that greater vulnerability.”

“3. In our opinion, this failure to treat these different cases differently in the enjoyment of the right to life is in breach of the ECHR. We consider that, on that basis, an application for judicial review in respect of the legislation once enacted could result in a declaration that it is “not law” for the purposes of section 29(1) of the Scotland Act 1998 (“the Scotland Act”).”

**HEALTH, SOCIAL CARE AND SPORT COMMITTEE REPORT HIGHLIGHTED  
HUMAN RIGHTS CONCERNS**

“10. ...At the end of the Stage 1 process, the Health, Social Care and Sport Committee produced a report on the Bill and highlighted some potential legal and human rights risks:

a. The Law Society expressed concerns over the Bill’s compliance with the ECHR, in particular the lack of oversight provisions: “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 committees 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.”

b. Those witnesses representing disabled people’s organisations who gave oral evidence to the Committee were “strongly of the view that the provisions in the Bill as introduced represented a direct threat to disabled people’s rights.””

## ARTICLE 14 SOMETIMES REQUIRES POSITIVE ACTION TO AVOID INDIRECT DISCRIMINATION

“15. [...]

a. Whilst relatively detailed consideration has been given over the years to the permissibility of a blanket ban on assisted suicide, the legalisation of assisted suicide, and the question of what is required by way of safeguards including to protect the most vulnerable, have received much less detailed judicial consideration. This no doubt reflects in part that very few Council of Europe

States have legalised assisted suicide. ...

b. There has been no decided case concerning whether a State's legalisation of assisted suicide has been discriminatory under Article 14 ECHR.

c. It follows that the ECtHR has not addressed the proper approach to the concept of “margin of appreciation” in a discrimination case. ...”

“19. Discrimination under Article 14 does not only relate to a failure to treat everyone in the same way. The ECtHR has also made clear that there will be occasions where the State is obliged to treat different groups differently because of ‘factual inequalities’ between them. In *DH v Czech Republic* (2008) 47 E.H.R.R. 3 at para 175 the Grand Chamber of the ECtHR held:

‘Art.14 does not prohibit a Member State from treating groups differently in order to correct ‘factual inequalities’ between them; indeed in certain circumstances a failure to attempt to correct inequality through different treatment may in itself give rise to a breach of the Article. The Court has also accepted that a general policy or measure that has disproportionately prejudicial effects on a particular group may be considered discriminatory notwithstanding that it is not specifically aimed at that group, and that discrimination potentially contrary to the Convention may result from a de facto situation.’”

“20. Discrimination by way of failure to attempt to correct inequality is often referred to as ‘Thlimmenos’ discrimination, after the case *Thlimmenos v Greece* (2001) 31 E.H.R.R. 15. ...”

## SAFEGUARDS AROUND CAPACITY AND COERCION FAIL TO RESOLVE ISSUE

“29. ...the Bill contains a major omission in relation to the position of the very most vulnerable persons included within the eligibility for assisted suicide for which it provides. As set out further below, the issue is not concerned with capacity or coercion, but the failure to ensure that people who have certain disabilities are adequately protected.”

## THOSE WITH CERTAIN DISABILITIES PARTICULARLY VULNERABLE TO SUICIDAL IDEATION

“31. There is clear and cogent evidence that particular disabilities are more likely to manifest in the sufferer expressing a wish to die, because they are more likely, by virtue of the disability, to experience suicidal ideation. While the precise scope of

those disabilities is a factual matter lying beyond the scope of this Advice, we observe that there is well-documented medical evidence that, for example, those who have been diagnosed with the following conditions have greater rates of suicide and attempted suicide than the general population:

a. Bipolar disorder, in respect of which the latest research suggests 15–20% of people with bipolar disorder die by suicide and 30–60% will make at least one attempt to end their own life; b. Depression; and

c. Autism, as to which the latest research suggests that 35% of autistic adults had planned or attempted suicide in their lifetime with 72% reporting suicidal ideation.”

“32. The Bill fails to treat those suffering with these disabilities in a way that reflects their significantly different situation. ...”

#### SUCH PEOPLE QUALIFY FOR SPECIAL PROTECTION UNDER ARTICLE 14

“33. Against that background we have no hesitation in concluding that persons whose disabilities manifest as above are in a significantly different situation for Thlimmenos purposes than those who have no such disability. That cohort of disabled persons, who undoubtedly possess a “status” for Article 14 purposes, are particularly vulnerable under an assisted suicide regime eligibility for which depends inter alia on expressing a wish to die. In order to avoid the risk arising from that comparatively greater vulnerability, they are in need of a safeguard requiring it to be determined (by a person able - and thus appropriately qualified - to do so) whether they are expressing a wish to die in consequence of their disability or otherwise. Absent such a safeguard, the State cannot know if it is treating them as eligible for assisted suicide because they have a disability manifesting in the expression of suicidal ideation.” **NONE OF THE BILL’S ‘SAFEGUARDS’ FIX THE PROBLEM**

“35. We have asked ourselves whether, on a close analysis of the Bill, it provides for a safeguard of the sort we have identified above. In order to be treated as eligible for assisted suicide, must it first be assessed by a suitably qualified person whether a person expressing a voluntary wish to die is, in doing so, manifesting their disability? The answer, in our view, is no. In fact, there is no requirement for such an assessment by any person, far less one qualified to make it.”

“36. In our view, none of the safeguards in the Bill meet this hurdle. We highlight two.”

“37. First, the provision for reporting and monitoring obligations does not amount to a safeguard. At the moment, the Bill does not even require information to be provided in respect of disability as a characteristic (Clause 24(3)). But even if disability was added as a characteristic, it is no more than monitoring, with no guarantee, or even indication, that a safeguard addressing the problem will ever eventuate. The time for ensuring that the Bill protects the most vulnerable is during its passage through Parliament. In our view, it is inadequate, on analysis, to adopt a “wait and see” approach, by which the State may come to learn in due course whether rights of its citizens have been violated. By that time the Bill will be law, and the horse will have

bolted.”

“38. Second, the ability to make a referral to a psychiatrist under Clause 7(2)(b) does not amount to a safeguard of the nature required. The purpose of that referral, which the coordinating doctor “may” make, is where “they have doubt as to the capacity of the person.” It is not made in order for a suitably qualified person to assess whether the individual is manifesting their disability by requesting to die. As soon as the person is assessed as having capacity, they are treated the same as anyone else who has capacity.”

“42. ...Here, the State has not sought to justify the discrimination at all, because it has failed to engage with the discrimination which we have explained. In any event, we do not see what justification could sensibly be advanced. We do not consider that it could be sufficient to assert that the State does not have the resources to incorporate the further safeguard required. To do so would be to accept that because of resourcing constraints some of the most vulnerable in society will be placed at greater risk of ending their lives through a manifestation of their disability.”

## CONCLUSION

“44. We have explained why we consider that the Bill unjustifiably discriminates against those persons whose disabilities manifest in the expression of suicidal ideation. In order to avoid an Article 14 violation, it would be necessary to include within its safeguards an assessment by a suitably qualified person of whether a person’s expression of a clear and settled wish to die is in manifestation of a disability.”

---

**Correspondence 03 (email)**

From: **[redacted S.38(1)(b)]**

Sent: 07 September 2025 17:04

To: Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

Subject: Assisted dying bill

Dear Neil Gray,

I am writing to you in your capacity as the health secretary in scotland to ask if the scottish government will be proposing amendments at stage 2 in relation to the Assisted Dying for Terminally ill adults scotland bill? And when can we expect to see these amendments published?

I look forward to your response.

Kind Regards,

**[redacted S.38(1)(b)]**

---

**Correspondence 04 (email)**

From: **[redacted S.38(1)(b)]**

Sent: 19 September 2025 12:06

To: Gray N (Neil), MSP <Neil.Gray.MSP@Parliament.scot>

Subject: Assisted Suicide Bill United Kingdom

*CAUTION: This e-mail originated from outside of The Scottish Parliament. Do not click links or open attachments unless you recognise the sender and know the content is safe.*

Good afternoon,

I am an **[redacted S.38(1)(b)]** in a school in **[redacted S.38(1)(b)]**, and this year I am sitting **[redacted S.38(1)(b)]** and have chosen the topic of Assisted Suicide in the UK, and I will be comparing to Switzerland as the procedure is currently legal there. I was seeking to find some information on the matter of Assisted Suicide in the UK to help me with my project, and I am hoping you could help me with this by answering some questions.

Firstly, are you for or against this bill? Do you have reasoning for this answer?

Secondly, why HAS this procedure been illegal in the UK?

Lastly, has something drastically changed to allow this bill to go through parliament?

If you have any other information that you think would be beneficial to me that is highly appreciated.

Thank you for your time,

**[redacted S.38(1)(b)]**

**[redacted S.38(1)(b)]**

**[redacted S.38(1)(b)]**

Tel: **[redacted S.38(1)(b)]**

E-mail: **[redacted S.38(1)(b)]**

---

## Correspondence 05 (email + attachment)

### Email

**From:** [redacted S.38(1)(b)]

**Sent:** 06 October 2025 13:49

**To:** Gray N (Neil), MSP <Neil.Gray.MSP@Parliament.scot>

**Subject:** Evidence - Assisted Dying for Terminally Ill Adults (Scotland) Bill

**CAUTION:** *This e-mail originated from outside of The Scottish Parliament. Do not click links or open attachments unless you recognise the sender and know the content is safe.*

Dear Mr Gray,

### Canadian Evidence

Campaign groups backing the Assisted Dying for Terminally Ill Adults (Scotland) Bill have long promoted the idea that Canada demonstrates such a law can be safely implemented.

**“Canada’s law has been working perfectly for 3 years. There’s been absolutely no evidence of any misuse.” Dignity in Dying, X, 2019 [1]**

**“Canada... found ways to craft safeguarded assisted dying laws”. Dignity in Dying website, 2020 [2]**

Yet, as the attached briefing shows, Canada’s story is one of safeguarding failures, jeopardising marginalised people. In one state alone, 400 violations of the law and malpractice have been exposed by whistleblowers. [3]

If it would be helpful to discuss this further, please do contact me.

Yours sincerely,

[redacted S.38(1)(b)]

[redacted S.38(1)(b)] The Christian Institute

M: [redacted S.38(1)(b)]



[redacted S.38(1)(b)]

### Attachment

**Canada’s dangerous euthanasia law – October 2025**

Evidence shows that Canada's Medical Assistance in Dying (MAID) law is extremely dangerous for some of the most vulnerable in society.<sup>18</sup> In Ontario alone between 2018 and 2024 over [400 cases](#) of malpractice were identified post-mortem. For these patients, safeguards failed.

1. Euthanasia now normalised and accepted
  - The number of MAID deaths has [risen significantly](#) year-on-year. In 2023, there were 15,343, an increase of 15.8% from [2022](#). Annual MAID deaths have risen more than five-fold since 2017, and now account for 4.7% of all deaths in Canada.
  - In April 2023, Canadian bioethicists Professor Amy Mullin and Kayla Wiebe published an article in the [Journal of Medical Ethics](#) claiming that euthanasia “should be available” for people “in unjust social circumstances”.
    - A [poll](#) has found that **27% of Canadians think it should be acceptable for people to be killed due to poverty**, and 28% think **homelessness** is an appropriate reason to die under MAID.
2. Examples of vulnerable people
  - In January 2024, [Normand Meunier](#), a quadriplegic man entered a Quebec hospital with a respiratory infection. Four days after being confined to an emergency-room stretcher, he was unable to secure a proper mattress despite his partner's pleas. He suffered from a painful bedsore that led him to apply for MAID. He spoke with Radio-Canada the day before he was euthanised: “I don't want to be a burden”.
  - [‘Kat’](#) suffers from Ehlers-Danlos Syndrome. She wants to live, but lack of specialist medical care means she feels it is “far easier to let go”.
  - [Nancy Russell](#)'s family say she chose MAID due to not wanting to be lonely.
  - 61-year-old [Alan Nichols](#) had a history of depression. A month after he was hospitalised over fears that he might be suicidal, he submitted an application to be euthanised, with the help of hospital staff. “Hearing loss” was the only reason cited for his request.
  - A physically disabled [breast cancer patient](#) who was “readying for a lifesaving mastectomy” [was asked](#) twice, whilst sat alone waiting for imminent operations, whether she was familiar with assisted dying. She shared: “There are people

---

<sup>18</sup> [One fifth](#) of Canadians aged 25-64 live with some form of disability, but they account for 41% of the low income population. [Disabled Canadians](#) got \$600 in additional financial assistance during Covid; university students got \$5,000. People with disabilities who are in poverty are more likely to feel a burden due to the cost of their care and inability to work.

who have lists of conditions like mine who don't have a big, happy loving family, or financial or emotional support... If those words are said to them when they're lonely and alone.... If my life were like that, I may not have had the strength or courage to either pretend that that question didn't exist or just say, 'No, I don't want to talk about it. Let's move on.'"

- When [Kathrin Mentler](#) attended Vancouver General Hospital seeking psychiatric help, a staff member asked if she had considered death by MAID. During her assessment by a clinician, the 37-year-old was told there were “no beds” and that she should expect a long wait to see a psychiatrist as an out-patient. Mentler said she was then asked, “**Have you considered MAID?**” and that the clinician went on to speak of her “[relief](#)” at the death of another patient struggling with mental illness.
- Lisa Pauli has been suffering from anorexia since childhood. She [plans to request MAID](#), when the rules are changed to allow euthanasia due to mental illness (NB this has been delayed until at least 2027).
- Sheila Elson's adult daughter [Candice Lewis](#) had medical conditions including cerebral palsy and spina bifida. Sheila was told by a doctor, within her daughter's hearing, that MAID was an option and that she would be selfish not to consider it. Lewis was capable of verbally communicating and was an avid painter.
- Mother-of-three [Rose Finlay](#) suffered a spinal cord injury at 17 and is quadriplegic. She says it is much easier to pursue MAID than to get Government support for her disability, noting that while the MAID eligibility assessment takes 90 days, it can take up to eight months to receive disability support.
- [55-year-old Madeline](#) has accumulated \$40,000 in debts trying to treat her multiple illnesses and disabilities. Ongoing money struggles and repeatedly having to ask for help mean that for her, MAID is a “brutal practicality”.
- [Donna Duncan](#) died through Canada's Medical Assistance in Dying (MAiD) program. Despite not being terminally ill, disabled, or diagnosed with a chronic condition, her request for assisted death was granted, after initially being refused by a first doctor. At the time, her daughter Alicia says, she was “severely underweight, had recently attempted suicide, and was suffering from what her family now understands was likely anorexia—yet this went unrecognized by the healthcare system. Rather than receiving psychiatric care or support for a suspected eating disorder, her request for MAiD was approved.”  
Alicia stated: “**In the weeks before her death, she told her daughters she felt like a burden to her partner and believed he would be better off without her.** Her partner even said to them, ‘As terrible as it would be to lose your mom, at least I would get my life back.’ These kinds of statements created a context in which Donna internalized the belief that her death would be a relief to others—a hallmark of emotional coercion.”

3. Expansion of MAID to those with a mental illness
  - The [Canadian Mental Health Association](#) has warned it is “not possible” to determine whether any particular case of mental illness is incurable and strongly opposes the coming expansion.
  - The [Centre for Addiction and Mental Health](#) has said: “We do not believe that eligibility for MAID should be extended to people whose sole medical condition is mental illness at this time.”
  - Dr Mona Gupta, a psychiatrist and the chair of an expert panel charged with recommending protocols and safeguards for psychiatric MAID, [told the special joint Parliamentary committee](#): “people with mental disorders are requesting and accessing MAID now”. They include patients whose requests are “largely motivated by their mental disorder but who happen to have another qualifying condition”, as well as those with “long histories of suicidality” or questionable decision-making capacity.
  - [Dr Madeline Li](#), a psychiatrist at Toronto’s Princess Margaret Hospital, has overseen hundreds of MAID deaths, but says: “Making death too ready a solution disadvantages the most vulnerable people, and actually lets society off the hook”. She also states: “I don't think death should be society's solution for its own failures.”
4. Other
  - [The Atlantic’s](#) summary states that in the absence of a legal definition of “incurable” for MAID, a condition is counted as incurable if “it could not be cured by means acceptable to the patient”.
  - Palliative care provision in Canada is inadequate. It has been [reported](#) that Canada does not have enough specialist palliative care doctors. A study by the [Canadian Institute for Health Information](#) (CIHI) found that palliative care is often not accessed early enough, most palliative care services were received only in the last month of life, and more than 80% of palliative care admissions in hospital were unplanned or emergencies. CIHI also found that 94% of patients who died in a hospital “could potentially have benefited from palliative care during their final stay”.
  - The rising cost of living means that some [people accessing food banks](#) are asking how to apply for MAID.
  - Dr Madeline Li says that while the concept of a ‘completed life’, or ‘being tired of life’ as a qualifying criteria for MAID is theoretically against the law, “the truth is, it *is* legal in Canada. It always has been, and it’s happening”. For many doctors, “it’s all about a patient’s autonomy, and if a patient wants this, it’s not up to us to judge. We should provide.”

**Assisted suicide in Scotland could expand eligibility beyond terminal illness on the grounds of human rights and inclusion. Creating a right for one group only, whilst excluding others, invites legal challenge.**

---

**Correspondence 06 (email + letter)**

**From:** [redacted S.38(1)(b)]

**Sent:** 08 October 2025 09:58

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Subject:** Assisted Dying

Dear Cabinet Secretary

Please find attached a letter from [redacted S.38(1)(b)] Royal College of Nursing Scotland.

Kind regards

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

Executive Assistant

RCN Scotland

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]



**Letter**

RCN Scotland  
42 South Oswald Road  
Edinburgh  
EH9 2HH

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

Telephone: [redacted S.38(1)(b)]

Email: [redacted S.38(1)(b)]

Date: 7 October 2025

Neil Gray MSP

Cabinet Secretary for Health and Social Care

CabSecHSC@gov.scot

Dear Cabinet Secretary

I write as promised following our meeting last week.

As you will be aware, RCN Scotland is neutral on the whether the law on assisted dying should be changed, reflecting our members' differing views. However, as discussed at our meeting of 1 October 2025, we have significant concerns that some of the provisions in the Assisted Dying for Terminally Ill Adults (Scotland) Bill. In its current form, it does not sufficiently protect RCN members who may want to be involved in an assisted dying service nor those who may not want to be.

We understand that you are engaging with the UK Government over the legislative competence of this Bill and we welcome that. However, as part of that discussion, we would urge you to consider whether, if passed, the Bill gives sufficient employment rights protection to staff in Scotland.

Section 18 of the Bill introduces a right to object to participate in anything authorised by the Bill to which they have a conscientious objection. RCN Scotland is of the view that this right to object needs to be extended to include for any reason.

However, in order to fully protect staff, and to provide confidence in the system, it is also necessary to introduce a protection stating that no individual should suffer professional detriment for their decision to be involved or not to be involved in assisted dying. This will in turn give staff the confidence that their choices around assisted dying will not affect their professional lives.

The Terminally Ill Adults (End of Life) Bill, currently going through the House of Lords, recognises this and inserts protection from detriment clauses into the Employment Rights Act 1996, including a right to appeal to an Employment Tribunal and a right to compensation for any discrimination as a result of taking part in, or refusing to take part in, assisted dying in England.

Given that the 1996 Bill is reserved to Westminster, it is not within the legislative competence of the Scottish Bill to afford the same protections to staff working in Scotland. We are of the view that this would be unacceptable and importantly, this imbalance would affect Registered Nurses to a greater extent than colleagues in England because the Scottish Bill gives Registered Nurses a specific role in assisting a death.

Schedule 3 of the UK Bill has been extended to Scotland, meaning one solution would be to seek an amendment to that Schedule to ensure that staff acting, or exercising a right not to act, under the Scottish legislation are similarly protected.

An alternative approach would be to seek a Section 30 order to provide the Scottish Parliament with the legislative competence to amend the relevant provisions of the 1996 Bill and its application in Scotland in relation to assisted dying.

We hope you agree that, notwithstanding our neutrality on the issue of assisted dying, it would be unacceptable for Registered Nurses in Scotland to suffer professional detriment as a result of their choices around this emotive topic.

As indicated last week we are keen to engage further and happy to have further dialogue with officials when appropriate.

Yours sincerely

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**

---

## Correspondence 07 (email + attachment)

### Email

**From:** [redacted S.38(1)(b)] On Behalf Of Gray N (Neil), MSP  
**Sent:** 22 October 2025 14:08  
**To:** Cabinet Secretary for Health & Social Care 2024  
**Subject:** FW: Glad to be alive - Assisted Dying for Terminally Ill Adults (Scotland) Bill

**From:** [redacted S.38(1)(b)]  
**Sent:** 22 October 2025 14:05  
**To:** Gray N (Neil), MSP <Neil.Gray.MSP@Parliament.scot>  
**Subject:** Glad to be alive - Assisted Dying for Terminally Ill Adults (Scotland) Bill

**CAUTION:** *This e-mail originated from outside of The Scottish Parliament. Do not click links or open attachments unless you recognise the sender and know the content is safe.*

Dear Mr Gray,

It is never right to give up on people – especially when they are at their most vulnerable. Nobody should be told by the State that they are better off dead.

Please find attached our ‘Glad to be alive’ briefing. This contains stories of hope.

Behind each story of lives being turned around are unsung heroes – family members, friends, psychiatrists, carers and doctors. People who were at their lowest were encouraged to not give up hope, and they are now glad to be alive.

The Scottish Partnership for Palliative Care describes how the desire to hasten death among terminally ill people can disappear quickly when people get the right support.[1] When people receive care and support suicide ideation in chronic illness resolves within 3 – 24 months.[2]

We hope these real-life stories are helpful as you assess the Assisted Dying for Terminally Ill Adults (Scotland) Bill and its potential ramifications.

If you wish to discuss the Bill further, please do contact me.

Yours sincerely,

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)] | The Christian Institute  
M: [redacted S.38(1)(b)]



## **Glad to be alive**

- Australian father of two **[redacted S.38(1)(b)]** was diagnosed with stage 4 pancreatic cancer in 2022 and given a few weeks to live. He quickly lost six stone and became wheelchair-bound. He lives in Victoria, where assisted suicide is legal. May 2025 marked three years since his diagnosis. Stephanus still has terminal pancreatic cancer but he is stable, and now enjoys a largely symptom-free, active life. After his diagnosis, his wife also found out she had terminal cancer, and died soon after. Stephanus reflected: “If I would have chosen assisted suicide, look at what I would have missed. My kids would have been orphans. I’ve got chemo, and my cancer has spread a bit, but I’ve got a good quality of life.”
- **[redacted S.38(1)(b)]**, a district councillor in Hertfordshire, was diagnosed with ovarian cancer in 2017. It caused her to spiral into despair, and she says if assisted suicide had been available, “I would have gone down that road”. She described going through “a moment – or period – of despair that felt permanent, but wasn’t”, and said she understood how easily a person can fall into thoughts “that it would be better – for you, for everyone – if you just slipped away”. She continued, “I just don’t want people to be written off and think that’s the easy option”. She now works with the cancer support charity One Vision, and describes herself as a “cancer thriver”.
- **[redacted S.38(1)(b)]**, age 22, changed her mind about euthanasia as the syringe was about to be plunged into her arm. She had been abused as a child, and struggled with self-harm, anorexia and mental illness. But when the moment came, she questioned if she really wanted to die. Thanks to a “persistent psychiatrist and friends”, Romy continued with therapy and sees value in living. “Now I know there is light at the end of the tunnel”.
- In 2005, **[redacted S.38(1)(b)]** from Texas was hospitalised with severe anorexia. She was a very difficult patient and the doctors had little hope for her. She says: “If the option for assisted dying had been available, I would have taken it.” However, she recovered after 16 months of mandatory treatment and today she runs a group that helps people with eating disorders. “I am alive today thanks to those who never gave up on me, and for that, I will always be grateful.”

After being diagnosed with terminal cancer in 2000, Oregon resident **[redacted S.38(1)(b)]** asked her doctor for assisted suicide, not cancer

treatment. She had been given six months to a year to live. Her doctor asked her to reconsider and to think of her son, who was about to graduate from police academy. In 2011, **[redacted S.38(1)(b)]** wrote: "I am so happy to be alive! It is now 11 years later. If my doctor had believed in assisted suicide, I would be dead. I thank him and all my doctors for helping me to choose 'life with dignity'".

- US Army veteran **[redacted S.38(1)(b)]** was diagnosed with terminal brain cancer in 2014, at 33 years old, and was given four months to live. **[redacted S.38(1)(b)]** said that in his [darkest moments](#) he had thoughts of giving up: "If I'd had suicide pills with me in my nightstand during my 5th month of treatment, I might have taken them, and you can't undo that." After surgery and treatment, he went on to live for another [three precious years](#) with his family, including welcoming another son.
- **[redacted S.38(1)(b)]**, who died in 2013, suffered from spina bifida, hydrocephalus, emphysema and osteoporosis. Though she attempted suicide several times, and wanted to die for a period of ten years, over time, with friends' support, she saw that her life was valuable and had meaning. She dedicated many years to working with children with disabilities in India, and to campaigning against assisted suicide and euthanasia in the UK. Alison said: "If euthanasia had been legal then, I would have requested it with no hesitation at all... And no one would ever have known that the future held such good times, and that the [doctors were wrong](#) in thinking I didn't have long to live."
- For twenty years, **[redacted S.38(1)(b)]** was an ardent supporter of euthanasia and assisted suicide and wished they were legally available in New Zealand. She has been tetraplegic since a car accident when she was 17. Following four suicide attempts, a suicide outreach clinic suggested to Claire that she go overseas for assisted suicide. At that time, Claire felt like a burden on those around her: "I just didn't feel like I was of any value". Now in her 40s, [she says](#): "I'm so glad that assisted suicide wasn't available in New Zealand, because if it were, I wouldn't be here today. That's scary for me." ["Now that I've put the support in place, I love my life."](#)

**[redacted S.38(1)(b)]** was diagnosed with colon cancer in 2009, which led half of his large intestine being removed. Despite this surgery and subsequent chemotherapy, new tumours were discovered just a few months later. Writing less than six months before his death at the age of 58, Christopher reflected: "I was subject to extreme stress and a sense of hopelessness, and I might have been open to the option of ending my life by legal means, had these existed. The legal prohibition of [assisted suicide] was immensely helpful in removing it as a live option... My experience has reinforced my conviction that the law prohibiting assisted suicide is an

essential bulwark against well-meaning but unwarranted judgements about the value of life”.

- **[redacted S.38(1)(b)]** from New York, was diagnosed with Complex Regional Pain Syndrome, a permanent condition also known as ‘suicide disease.’ She used to wonder if she would qualify for assisted suicide, and if so whether she would do it. Her pain is now under control and she says “every day is a gift”.
- Most people with **[redacted S.38(1)(b)]** kind of brain cancer live for about three years. But writing over 13 years after her 2005 diagnosis, Sarah expressed her fears that a terminal diagnosis might push people to choose assisted suicide when they could live for years or decades. This is especially true for those who experience illness-induced clinical depression and anxiety – which she says come and go. She urged her home state of New Jersey to face the challenges of terminal illness and disability with “compassionate counselling, in-home personal care support, and painstaking social work”.
- **[redacted S.38(1)(b)]** from Oregon, had a 43-year medical history of [acute depression](#) and suicidal ideation. Yet he managed to obtain assisted suicide drugs, keeping them at home for more than two years before his death from lung cancer in 2002. His prescribing doctor said he didn’t think that a mental health evaluation was necessary. Thankfully, through a nonprofit group, Michael was offered improved medical care and suicide prevention services and chose not to commit suicide. Before he died, he was able to reconcile with his estranged daughter which may have not been possible had he taken his life.

Former Sheffield **[redacted S.38(1)(b)]** suffers incurable pain, and is [“very grateful”](#) that assisted suicide has always been illegal. “When reduced to despair and wanting to die, devoted medical care has got me through.” Speaking to [BBC Radio Leeds](#), he said: “If there had been even one of the milder laws which are being proposed in place then there’s a fair chance I would not be speaking to you today”.

---

## **Correspondence 08 (email)**

**From:** [redacted S.38(1)(b)]

**Sent:** 02 November 2025 20:55

**To:** First Minister

**Subject:** More than 800 deaths

Dear First Minister,

I hope you are well.

More than 800 deaths of Scottish people waiting in corridors in A and E due to poor resourcing is an indictment on this government .

How can you and your government justify the time and money spent on a bill to allow assisted dying in Scotland for a tiny portion of people whilst abandoning day after day people who need medical help ?

My own friend was left overnight in a corridor till a bed was found for her at 7 in the morning.

It as absolute dereliction of duty to bring in a bill that will harm the majority for the sake of a tiny minority .

It's nothing short of criminal and immoral for Scottish MPS to have found the time for this bill while people wanting to live have been dying day after day unnecessarily in our Scottish hospitals due to the gross failures on the watch of this government

Whilst they sit talking about assisted dying ,Scots are dying daily due to failure by this government .

Fix your broken system and save lives .

"For years Scots have been dying as a result of dangerously long waits in A&E, but the SNP has stood idly by while this crisis ran riot.

Why is this government even considering an Assisted dying bill?

Why is a Health committee wasting precious time and money on new initiatives to help people to die whilst they are failing to help people to live ?

Yours faithfully,

**[redacted S.38(1)(b)]**

## Correspondence 09 (email)

From: [redacted S.38(1)(b)]

Sent: 06 November 2025 17:55

To: Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

Subject: Failure

Dear Sir ,

800 deaths last year in Scotland 's hospitals' corridors that could have been avoided. This is dereliction of duty by this government Day by day people are dying unnecessary.

Did the government learn nothing from Covid ?

If government had had to pay put compensation to all who were abandoned there would be far more rigour now .

If the government had had to pay out compensation for everyone with disability or learning needs abandoned callously as expendable in Covid they would be not be so careless of people's lives.

The absolute disgrace of the early deaths in Scotland of Down's syndrome ,people who are NOT getting the appropriate medical interventions .It is not as if there was no warning .The government has known since 2017when the statistics were reported by Downs Syndrome Research paper.The recent statistics are horrendous .

NHS is Scotland is on its knees .

Why is Holyrood spending time and resources on Liam McArthurs bill for a tiny minority who want to die and ignoring day after day those of want to live?

This government has lost any moral authority.

11,000 people die annually in Scotland without getting access to the palliative care they want .

50 % of people who die in hospital would prefer to die at home with palliative care .

Guarantee palliative care for the public now .If you cannot, don't introduce suicide for the few .

Yours faithfully ,

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

---

## Correspondence 10 (letter + attachments)

### Letter

[redacted S.38(1)(b)]  
Tel. [redacted S.38(1)(b)]  
[redacted S.38(1)(b)]  
christian.org.uk

Mr Neil Gray  
Cabinet Secretary for Health and Social Care  
MSP for Airdrie and Shotts  
The Scottish Parliament  
Edinburgh  
EH99 1SP

31 October 2025

Dear Mr Gray,

### **Disability, the NHS and assisted suicide**

The rhetoric of 'autonomy' in the ongoing assisted suicide debate in the Scottish Parliament is troubling. Supporting assisted suicide on this basis risks sending the message to people with disabilities that: 'if my life was the same as yours, if I lost my autonomy and faced physical limitations and pain because of an illness, then I would want the right to be able to kill myself'. This would have significant repercussions for how we value people with disabilities.

The reality is that people with disabilities are already treated worse in the NHS. If the McArthur Bill is passed, these people (many of whom would be eligible for assisted suicide) would be put at far greater risk. This is why the Bill has been described by leading lawyers as 'incompatible' with the ECHR on grounds of discrimination.

### **Real life stories**

STV shared the tragic story of Adrian Poulton, a 56-year-old man with Down's Syndrome. He was starved to death in an NHS hospital after he broke his hip and was not fed for nine days. His family assumed he was being fed, but he wasn't. He even told his family 'I don't want to die'. When they realised what was happening, it was too late.

STV then described Jackie's story. She lost her son Louis, who was just 17, after he was sent away from hospital without basic healthcare. Jackie is adamant he was not treated, and consequently died, due to his Down's Syndrome.

### **Hard data**

The University of Glasgow found young adults with learning disabilities are almost **nine times more likely to die** from treatable causes in Scotland. Adults with

learning disabilities of any age are over four times more likely to die from treatable causes than the general population. [1]

**'Incompatible with ECHR'**

The Christian Institute commissioned a legal opinion on the Assisted Dying for Terminally Ill Adults (Scotland) Bill from leading lawyer Tom Cross KC and fellow barrister Ruth Kennedy. [2] They concluded that 'because, without justification, **it contains no adequate safeguard protecting the position of those with disabilities where suicidal ideation is more likely**, and who are, because of that feature of their disability, more likely to express a wish to die', the Bill 'would not be compatible' with the ECHR.

Jackie, Louis's mum, said: "When you are a mum of a child with disability, everything is 20 million times harder than for anybody else. It's constant battle, battle, battle, battle. You're just resigned for the fact: **Here we go again. Another difficulty. Another excuse.**'."

This is the context in which assisted suicide would be legalised. People with disabilities have dignity and worth. We can't celebrate their lives while saying if we became like them as a consequence of an illness then we should have the 'choice' of killing ourselves.

If it would be helpful to discuss the legal opinion or the Bill in greater detail, please do contact me.

Yours sincerely,

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]

[1] Rydzewska, E, Nijhof, D, Hughes, L et al, 'Rates, causes and predictors of all-cause and avoidable mortality in 514,878 adults with and without intellectual disabilities in Scotland: a record linkage national cohort study', BMJ Open, 2025, 15

[2] In the matter of the Assisted Dying for Terminally Ill Adults (Scotland) Bill, Tom Cross KC, Ruth Kennedy, 20 August 2025 (available at [http://christian.org.uk/wp-content/uploads/Legal-opinion\\_Tom-Cross-KC-and-Ruth-Kennedy-copy.pdf](http://christian.org.uk/wp-content/uploads/Legal-opinion_Tom-Cross-KC-and-Ruth-Kennedy-copy.pdf))

***Attachments:***

Scans of newspaper attachments also included which are publicly available here:  
*'I don't want to die': Man with Down syndrome 'starved to death' in hospital | ITV News*

*University of Glasgow - University news - Archive of news - 2025 - February - Adults with learning disabilities 9 times likely to die from treatable causes*

---

## Correspondence 11 (letter + attachments)

### Letter

[redacted S.38(1)(b)]  
Tel. [redacted S.38(1)(b)]  
info@christian.org.uk  
christian.org.uk

Mrs Mairi Gougeon  
Cabinet Secretary for Rural Affairs, Land Reform and Islands  
MSP for Angus North and Mearns  
The Scottish Parliament  
Edinburgh  
EH99 1SP

10 November 2025

Dear Mrs Gougeon,

### **'Assisted Dying for Terminally Ill Adults (Scotland) Bill', Committee Roundup, Stage 2, Week 1**

Thank you for voting against the Assisted Dying for Terminally Ill Adults (Scotland) Bill at Stage 1.

Within a single committee meeting, Stage 2 scrutiny has now concluded debate on five huge, key topics:

- who would be eligible,
- the definition of terminal illness,
- coercion and pressure influencing someone to end their life,
- the administration and regulation of 'assisted dying' services,
- and who could act as witness or proxy during the authorisation of the provision of lethal drugs.

All amendments lodged by Members other than the sponsor of the Bill were rejected. This included obvious, sensible safeguards. I've included a table of rejected and passed amendments and key points of debate, which I hope are useful.

If you would like to discuss the Bill, please do contact me.

Yours sincerely,

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]

### **Attachment 1**

## **Notable rejections and key points of debate**

### **People with decades left to live to be given drugs to kill themselves**

Daniel Johnson highlighted how the Bill "could be exercised by people who may have years to live". Pam Duncan-Glancy explained how the Bill makes her eligible for lethal drugs to end her life. Jeremy Balfour said people with disabilities will "face extreme pressure" to end their lives as a consequence of the Bill.

Liam McArthur previously told committee his Bill "offers an element of control and comfort ... when death becomes inevitable and imminent". Yet this week he refused to answer whether he intends the Bill to include those with decades left to live. As the Bill stands, someone with decades to live could be given drugs to kill themselves. The committee voted against amendments to limit eligibility. (Amendments 4, 83 and 144.)

Mr McArthur says his amendment (24) precludes a disabled person being given an assisted suicide based on their disability. But of course, if a disabled person is terminally ill due to their condition, then this amendment is not relevant

Pam Duncan-Glancy talked about societal discrimination against disabled people: "When people around us start to think that not being able to get out of bed on your own ... is a life not worth living ... [people with disabilities] can find themselves internalising that and thinking, 'What is my life worth if I can't do that? Other people don't think that's a life worth living.' That ... is a real danger."

### **People ending their lives because of social isolation, eating disorders, feeling a burden and financial hardship**

Safeguards to ensure people with self-harming disorders do not receive reduced levels of care were rejected.

As argued by Tom Cross KC, this Bill contravenes the ECHR. It does nothing to protect people with disabilities whose condition makes them prone to suicidal thoughts.

Amendments aimed at ensuring nobody is given lethal drugs to end their lives as a result of an eating disorder, anxiety disorder or mood disorder were rejected.

A terminally ill person with a propensity to self-harm should get protection, not drugs to end their lives.

Another amendment would have made it impossible for someone to intentionally starve themselves in order to be considered terminal. In countries where assisted suicide or euthanasia is legal, this technique is encouraged by pro-euthanasia groups to get around the law.<sup>1 2</sup> (Amendments 144 and 147 rejected.)

These amendments also sought to ensure that a patient who tells a doctor their primary motivation for wanting to end their lives is loneliness, feeling like a burden, lack of accessible housing, poor mental health, is not be granted drugs to kill

themselves. Today, if a person tells a doctor they want to end their life, they will be given care and support to live. But the rejection of amendment 147 means these protections will be stripped away from terminally ill people by the Bill.

Suicidal thinking in chronic illness peaks at 90 days but then resolves within three to 24 months. The Scottish Partnership for Palliative Care gave evidence that with the right support, it can resolve much quicker. In places like Oregon and Washington around 50% of people ending their lives through euthanasia and assisted suicide (EAS) cite feeling like a burden as a reason.

Doctors allowed to raise assisted suicide with patients, unprompted Stephanus Breytenbach, who has pancreatic cancer and has outlived his two-week prognosis by over three years, told The Christian Institute how glad he is to be alive, and relieved that his doctors in Australia did not raise assisted suicide with him in his lowest moments.

In Canada, many of the worst stories about people being pressured into assisted suicide exist because doctors are allowed to raise assisted suicide with patients unprompted. (They are also now allowed to do so in Australia.) Doctors can have huge influence over patients at the most vulnerable moments of their lives.

The health committee rejected amendments which would have avoided replicating the situation in Canada, where people are invited to consider assisted suicide when they are simply seeking medical support to live well. (Amendments 220 and 223).

Far too little time has been given for debate over the critical aspects of this Bill, and the sponsors seem unwilling to countenance any meaningful amendments.

Attachment 2

Amendment	MSP	SECTION	SUMMARY	Accepted or rejected
4	Johnson	2	Replaces premature death with 6 month prognosis.	Rejected
24	McArthur	2	Not terminally ill only because of disability or mental disorder.	Passed
25	Grant	3	Anticipatory care plan in place (argues this ensures right to palliative care).	Rejected
26	McArthur	3 (4)	Drafting tidy - moving detail on definition of mental illness, covered by amendment 24.	Passed
83	Doris	3	Reasonably expected to die within 6 months into eligibility definition.	Rejected
144	Balfour	2	Death within 6 months established with reasonable certainty, excluding cases controlled or slowed by treatment, and VSED.	Rejected
145	Whittle	3	Requires a costed palliative care support plan meeting minimum requirements set out by SG Ministers in regulations.	Rejected
147	Balfour	3	Applicant doesn't have capacity if primary motivation for request arises from non-terminal conditions (eating disorders, intellectual disabilities, mood disorders, anxiety disorders; benefits; loneliness isolation ; financial; burden; housing conditions; any mental health condition or mental health disorder that is not terminal illness). Can be one of the motivations but not primary.	Rejected
148	Fraser	3	Creates a designated statutory body (independent of the NHS) to administer functions under the Act. Scottish Ministers to designate the body and set out its remit in relation to powers, duties, governance arrangements and operational procedures.	Rejected
149	Fraser	4	First declaration must be witnessed by notary public (in addition to existing requirement of the coordinating registered practitioner & other person).	Rejected
219	Duncan Glancy	3	Adds requirement for applicant to have accessed appropriate social care before eligibility confirmed.	Rejected
220	Duncan Glancy	3	Only eligible if not encouraged into AS, not suggested, or initiated by a medical practitioner or other professional involved in that person's care.	Rejected
221	Duncan Glancy	3	Applicant ineligible if unable to access appropriate social care and on waiting list continuously for over six weeks prior to making request.	Rejected
222	Duncan Glancy	3	Defines appropriate social care (includes palliative care). Application made entirely on the initiative of the terminally ill adult without any encouragement, suggestion or influence from - a registered medical practitioner, witness to the declaration or any other person involved in the care of the person making the decision.	[Pre-empted by 219]
223	Duncan Glancy	4		Rejected

**Correspondence 12 (email)**

**From:** [redacted S.38(1)(b)] **On Behalf Of** Gray N (Neil), MSP  
**Sent:** 24 November 2025 11:04  
**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
**Subject:** FW: 'Assisted Dying for Terminally Ill Adults (Scotland) Bill' - meeting with [redacted S.38(1)(b)]

**From:** [redacted S.38(1)(b)]  
**Sent:** 21 November 2025 17:11  
**To:** Gray N (Neil), MSP <Neil.Gray.MSP@Parliament.scot>  
**Subject:** 'Assisted Dying for Terminally Ill Adults (Scotland) Bill' - meeting with [redacted S.38(1)(b)]

**CAUTION:** *This e-mail originated from outside of The Scottish Parliament. Do not click links or open attachments unless you recognise the sender and know the content is safe.*

Dear Neil Gray MSP,

[redacted S.38(1)(b)] would welcome the opportunity to discuss the Assisted Dying for Terminally Ill Adults (Scotland) Bill with you.

I would be grateful if we could arrange a 30-minute online meeting within the next few weeks. Could you please share your availability at your earliest convenience, and I will gladly make the necessary arrangements?

Kind Regards

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]

---

[redacted S.38(1)(b)] |Diocesan Offices| [redacted S.38(1)(b)] email: [redacted S.38(1)(b)] |tel: [redacted S.38(1)(b)] |web:www.rcdop.org.uk

---

## Correspondence 13 (letter + attachment)

### Letter

[redacted S.38(1)(b)]  
Tel. [redacted S.38(1)(b)]  
info@christian.org.uk  
christian.org.uk

Mrs Natalie Don-Innes  
Minister for Children, Young People and The Promise  
MSP for Renfrewshire North and West  
The Scottish Parliament  
Edinburgh  
EH99 1SP

20 November 2025

Dear Ms Don,

### **ADTIA Bill, Committee Roundup, Week 3**

On Tuesday, the Health, Social Care and Sport Committee considered more than 150 amendments to the McArthur Bill. These covered the provision of fatal substances, raising assisted suicide with a patient, and advertising.

Below is a summary of notable amendments rejected by the majority of the Committee, with some of the key arguments. I've also enclosed a table of amendments voted on.

- Despite resistance from the Bill's sponsor, the Committee agreed to write to the UN Committee on the Rights of Persons with Disabilities to seek its view on whether the Bill is compatible with the Convention.
- However, the majority rejected Pam Duncan-Glancy's amendment 231. This would have required doctors to ask what advice and support a patient has received from their local authority to enable them to live independently in accordance with Article 19 of the UN Convention on the Rights of Persons with Disabilities.
- Stuart McMillan's amendment (232) requiring doctors to consult a specialist in the patient's terminal condition was also rejected.
- Members highlighted the crucial role social workers can play in identifying when a person feels lonely, unsupported, under pressure, or a burden to others. However, amendment 101 requiring the coordinating doctor to refer concerns about coercion to a social worker was rejected. The Scottish Partnership for

Palliative Care regarded this as a key safeguard.

- Paul Sweeney's amendments (239, 240 and 241) requiring patients to receive a final sign-off from a multi-disciplinary panel before being given the lethal drugs, were rejected by the Committee.
- Several Members expressed frustration at Mr McArthur's unwillingness to support amendments from bodies representing those who would be directly involved in implementing his Bill. For example, amendments lodged on behalf of the Royal College of Nursing to address concerns that a nurse could be required to administer the lethal drugs alone (76, 77 and 79), were described by Mr McArthur as "disproportionate" and "limiting".
- Sue Webber's amendments (158 and 176) to ensure the patient is fully informed about the potential side-effects and risks of the lethal drugs were rejected.
- Amendment 125 from Bob Doris requiring Scottish Ministers to set out what health professionals should do in cases of long, drawn-out deaths, was also rejected. Mr Sweeney warned that the Bill puts doctors at risk of being prosecuted when the drugs don't work as painlessly or quickly as expected.
- Mr McArthur opposed amendments 178 and 179 requiring the healthcare professional - after administering the lethal drugs - to remain in the same room as the patient until death. Instead, his amendment 33 which requires only that they be 'in the premises' was accepted by the Committee. Douglas Ross pointed out that the health professional's presence in the room is essential to ensure that patients are not left alone, untreated and in pain in the event of complications.

If you would like to discuss the Bill, please do contact me.

Yours sincerely,

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**

Attachment

Amd.	MSP	SECTION	SUMMARY	Vote
3	Gulhane	Schedule 3	Tidying up.	Accepted
87	Doris		6 Removal of 'by any other person' (coercion could be societal). Creates an independent assessor mechanism where concerns around coercion and pressure are raised; report to practitioner and Police Scotland if needed.	Rejected
161	Whittle	After section 7	Requires the coordinating practitioner's statement to confirm they are satisfied the applicant made the application entirely of their own initiative, without any encouragement, inducement, or suggestion from the coordinating practitioner, independent practitioner, or any other person involved in the applicant's care.	Rejected
237	Duncan-Glancy		8 delete 'by any other person' (links to previous amts). requires the independent practitioner's statement to confirm they are satisfied the applicant made the declaration entirely of their own initiative, without any encouragement, inducement or suggestion from the coordinating practitioner, independent practitioner or any other person involved in the applicant's care (see Duncan-Glancy 223).	Rejected
105	Doris		8 requires the independent practitioner's statement to confirm they are satisfied the applicant has not been coerced or pressured by any other person (consequential on Whittle 161).	Rejected
238	Duncan-Glancy		8 requires the independent assessor to make a statement confirming they are satisfied the applicant has not been coerced or pressured by any other person (consequential on Whittle 161).	Rejected
162	Whittle		8 Requires the independent assessor to be satisfied the applicant has not been coerced or pressured by any other person, before a second declaration can be made (following family members being able to raise concerns with independent assessor).	Rejected
164	Whittle		10 States the independent assessor need not carry out an assessment where a first declaration is cancelled.	Rejected
169	Whittle		11 Ensures the independent assessor's statement is recorded in the applicant's medical records.	Rejected
172	Whittle		13 Requires the independent assessor to be satisfied the applicant has not been coerced or pressured by any other person, before the substance is provided.	Rejected
174	Whittle		15 Expands the offence to include coercing or pressuring the person to take the substance.	Accepted
42	McArthur		21 Technical fix.	Accepted
43	McArthur		21	Accepted

	62 Baillie	After section 20	NEW: Creates new grouping: regulation of 'assisted dying' services outwith the NHS. Requires Scottish Ministers to specify and regulate where AS cannot be provided outwith the NHS, as well as where it can, as well as the regulation of Healthcare Improvement Scotland and the Care Inspectorate.	Accepted
	32 McArthur	12	McArthur delegates criteria of proxy signatories to Scottish Ministers. Proxy signatories must have known applicant for at least two years OR meets the description set out by Scottish Ministers in regulations. (Rules out those disqualified in schedule 5, e.g. family members, those who could gain financially, or care/healthcare worker.	Accepted
	67 McArthur	6	The independent registered practitioner (who approves second declaration) to be trained as set out by Scottish Ministers (who <u>may</u> by regulation specify this alongside qualifications and experience)	Accepted
	230 Sweeney	6	Changes 'may' to 'must', requiring Scottish Ministers to set out by regulation the qualifications and experience of independent registered medical practitioners (who assess the second declaration).	Accepted
	68 Baillie	6	Introduces requirement on independent registered medical practitioner to have completed training according to a new section of the act (if consequential amendment passed) called 'Training provisions for persons willing to carry out functions under this Act'	Rejected
	34 McArthur	15	For any registered practitioner or nurse who is involved in the provision of lethal drugs to the patient to end their own life, Scottish Ministers <u>may</u> set out regulations for their required qualifications and experience. This is because they are be assessing whether a person has mental capacity to end their life, and whether they are doing so voluntarily and is not a victim of pressure or coercion to take their life.	Accepted as amended
	34A McArthur	15	Adds 'training' to amendment 34. Scottish Ministers <u>may</u> set out training, as well as qualifications and education that a registered practitioner or nurse <u>may</u> have to have to be a facilitator of a person ending their own life.	Accepted
	34B Sweeney	15	Changes amendment 34 to force Scottish Ministers to regulate the training, qualifications and experience of registered practitioners and nurses who would be involved in directly facilitating a person taking their own life: 'the provision of assistance ... [for the adult to] end their own life.'	Accepted

70	Baillie	15	Requires any registered practitioner nurse involved in facilitating a person taking their own life as part of the Act to have completed training set out in (added by amendment, to be voted on) new section 15 (as set out in section 15 of the Act).	Rejected
35	McArthur	15	Requires the Scottish Government to consult appropriate people before laying regulations relating to the qualifications and education of an 'authorised health professional', and the specification of an approved substance, to be involved in facilitating a person taking their own life, as set out by the Act.	Accepted as amended
35A	McArthur	15	Tidying amendment. Amends amendment 35 to include 'training'. Scottish Government must also consult relevant people before laying regulations on the training, as well as education and experience of 'authorised health professionals' involved in a person taking their own life (as set out in section 15 of the Act).	Accepted
35B	McArthur	15	Tidying amendment. Amends amendment 35 to include 'training'. Scottish Government must also consult relevant people before laying regulations on the training, as well as education and experience of 'authorised health professionals' involved in a person taking their own life (as set out in section 15 of the Act).	Accepted
74	Baillie	7	If in the assessment there is doubt as to a person's capacity, and the doctor decides to refer that person to a psychiatrist for a capacity assessment, that psychiatrist must be on a 'Register of Psychiatrists' (see Baillie amendment 80, new section). Removes current vagueness in section 7, subsection 2 b) which states the referral can be to someone who 'or otherwise holds qualifications or has experience in the assessment of capacity' or someone with specialism in psychiatry in the GMC Specialist Register. The assessor of capacity must be a psychiatrist.	Rejected
39	McArthur	18	Limits conscientious objection to only those 'directly' participating in anything in the Act to which that individual has a conscientious objection - so those working in a care home who object, if it takes place there, or in a GP surgery, or pharmacist involved in dispensing the drugs will likely have right to conscientiously object removed by this amendment.	Accepted

190	Balfour		18	Ensures conscientious objection includes pharmacists, care workers and others. Adds: 'or facilitate in any way, anything authorised... which that individual has a conscientious objection to or objects for any other reason.' This includes, but is not limited to, referring, prescribing, supplying, preparing, witnessing or providing any form of logistical or administrative support in relation to assisting a person to end their own life.'	Rejected
40	McArthur		18	removes the wording 'conscientious objection'	Accepted
11	Johnson		18	Extends conscientious objection to institutions & conscientious objectors not to face detriment as a result of their objection and refusal to participate in the Act.	Accepted
248	Sweeney		28	An individual to not face any detriment for participating or, as the case may be, not participating in anything authorised by the Act. Removes legislative requirement that the burden of proof of conscientious objection lies on the objector in any legal proceedings. (Though does not positively state that no burden of proof would be required - i.e. it leaves the matter unclear about what would happen in court, should a conscientious objection be legally challenged. Note again McArthur has narrowed the scope of conscientious objection in 18 amendment 39).	Accepted
41	McArthur		18	Adds protections to conscientious objectors against discrimination in their workplace or any other adverse impact on their current or future employment, training or development.	Accepted
192	Balfour		18	New section: Conscientious objection: care home or hospice. A regulated care home or hospice is not under any duty to participate in, or require staff to participate in, anything authorised by the Act to which the organisation has a conscientious objection. Narrower than other amendments aimed at protecting all institutions, and there is no protection against detriment.	Accepted
16	Johnson	After section 18		New section: No detriment for care home or hospice not providing assistance. A regulated care home or hospice must not be subject to any detriment by a public authority as a result of a) not providing lethal drugs for patients to take their lives (any assistance in accordance with the Act) and b) not permitting the facilitation of a patient or resident being killed on their premises. No funding given by a public authority can be conditional on a care home or hospice providing assistance in accordance with the Act, or permitting patients/residents to be killed/assisted in accordance with the Act on their premises.	Rejected
20	Johnson	After section 18			Rejected

52	Baillie	After section 18	<p>New section: Reasonable grounds not to provide assistance etc. Doesn't use wording of 'conscientious objection', but rather says that a regulated care home or hospice is not under any duty to participate or require staff to participate anything authorised by the by the Act which that organisation has 'reasonable grounds for not so participating.' However, that care home or hospice 'must not inhibit any person from being provided with assistance to end their own life'. Requires Scottish Ministers to specify 'reasonable grounds' by regulations. [How this would work in practice, balancing the right to object and not further, whilst also facilitating the furthering of assistance via other means, is questionable.]</p>	Rejected
193	Balfour	After section 18	<p>New section: Institutional objection. Enables a wide variety of healthcare institutions (including hospices, hospitals, hostels, care homes, or other healthcare institutions) to create ethical, religious, or philosophical policies that would exempt the organisation from participating in the Act. They must let patients and families know of the policies in a timely manner. This section would also protect the organisations from the denial of public funding, or reduced or conditional funding on the basis of refusing to participate in, support, or facilitate the killing of patients/residents under the Act. Any attempt of a public authority to make the allocation of funds to a hospice conditional on participation would be discriminatory and unlawful. Scottish Ministers may make regulations to ensure institutional conscience protections and funding equity across hospices, irrespective of participation. Nothing in the Act permits or requires a regulatory body or public authority to interpret non-participation of an institution as failure to meet professional, ethical or contractual standards.</p>	Rejected
249	McMillan	After section 18	<p>New section: Conscientious objection: organisations. No company, charity, or other organisation is under any duty to participate in, facilitate, or permit on premises the provision of lethal drugs under Act for patients to kill themselves. Funding for such organisations not to be conditional on participation/facilitation/permission of people ending their lives on premises. This does not relate to NHS health boards.</p>	Rejected
156	Whittle	7	<p>Embeds discussion of advanced care directives into the assessment process (see amendment 153). Highlights the need for discussion about whether CPR should be attempted in case of complications.</p>	Rejected

100	Doris	7	The medical practitioners must request a statement from the local authority where the applicant resides on whether it knows or believes that person to be an adult at risk. Definition of adult at risk to be taken from existing legislation (Adult Support and Protection (Scotland) Act 2007).	Rejected
101	Doris	7	Medical practitioners must refer the person for assessment by a registered social worker when a) the applicant requests this assessment, b) the local authority has flagged the applicant to be at risk (see amendment 100), or c) if the doctor doubts whether the applicant is seeking drugs to kill themselves voluntarily.	Rejected
229	Duncan-Glancy	6	Applicant to be asked by assessing doctor <i>what their primary reason is</i> for requesting drugs to end their life. If the primary reason is not related to the terminal illness of the person or otherwise falls outwith the provisions of the Bill, the assessment must stop immediately and the doctor cannot proceed further.	Rejected
88	Doris	6 100)	Changes requirement from <i>may</i> to <i>must</i> . Registered practitioners (assessing doctors) must also follow steps relating to local authorities advising whether an applicant is considered 'at risk.' (See amendment	Accepted
69	McArthur	7	Makes provision for the registered practitioners to make enquiries of professionals who have provided the applicant with support in the areas of health, social care, or social work, as the doctor deems appropriate during the assessments. It also allows for the registered practitioner to make enquiries of a health professional, social care professional or social work professional with qualifications or experience relevant to the applicant being assessed for whether they should be approved to be given drugs to kill themselves.	Accepted
90	Doris	7	Requires registered practitioners to enquire about and discuss the person's reason for wanting to be provided with drugs to kill themselves.	Accepted
231	Duncan-Glancy	7	Enquire about and discuss with the person being assessed what advice and support they have received to enable that person to live independently in accordance with article 19 of the UN Convention of Human Rights of Persons with Disabilities.	Rejected

91	Doris	7	Changes the Bill to ensure that doctors are required to explain to and discuss with the patient requesting assisted suicide: the person's diagnosis and prognosis, treatment available and how the treatment will impact on the person's illness, palliative care and other care options available, the nature of the lethal drugs and how they will work to kill that person. Removes 'in so far as the [doctor] deems appropriate' to ensure doctors must discuss these topics with the patient.	Rejected
29	McArthur	7	Makes provision for the doctor, though they are not required to, to discuss hospice care and other care including symptom management and psychological support.	Accepted
157	Balfour	7	Requires the assessing doctor to refer the person for assessment by a registered social worker and registered psychiatrist, and take account of any opinion provided by these professionals on the patient's application to receive drugs to take their own lives.	Rejected
92	Doris	7	Requires the registered practitioner to inform the person wanting to end their life that they may request a social work assessment referral, and to discuss any potential benefits to receiving that assessment.	Accepted
93	Baillie	7	Requires the registered practitioner to inform the person wanting to end their life that they can be referred for a palliative care assessment to explore whether any additional support could be provided to them.	Accepted
158	Webber	7	Requires the registered practitioner to inform the person wanting to end their life of any potential side effects of the lethal drugs they would be consuming to take their own life, and any potential risks of complications that may arise from taking these lethal drugs, including any potential risks of pain.	Rejected
94	Doris	7	Requires the registered practitioner to advise the patient wanting drugs to end their life to inform their GP (if they haven't done so already) and to discuss their application to take their life with those they are close to.	Rejected
232	McMillan	7	Requires the registered practitioner to consult with, and take account of any opinion provided by, a doctor with qualifications or experience in the management of the terminal illness involved.	Rejected

95	Doris		7	Adds "must" to the provision for the registered practitioner to, if they have doubt about a person's capacity, refer the person to a psychiatrist (or someone who otherwise holds qualifications or has experience in the assessment of capacity. If they have doubt as to whether the applicant is terminally ill, they must refer the person for an assessment by a doctor with qualifications or experience in the diagnosis and management of the terminal illness involved).	Accepted
96	Doris		7	Tidying amendment for amendment 95.	Accepted
159	Balfour		7	Tidying amendment for amendment 157 - replaces original provisions on referring someone to a psychiatrist if there are doubts over capacity.	Rejected
98	Doris		7	Tidying amendment for amendment 95.	Accepted
99	Doris		7	Tidying amendment for amendment 95.	Accepted
160	Balfour		7	Tidying amendment	Rejected
51	Baillie		7	Requires the registered practitioners, when assessing someone under the age of 25 who wants to end their life, to refer the person for assessment by a social worker and psychiatrist, and to take account of their opinions. Scottish Ministers to set by regulations the qualifications the social workers and psychiatrists must meet to fulfil this role. The Scottish Government must consult on this prior to laying draft regulations or making subsequent regulations. A registered social worker means a social worker registered with the Scottish Social Services Council.	Rejected
234	Duncan-Glancy		7	Makes provision for an assessing doctor (registered practitioner) to refer the person to disability organisations for advice on independent living with a terminal illness during the assessment stage of the process.	Rejected
235	Duncan-Glancy		7	Makes provision for an assessing doctor (registered practitioner) to refer the person to the local authority for an assessment to see what support is available to enable them to live independently (in accordance with Article 19 of the UN Convention on the Rights of Persons with Disabilities).	Rejected
75	Baillie	After section 7		In cases of a second psychiatric assessment for capacity being desired by one of the two registered practitioners or the applicant themselves, the coordinating practitioner or the independent practitioner (as the case may be) <i>must</i> refer the applicant to another psychiatrist for a second capacity assessment. The coordinating practitioner or independent practitioner must take account of any opinion provided by the psychiatrist.	Rejected

106	Doris		The independent and coordinating practitioners must say on their respective statements (following first and second declarations), the reasons the applicant gives for why they have applied.	Rejected
111	Doris	Schedule 2	Tidying amendment. Coordinating doctor to specify on statement the reasons given by a person for wanting drugs to take their own life.	Rejected
115	Doris	Schedule 2	Tidying amendment. Independent doctor to specify on statement the reasons given by a person for wanting drugs to take their own life.	Rejected
116	Doris	After section 8	New section: Assessment of palliative care needs. Requires coordinating practitioner to, after the first declaration is made, refer the person requesting lethal drugs to have a palliative care assessment, to ensure they are getting their care needs met. The assessment must be made by a palliative care specialist. Palliative care needs includes relevant social care needs.	Rejected
117	Doris	After section 8	New section: Medical practitioner's report. Amendment for increased accountability and strengthening protections against doctor-shopping. Both the coordinating and independent practitioners must prepare a report detailing the information gathered during their assessments and their reasons for approving or turning down an application for a person to end their life. The form is to be set out by Scottish Ministers in regulations. This does not apply if the applicant cancels their request for lethal drugs to end their lives after the first declaration.	Rejected
117A	McMillan	After section 8	Amendment to amendment 117, adds time limited protection against doctor shopping. Adds that if either assessing doctors have turned down an application, another doctor cannot, in relation to the same request, make a new assessment within a six-month window, starting from the date of which the assessing doctors' reports are recorded in the patient's medical records. This amendment does not stop psychiatrist capacity assessment referrals within this window, or an assessment to verify whether the applicant is terminally ill or not.	Rejected
239	Sweeney	After section 8	New section: Referral to multidisciplinary panel. When both declarations have been made by the registered practitioners, the coordinating practitioner must refer the person's case to an Assisted Dying Review Panel for determination of a person's eligibility to be provided with lethal drugs to kill themselves. Scottish Ministers to make, by regulations, provision for the Assisted Dying Review Panels.	Rejected

			<p>New section: Determination by panel for eligibility for assistance. Specifies that the panel must hear from and may question the coordinating or independent practitioners (or both), and the person who has requested drugs to end their lives, and may hear from and question any other person, and may ask any person with relevant knowledge or experience as considered appropriate. This allows for pre-recorded audio or video where appropriate for medical reasons. In exceptional circumstances, the panel can justify not hearing from the person applying for lethal drugs to kill themselves. If satisfied with the application for lethal drugs, the panel must grant a certificate of eligibility. The coordinating practitioner, the applicant and any other person specified by Scottish Ministers by regulations must be informed of the decision by the panel.</p>	Rejected
240	Sweeney	After section 8	10	Rejected
241	Sweeney		<p>Tidying amendment in relation to amendments 239 and 240.</p> <p>New section: Right to advocacy. Creates advocacy service similar to that of Australia's 'care navigators'. The advocate is to be available to any person applying for drugs to kill themselves to offer emotional support, and legal and procedural guidance through the process. They are also to ensure the person's rights, autonomy and wellbeing are prioritised. The advocate is to be a person not previously known to the applicant - they cannot be a family member or a person otherwise involved in the provision of care or support to that individual. The advocate is to act if the individual's rights are at risk of being breached, though there is no detail on which rights these are. [Which rights are being referred to is unspecified in the amendment. Opponents of the Bill and supporters of the Bill talk about 'Rights' in very different ways. Is it a 'right' to have easy access to lethal drugs, or is it a 'right' to care and support, which would not lead a person to want to kill themselves - e.g. help with independent living, social care support, suicide prevention services, psychological intervention, reduced waiting times for essential support services, and emotional support that prevents the harm of isolation and loneliness?]</p>	Rejected
242	Greer	After section 14		Accepted

243	Greer	After section 14	Ministers in regulations. There is no requirement for Scottish Ministers to specify who these advocates may be, or what sort of training they need to have. They could be non-medical third sector professionals, or psychiatrists - there is no detail on this, and no requirement for subsequent detail. There is no requirement for the Scottish Government to consult before laying legislation before the Scottish Parliament.	Accepted
173	Whittle	15	Lethal drugs must only be supplied to a coordinating practitioner or authorised health professional (nurse) by a registered pharmacist. Writing pharmacist into the Bill	Accepted
175	Whittle	15	The coordinating practitioner or authorised health professional does not provide the lethal drugs to the person wanting to kill themselves. Rather they must be present when they are handed over to the person for ending their life.	Rejected
76	Baillie	15	Where a nurse is providing the lethal drugs to the adult about to kill themselves, there must be a registered practitioner (coordinating or independent practitioner) present. This provides a safeguard for the nurse against accusations of malpractice (e.g. euthanising a patient or mishandling lethal drugs).	Accepted
77	Baillie	15	Nurses cannot assess whether a person wanting to kill themselves has capacity to request lethal drugs to commit suicide. Nurses also cannot assess whether someone has been coerced or pressured into committing suicide. The amendment was drafted with the Royal College of Nursing, which expressed concern that coercion is very difficult to detect and nurses are not trained to do this, or assess capacity. Only doctors (registered practitioners) are to make these assessments in the final stage before a person kills themselves.	Accepted
176	Webber	15	The doctor must inform the patient at the time, or immediately prior to the lethal drugs being provided, of potential risks of complications of the lethal drugs, including risks of pain, and any potential side effects.	Rejected
244	Marie McNair	15	No health practitioner or doctor can commit euthanasia (administering the lethal drugs themselves, rather than the patient self-administering the drugs).	Accepted
78	Baillie	15	Rules out the coordinating practitioner being accompanied by a nurse when giving lethal drugs to a person to kill themselves. Instead they may be accompanied by another registered practitioner (i.e. an independent practitioner).	Accepted

10	Johnson	15	Allows the doctor to 'assist' an adult with ingesting lethal drugs to kill themselves, though the amendment does clarify the final act must be taken by the terminally ill adult and says euthanasia is not allowed. Permitting assistance with <i>ingesting</i> does blur the line and move the Bill much closer to the act of a doctor euthanising the patient. The coordinating practitioner may prepare a medical device to enable an adult to kill themselves.	Accepted
79	Baillie	15	During the act of suicide, where the applicant is provided with lethal drugs and uses them, a nurse must be accompanied by another authorised health professional to provide a safeguard for that nurse and that patient.	Accepted
177	Whittle	15	When a coordinating practitioner (doctor) is accompanied by another authorised health practitioner (nurse), or a nurse is accompanied by another nurse, they may delegate all aspects of the final approval and provision of lethal drugs to that accompanying health professional. This also includes staying with the person until they have died. [Note that amendments requiring the doctor to stay in the same room in case of complications was rejected by the committee.]	Rejected
178	Whittle	15	Requires the doctor to stay in the same room as the person whilst they are dying in case of complications, pain, regurgitation, or failed assisted suicide.	Rejected
179	Ross	15	Adds that the doctor or health practitioner must remain with the person until that practitioner determines that the lethal drugs have failed to take effect.	Rejected
33	McArthur	15	Clarifies that the doctor or nurse need not stay with the patient after they have swallowed or otherwise ingested lethal drugs to kill themselves. [They do not need to wait with the patient to check that there are no complications, such as choking, vomiting, or fluid in the lungs, or failure of the drugs to kill the person.]	Accepted
181	Webber	15	Where the lethal drugs fail to kill a person, the coordinating practitioner (doctor) or authorised health practitioner (nurse) must take all reasonable steps to preserve life, including reversing the effects where possible. Any incident of this kind must be recorded, detailing the substance used, sequence of events, and action taken to preserve life.	Rejected
182	Webber	15	If any person provides or administers an additional substance, drug or treatment to kill the adult after that adult has taken the approved lethal drugs to kill themselves, they will be subject to homicide laws.	Rejected

183	Webber		15	The coordinating practitioner must record any complications, adverse reactions, or unintended consequences caused by the lethal drugs. The coordinating doctor must submit an anonymised report to Public Health Scotland.	Accepted
184	McMillan		15	The coordinating practitioner must report any complications, adverse reactions, or unintended consequences caused by the lethal drugs to Public Health Scotland. Does not specify that it must be anonymised.	Accepted
245	Sweeney		15	The coordinating practitioner or authorised health professional must report to Public Health Scotland where a poisonous substance has been consumed, with the intent to kill a person under provisions of the Bill, but has failed to kill that person within a reasonable period or caused adverse side effects (e.g. vomiting, pain, choking, fluid in the lungs.) Scottish Ministers are to set out what is considered a reasonable period. (Note that Oregon's 2023 report showed half of deaths by assisted suicide took between 53 minutes and over 5 and a half days.)	Rejected
185	Whittle		15	Authorised health professional also includes pharmacist. This authorised health professional is allowed to provide lethal drugs to a person to kill themselves. They would then have to witness the ingestion of lethal drugs, and remain with (as defined by the Bill - in the same building) the person until they have died.	Rejected
125	Doris	After section 15		New section: Provision of assistance: further regulations. Scottish Ministers to set out by regulations how cases should be managed where deaths have not occurred within a reasonable period. Scottish Ministers to determine what is a reasonable period.	Rejected
187	McMillan	After section 15		New section: Further procedure: regulations under section 15. Scottish Ministers cannot specify which drugs are used until the Chief Medical Officer has prepared a report on the suitability of each drug or other substance used to kill those applying to end their lives under the Bill. This report must detail the safety of the substance and any associated side effects of using the substance. The Scottish Parliament must decide every three years whether these lethal drugs can continue to be used. The Chief Medical Officer is required to prepare a new report every three years.	Rejected
126	Kerr		16	After the patient has died, the coordinating doctor's final statement must include how long it took for the lethal drugs to kill the patient and any complications that arose during the death.	Rejected

188	Kerr	Schedule 4	17	Adds 'any complications arising during procedure' to the final statement form.	Rejected
36	McArthur		17	Tidying amendment	Accepted
246	Duncan-Glancy		17	Changes death certificate to clarify that the terminal illness is an underlying condition contributing to the person's death. This amendment removes the Bill's negation of any reference to the lethal substance used to kill the patient.	Rejected
37	McArthur		17	Inaccurately changes the death certificate to recording the terminal illness as the "direct cause of death".	Accepted
38	McArthur		17	Adds to the death certificate that the poisonous substance given to the adult to kill themselves is to be recorded as "other relevant medical information".	Accepted
247	Duncan-Glancy		17	Adds clarity to the death certificate that the "act of assisted dying, including use of the approved substance... is to be recorded as a direct cause of death".	Rejected
189	Fraser	After section 17		Families to be able to request a medical review of the case if they reasonably believe their loved one was not eligible to be legally provided with lethal drugs to kill themselves. The panel is to be conducted by a panel of registered practitioners, but not those involved in approving the person's death. They must examine medical records, declarations, statements and other appropriate information. If there is evidence of a person being wrongly killed by assisted suicide, then the panel must raise with the procurator fiscal.	Rejected
195	Briggs	After section 18		Embeds into the Bill that doctors are permitted to raise assisted suicide <b>unprompted</b> with patients, creating strong similarities between this Bill and the Canadian model.	Accepted
53	Baillie	Before section 21		Doctors or other health professionals cannot raise the subject of a person being provided with drugs to end their life with children (under 18s), unless the child has raised the topic with the doctor or other health professional previously. Assisted suicide cannot form an anticipatory care plan for any child.	Accepted
252	Duncan-Glancy	After section 21		Makes it illegal to advertise assisted suicide.	Accepted

253	Webber	After section 21	<p>New section: Offence of dissemination of information relating to substances used for assisted dying. Other than cases where Scottish Ministers have granted the disclosure of information relating to lethal drugs for the purposes of safe clinical practice for a defined period and to particular people, it is illegal to provide, publish, communicate, or make information available to others about the poisonous substances used. This includes information on quantities, combinations, methods of preparation, or suppliers for the drugs.</p>	Rejected
-----	--------	------------------	---	----------

## Correspondence 14 (email)

From: [redacted S.38(1)(b)]  
Sent: 26 November 2025 22:44  
To: First Minister  
Subject: ASSISTED SUICIDE

Dear Mr Swinney,

I write about the above bill going through Parliament currently. My constituency will be fought between Labour and SNP at the next election in May 2026. I have met both candidates and they say they are both pro life and would not support this legislation if it were to be voted on if they were in Parliament.

Putting aside people's views on the rights and wrongs of assisted suicide my overriding concern is the damage it will do to our already stretched health and social care services, which are under so much strain in Scotland at the present time. There has been a commitment by the government to fund the requirements of this bill if it is voted in. This will require a multi million pound budget to service all the elements of such a provision and will result in very stretched medical resources being diverted to end people's lives rather than treat patients who wish to live. In addition it appears that assisted suicide will be fully funded whereas services like palliative care are nowhere near fully funded and clearly will be adversely affected by the introduction of assisted suicide as most palliative care doctors would not wish to be involved. Whilst they might be able to opt out their organisations cannot, most likely resulting in reduced funding both from donors and also government and indeed staff leaving a service that no longer motivates them and I know from personal experience that hospice staff are perhaps the most dedicated members of the NHS.

In conclusion I would consider that it is wholly irresponsible and unforgivable for any government to introduce such a measure without fully funding palliative care and indeed social care to protect the most vulnerable in our society and to give people a genuine choice. This would be a deal breaker for me as I could not vote for your candidate knowing that his party had knowingly damaged our already fragile health service. It would not be sufficient to say that health boards have a duty to fund all the services that they are mandated to provide, as they are already required to do this currently. No this requires a major injection of new funding and I hope you can reassure me that your government would not introduce assisted suicide until the funding for these other essential services is secured.

Yours sincerely

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]

---

## Correspondence 15 (email)

**From:** Our Duty Of Care <info@ourdutyofcare.org.uk>  
**Sent:** 08 January 2026 09:56  
**To:** scottish.ministers@gov.scot  
**Cc:** Gray N (Neil), MSP <Neil.Gray.MSP@Parliament.scot>  
**Subject:** Conscience clauses in the Assisted Dying Bill

Neil Gray MSP  
Cabinet Secretary for Health and Social Care  
Scottish Parliament

Dear Mr Gray

### **Assisted Dying for Terminally Ill Adults (Scotland) Bill – legislative competence issues**

We are writing to you to seek clarification following your letter of 16 December to the Chair of the Health Social Care and Sport Committee.

We note the following paragraph in your letter:

*“It will be necessary to remove those sections of the Bill which are determined to be outwith competence during Stage 3 considerations, with the intention of these being addressed via a section 104 Order if the Bill passes, and discussion around which provisions would be required to be dealt with in this manner are continuing at pace between the Scottish Government and the UK Government.”*

We would be grateful if you would clarify which sections of the Bill require to be removed during Stage 3.

In particular, will it be necessary to remove clauses 18 (‘Conscientious objection’), 18A (‘No duty to raise assisted dying’), and/or 4A (‘Registered medical practitioner unable or unwilling to act: duty to direct’)?

Can you confirm that the Assisted Dying Bill will contain no clauses making provision for professionals to opt out of involvement in assisted dying when it has its final debate and vote in the Scottish Parliament?

Yours sincerely,

**[redacted S.38(1)(b)]** Our Duty of Care UK, **[redacted S.38(1)(b)]**.  
**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]** Honorary Professor of Surgery, **[redacted S.38(1)(b)]**.  
**[redacted S.38(1)(b)]**, Consultant in Palliative Medicine, **[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**, Emeritus Professor of Primary Palliative Care, **[redacted S.38(1)(b)]**

---

## Correspondence 16 (email + attachments)

**From:** [redacted S.38(1)(b)]

**Sent:** 08 September 2025 10:12

**To:** Cabinet Secretary for Health & Social Care 2024 <cabsechsc@gov.scot>

**Cc:** [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]

**Subject:** BMA bilateral follow up

Good morning

Please find attached a letter from [redacted S.38(1)(b)] BMA Scotland, following last week's bilateral meeting.

Best, [redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

**BMA Scotland**

British Medical Association

14 Queen Street, Edinburgh, EH2 1LL

T: [redacted S.38(1)(b)] | M: [redacted S.38(1)(b)] |

### ***Attachment 1 [Extract of relevant section within scope]***

[redacted - out of scope]

#### **Physician Assisted Dying**

[redacted S.38(1)(b)] explained that the Bill was an existential issue for the profession and stressed the importance of working together to make sure the final legislation is fully competent and protects all doctors. She asked what support the Scottish Government would be offering, acknowledging it is a Private Members' Bill, and specifically asked for safeguards, stressing that: the ability to opt-in is important; that must include the general right to refuse to participate; that there is no duty placed on any doctor to raise assisted dying with a patient; and that it is fully funded and equitable. [redacted S.38(1)(b)] BMA Scotland, outlined some further detail around our neutral position on the Bill and committed to sharing the 10 key points that form our policy position (please find attached). As confirmed in the meeting, we would be delighted to meet with the Scottish Government's shadow bill team. Please share [redacted S.38(1)(b)] contact email [redacted S.38(1)(b)] with your officials to arrange the meeting. I would like to thank you for the open and engaging conversation about the Bill, and it is reassuring to know you have a close and constructive relationship with Liam McArthur MSP. On one point of clarification, as outlined in detail in the attached paper, the BMA's position is for an opt-in model for doctors to provide assisted dying, namely only those who positively choose to provide the service should be able to do so.

[redacted - out of scope]

## **Attachment 2**

### **BMA Scotland position on Physician Assisted Dying**

Since 2021 the BMA has taken a position of neutrality on assisted dying, including physician assisted dying. This means that the BMA neither supports nor opposes a change in the law. We have been clear, however, that we have a responsibility to represent the views of our members in discussions on any legislative proposals. In order to do this, the BMA's Medical Ethics Committee (MEC) – which has a UK-wide remit and includes members from Scotland - undertook a significant piece of work to consider how we can best represent our members in debates across the UK and Crown Dependencies on assisted dying.

As was evident from our survey of BMA members, conducted in 2020, we represent members with a diverse range of views; as doctors we also have responsibilities to our patients. Central to the MEC's work, therefore, was the need to balance the different, and sometimes competing, interests of four different groups:

- Doctors who, for whatever reasons, would not be willing to participate in assisted dying;
- BMA members who would be willing to provide assisted dying if it were legalised;
- patients who may wish to access a lawful assisted dying service; and
- patients who may feel anxious about the provision of such a service.

To develop positions, the MEC reviewed what we already knew about our members' views (from previous engagement work including our member survey and dialogue events); communicated with other national medical associations about the issues their members were concerned about and how they were engaging in the debates; spoke with individuals working in jurisdictions where assisted dying is lawful (both providers and opponents); and carried out a literature review. With these considerations in mind, the MEC identified those issues that would significantly impact on our members, should the law change, and considered what, if any, view the BMA should take on those issues. As the work developed, the MEC sought views from other BMA committees – across all branches of practice – and our patient liaison group. This work was then approved and agreed by BMA Scottish Council and the three other national Councils across the UK. These views are set out below.

#### **An opt-in model for doctors to provide assisted dying**

Only those who positively choose to provide the service should be able to do so. This would give our members the maximum amount of choice about whether, and if so how, they are involved if assisted dying were legalised. It would also ensure that those who wanted to participate would receive the proper training and support and make the service easier to audit. This would also mean that patients would be assured that they will see a doctor who is supportive of their request and who has the knowledge, skills, experience and confidence to provide the care and support they need.

### **A general right to refuse to carry out activities directly related to assisted dying**

A standard conscientious objection clause is not sufficient for legislation on assisted dying. Doctors who do not opt-in to provide the service may, nonetheless, be asked to carry out tasks such as assessing capacity or life-expectancy as part of the assessment of eligibility. We know from our survey that some doctors do not oppose assisted dying in principle (and so would not be protected by a conscientious objection clause) but would not personally want to participate. If assisted dying were legalised, there should be a general right to decline to carry out these activities, which does not need to be based on matters of conscience.

### **No duty to raise the issue of assisted dying with patients**

The BMA's view is that assisted dying is not a 'treatment option' in the conventional sense and so, the Supreme Court judgments of *Mongomery* (concerning the scope of information that must be provided when seeking consent to treatment) and *McCulloch* (which covers doctors' duties to raise treatment options with patients) are not relevant to assisted dying. For the avoidance of any doubt, however, the BMA would want to see specific provision in any legislation to make clear that there is no duty on doctors to raise assisted dying with patients if it was legalised. Doctors should be trusted to use their professional judgement to decide when and if a discussion about assisted dying would be appropriate, taking their cue from the patient as they do on all other issues.

### **No prohibition on raising the issues of assisted dying with patients**

Doctors should be able to talk to patients about all reasonable and legally available options, a provision that limits or hinders open discussion about any aspect of death and dying is likely to be detrimental to patient care. A prohibition would also create uncertainty and legal risks for doctors, which may inhibit effective doctor/patient communication and understanding. Some patients find it difficult to bring up sensitive subjects in their consultations, and doctors are skilled at reading between the lines of what patients say and working out what has been left unsaid. They may therefore need to gently explore whether this is an issue the patient wishes to discuss. Official bodies in New Zealand and Victoria have raised concerns about the impact of this provision in their legislation and have recommended that it is amended.

### **Assisted dying should be provided as a separate service.**

If legalised, the BMA does not believe that assisted dying should be part of the standard role of doctors or integrated into existing care pathways. Rather, it should be arranged (but not necessarily delivered) through a separate service – the BMA has not taken a position on whether or not this should be part of the NHS. This could take the form of a professional network of specially trained doctors from across the country who have chosen to participate, who come together to receive specialised training, guidance, and both practical and emotional support. They would then provide the service within their own locality – for example, in the patient's usual hospital, or their home. Or it could be a combination of some specialist centres and an outreach facility to ensure that people across the country have access. In our view, having this degree of separation would be better for doctors and for patients and would help to ensure consistency, and facilitate oversight, research and audit of

the service. The model proposed in Jersey provides an example of how this could work.

### **An official body to provide information for patients**

If assisted dying were to be legalised, the BMA would wish to see the establishment of an official body (with legal accountability) to provide factual information to patients about the full range of options available to them, so that they can make informed decisions. This would ensure that doctors who did not wish, or did not feel confident, to provide information to patients about assisted dying had somewhere they could direct patients to, in the knowledge that they would receive accurate and objective information. It would also ensure that patients who may meet the eligibility criteria would be able to access the information they need without the requirement to go through their doctor and would have support to navigate the process.

### **Adequate funding and equitable access**

Governments must provide additional resources so that money and staff are not diverted from other, already over-stretched, services if assisted dying were to be legalised. The BMA has not taken a position on how assisted dying should be funded (and, in particular, whether it should be part of the NHS) but we are clear that it should be available to all those who meet the eligibility criteria on an equitable basis.

### **Statutory protection from discrimination or detriment**

If assisted dying were to be legalised, the BMA would want to see specific provisions in the legislation making it unlawful to discriminate against, or cause detriment to, any doctor on the basis of their decision to either participate, or not participate, in assisted dying.

### **Provision for safe access zones**

The BMA believes that any Bill to legalise assisted dying should include provision for safe access zones that could be invoked should the need arise, to protect staff and patients from harassment and/or abuse.

### **A formal review of all assisted deaths**

The BMA would want to see a system for routinely reviewing all assisted deaths to ensure that the correct process was followed, and to identify learning points to improve the management of cases, if assisted dying were legalised. Review committees are common in countries that have legalised assisted dying.

### **The collection and publication of data**

If legalised, there should be a requirement for data about all assisted deaths to be collected centrally, and for aggregated data to be published on a regular basis, to ensure openness and Transparency.

### **Open and transparent regulation**

The BMA does not have a view on what form it should take but, if the law changed, we would strongly support the establishment of an independent and transparent system of oversight, monitoring and regulation.

## Correspondence 17 (letter extract)

Neil Gray MSP  
Cabinet Secretary for Health and Social Care  
St Andrew's House  
Regent Road Edinburgh  
EH1 3DG

Sent by email – CabSecHSC@gov.scot

December 16, 2025

### Bilateral Meeting

#### Assisted dying for terminally ill adults (Scotland) Bill

[redacted - out of scope]

I acknowledged the huge amount of progress made as the Bill has passed through Stage 2 of the parliamentary process but highlighted that there was still some work required to make the Bill legislatively robust and the provisions workable for doctors.

My colleague [redacted S.38(1)(b)] outlined the BMA's concern at the amount of work required at Stage 3 to make the legislation competent and technically sound, which due to the upcoming Scottish Parliament election, adds time constraints. She asked for reassurances that the Scottish Government is reviewing the newly amended Bill and requested that they provide technical support to the member and the Private members Bill team leading the Bill on drafting. [redacted S.38(1)(b)] also asked if there is engagement with the UK Government on issues of legislative competence, particularly around 'no detriment', to anyone choosing to, or not to participate in assisted dying - being subject to discrimination or detrimental treatment in their current or any future job they apply for. We would welcome the opportunity to meet with the Scottish Government's Bill team prior to Stage 3 to discuss further specific areas of interest including safe access zones; the creation of a separate service; details of how an advocacy service, care navigator would work; formal review of all assisted dying deaths; and for 'opt-in' to be on the face of the Bill. It is also important to stress the importance of the principle that any cost does not come from the current NHS budget.

We welcomed your confirmation that discussions with the UK Government are advanced and look forward to hearing the detail in due course. You acknowledged that you had heard our message that we want the Scottish Government to become more involved, but we reject the suggestion that neutrality is a barrier to addressing the technical aspects of the Bill. As I pointed out, The BMA is neutral but that does not mean we will not act to ensure legislation is competent.

[redacted - out of scope]

With kind regards,

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**  
BMA Scotland

---

## Correspondence 18 (email + letter)

### *Email*

**From:** [redacted S.38(1)(b)]

**Sent:** 23 February 2026 10:01

**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>

**Cc:** Central Correspondence Unit <scottish.ministers@gov.scot>

**Subject:** Letter to Mr Neil Gray, Cabinet Secretary, re: proposed changes to Assisted Dying for Terminally Ill Adults (Scotland) Bill

Dear Mr Gray,

Please find attached a letter from seven medical and healthcare organisations in relation to the proposed changes to the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Kind regards

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

**Royal College of Physicians and Surgeons of Glasgow**

232 - 242 St Vincent Street, Glasgow, G2 5RJ

### *Letter*

Neil Gray MSP

Cabinet Secretary for Health and Social Care

Scottish Government

St Andrew's House

Regent Road

Edinburgh

EH1 3DG

Dear Cabinet Secretary,

### **Consensus statement – concerns about ADTIA (Scotland) Bill**

We, the undersigned medical and healthcare organisations, wish to express our significant collective concern regarding recent proposed changes to the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

The Scottish Government has now indicated that provisions relating to no duty to participate - and potentially other areas linked to professional regulation and employment protections - be removed from the Assisted Dying for Terminally Ill Adults (Scotland) Bill at Stage 3. This is on the basis that these issues are considered reserved matters, with the intention of addressing them subsequently

through a Section 104 Order. The prospect of removing matters of such professional, ethical, and legal significance from parliamentary scrutiny at Stage 3, and deferring them to secondary legislation after the Bill has passed, raises important questions about transparency, accountability, and the robustness of the legislative process. These protections are central to the safe, ethical, and fair delivery of care, and to the confidence of our medical workforce who may be affected by the legislation.

We recognise that views within the healthcare professions on assisted dying are diverse. Our organisations represent members with a wide range of ethical perspectives, and we respect the differing positions held by colleagues across health and social care. While we take **no collective view on the principle of assisted dying itself**, we are unified in our concerns about the legislative process now being proposed.

**Our shared concerns are as follows:**

**1. Removal of key safeguards from primary legislation**

Issues such as no duty to participate, regulatory protections, and employment rights are of significant ethical, professional, and operational importance. Their removal from parliamentary scrutiny at Stage 3 would represent a substantial weakening of the transparency and rigour expected in the development of major legislation affecting healthcare delivery.

**2. Risk to professional confidence and public trust**

Healthcare professionals must be able to rely on clear, robust statutory protections when legislation may require involvement in ethically sensitive practices. Addressing such protections only after the passage of the Bill - via secondary legislation not subject to the full parliamentary process - could undermine both professional confidence and wider public trust.

**3. Inadequate scrutiny of consequential provisions**

A Section 104 Order, by its nature, receives limited parliamentary scrutiny. Matters central to professional regulation, employment protections, and the rights of staff should not be left to a later process in which detailed debate, amendment, and accountability are significantly constrained.

**4. Implications for safe and ethical implementation**

If the Scottish Parliament is to consider legislation with such profound ethical and clinical implications, it is essential that all key safeguards, responsibilities, and protections form part of the primary legislation from the outset.

Our organisations remain committed to constructive engagement with the Scottish Government and Scottish Parliament as this Bill progresses. We stand ready to engage with a legislative process that is transparent, robust, and fully informed by the perspectives of the healthcare workforce it will affect.

**Signed**

- Association for Palliative Medicine (Scotland)
- Medical and Dental Defence Union of Scotland

- Royal College of General Practitioners Scotland
  - Royal College of Physicians and Surgeons of Glasgow
  - Royal College of Psychiatrists in Scotland
  - Royal College of Surgeons of Edinburgh
  - Royal Pharmaceutical Society
-

**Correspondence 19 (email)**

**From:** [redacted S.38(1)(b)]

**Sent:** 16 February 2026 17:35

**To:** Minister for Social Care and Mental Wellbeing

**Subject:** Assisted Dying Bill

Dear Tom,

As a constituent of yours I write to let you know that my wife and I are totally in support of the assisted dying bill and urge you to support the bill on our behalf.

My wife and I have personal experience of watching relatives and close friends in terrible pain and just wishing their life to end peacefully. No one should have the right to deny them their choice. We want this choice.

Please vote for this bill.

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

---

## Correspondence 20 (email + letter)

### *Email*

From: Chair-Scottish-Council  
Sent: 04 February 2026 13:39  
To: Cabinet Secretary for Health & Social Care 2024  
Cc: Chair-Scottish-Council  
Subject: Correspondence from RCGP Scotland - Assisted Dying for Terminally Ill Adults (Scotland) Bill

Good afternoon,

Please find attached correspondence from **[redacted S.38(1)(b)]** Royal College of General Practitioners (RCGP) Scotland, regarding the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Many thanks and kind regards,

**[redacted S.38(1)(b)]**

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]** | RCGP Scotland  
Royal College of General Practitioners  
**[redacted S.38(1)(b)]** 38 Thistle Street, Edinburgh EH2 1EN  
Tel: **[redacted S.38(1)(b)]** | **[redacted S.38(1)(b)]**

### *Letter*

**Neil Gray MSP**  
Cabinet Secretary for Health and Social Care

**Douglas Alexander MP**  
Secretary of State for Scotland

Via email: CabSecHSC@gov.scot; enquiries@ukgovscotland.gov.uk

4 February 2026

Dear Cabinet Secretary and Secretary of State for Scotland,

## **SAFEGUARDS FOR HEALTHCARE PROFESSIONALS**

I am writing regarding the legislative competence of parts of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of general practice. In March 2025, the RCGP

moved from a position of opposition to neither supporting nor opposing assisted dying, following a survey of our membership and a vote of our UK Council.

As you will be aware, the College has continued to engage with the legislative debate both to ensure that any changes to the law protect the interests of all patients and healthcare professionals, and that palliative care is appropriately resourced. We have sought to represent our member concerns during legislative stages of the Bill in Scotland to date, based on the principles we believe should be applied if legislation is to be introduced to legalise assisted dying.

Two of our central priorities have been to ensure that GPs and all healthcare professionals have a real choice to opt in to participating in delivery of an assisted dying service, and that there is protection from discrimination based on that decision.

Working with other Royal Colleges, professional bodies and health stakeholder groups, we supported a number of amendments at Stage 2, including those which strengthened Section 18 as a priority.

We are deeply concerned by the proposal to remove some important provisions from the Bill at Stage 3 and the uncertainty surrounding the process going forward.

- While we note that negotiations between the Scottish and UK Governments are ongoing, we urgently request clarity on the specific provisions of the draft legislation that have identified as requiring removal, and the reasons for their removal.

We would also welcome clarity on the reason for using a Section 104 rather than a Section 30 Order. To date, Section 104 subordinate legislation has only been applied to relatively minor or consequential amendments. We firmly object to the notion that the regulation of professionals with regards to a new assisted dying service in Scotland is minor or consequential. A Section 30 Order would offer the benefit of being clear to MSPs what the final wording of the Bill was going to be, rather than having to rely on negotiations between the UK and Scottish Governments which can only be finalised after a Bill has been passed in Scotland.

- Will MSPs be given absolute clarity of the process, and cast-iron assurance that these specific provisions of the Bill will be reintroduced should the Bill be passed?
- Will a draft of a section 104 order be available ahead of Stage 3 of the Bill?
- Will MSPs be afforded the opportunity to further amend the sections relevant to professional regulation at Stage 3, as they would in normal circumstances, or are those sections to miss their third stage of scrutiny?

I am sure you agree that utmost care must be taken in the development of legislation for assisted dying in Scotland. Our members are deeply concerned that such uncertainty now surrounds these critical safeguards.

I look forward to your response and my thanks for the continued collaboration for the strengthening of general practice.

Yours sincerely,  
**[redacted S.38(1)(b)]**



## Correspondence 21 (email + letter)

### *Email*

**From:** [redacted S.38(1)(b)]

**Sent:** 02 February 2026 09:32

**To:** Cabinet Secretary for Health & Social Care 2024 ; Central Correspondence Unit

**Cc:** liam.mcarthur.msp@parliament.scot

**Subject:** FAO: Secretary of State for Scotland and Cabinet Secretary for Health & Social Care - Assisted Dying

Good morning

Please find attached a letter from [redacted S.38(1)(b)] Royal College of Nursing Scotland.

Kind regards

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

RCN Scotland

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

### *Letter*

Neil Gray

Cabinet Secretary for Health & Social Care

CabSecHSC@gov.scot

Douglas Alexander

Secretary of State for Scotland

scottish.ministers@gov.scot

Dear Cabinet Secretary and Secretary of State for Scotland

I am writing regarding the ongoing discussion around the legislative competence of parts of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

As you will be aware, RCN Scotland continues to hold a neutral position on the principles of assisted dying but took a very active role in Stage 2 considerations of the Bill. One of our central priorities was to ensure that nursing staff have a real choice as to be involved in an assisted dying service or not and are protected regardless of their choices. We supported a number of amendments at Stage 2, including those which strengthened section 18.

We are therefore strongly concerned about the proposal to remove some important provisions from the Bill at Stage 3. While we note that negotiations between the

Scottish and UK Governments are ongoing, we would appreciate clarity on the below three questions.

**What specific provisions have you identified as potentially requiring removal?**

While the final content of any section 104 orders remains subject to negotiation, which provisions have been identified (by either the Scottish or UK Governments) that might require removal at Stage 3? In particular, are you considering the removal of any of the following: Sections 15(4A), (8) or (9); Section 18 (and if so, in its entirety or only specific subsections); any of Section 23 or any of Section 29?

**Why do you think they need removed?**

RCN Scotland is of the view that nothing in section 18 relates to reserved areas of the law and has received clear legal advice supporting this position. In summary, section 18 (even as amended at Stage 2) does not relate to “professional regulation,” it simply affords individuals with the protection that they cannot be compelled to take on a statutory function which would be created by a devolved health service. This protection is comparable to existing provisions in the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and Public Services Reform (Scotland) Act 2010.

In respect of the protection from detriment provisions, we do not consider that these are employment law provisions in the reserved sense and they clearly do not amend any of the employment rights statutes specified in the Scotland Act. Again, comparable protections linked to the delivery of other devolved public services exist in other legislation passed by the Scottish Parliament, most notably

- Mental Health (Care and Treatment) (Scotland) Act 2003- protections and duties affecting staff conduct
- Adult Support and Protection (Scotland) Act 2007- obligations and legal protections affecting workers
- And Section 42 of the Public Services Reform (Scotland) Act 2010- explicit no detriment provision which you have also correctly identified.

On the no detriment clause, we accept that there is a separate issue around the question of remedy and enforcement which would require an amendment to the Employment Rights Act 1996. This could be addressed via a section 104 order, but this does not change our view that the provisions currently in the Bill fall within the competence of the Scottish Parliament.

We also note earlier comments from the Scottish Government, ahead of Stage 2 that some of the provisions on training requirements of professionals contained in section 15 of the Bill may related to the regulation of health professionals and therefore be a reserved matter. Again, we do not consider that these provisions create a new regulatory regime for nurses and it appears analogous to the training requirements set out in the Health and Care (Staffing) (Scotland) Act and specific qualifications required under the Adults with Incapacity (Scotland) Act 2000.

**Why have you gone down the s104 route?**

If it is the case that some provisions of the Bill fall outwith the legislative competence of the Scottish Parliament, why have you decided to go down the section 104 route instead of dealing with these via a section 30 order? The latter approach would have

had the benefit of being clear to MSPs what the final wording of the Bill was going to be, rather than having to rely on negotiations between the UK and Scottish Government's which can only be finalised after a Bill has been passed in Scotland.

Looking at previous subordinate legislation laid under section 104, the approach taken to date appears to be that only relatively minor, or consequential amendments are made via these orders. Why is a different approach proposed for this Bill and will a draft of a section 104 order be available ahead of Stage 3 of the Bill?

I appreciate your consideration of our correspondence.

Yours sincerely

**[redacted S.38(1)(b)]**  
**[redacted S.38(1)(b)]**

Cc Liam McArthur MSP [liam.mcarthur.msp@parliament.scot](mailto:liam.mcarthur.msp@parliament.scot)

---

## Correspondence 22 (email)

**From:** [redacted S.38(1)(b)]

**Sent:** 20 January 2026 19:40

**To:** Cabinet Secretary for Health & Social Care 2024

**Subject:** Assisted Dying Bill - Section 17

Dear Cabinet Secretary

I noted with interest your reported concerns that there appears to be conflict between the Assisted Dying Bill and the regulation of health professionals in terms of protections for health care staff. I have previously raised a similar issue relating to death certification with Liam MacArthur MSP when the Bill was introduced.

Section 17 of the Bill relates to the certification and registration of death. The Bill as introduced has as Paragraph 2 of Section 17 *'For the purposes of section 24 (certificate of cause of death) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, the terminal illness involved is to be recorded as the disease or condition directly leading to their death (rather than the approved substance provided to them by virtue of section 15).'*

This differs markedly from the guidance on death certification from the General Medical Council. Any doctor completing a Medical Certificate of the Cause of Death is both legally and ethically obliged to complete to 'the best of his or her knowledge and belief'. The quotation is from the GMC Duties of a Doctor and re-iterated in the relevant legislation. A doctor aware that the patient has knowingly ingested, injected or had administered to them a lethal drug or mixture thereof is obliged to state the cause of death as Suicide by poisoning. Anything other would be unlawful and liable to the serious penalties.

In my capacity as [redacted S.38(1)(b)] I worked closely with Scottish Government on the formulation and then implementation of the Scottish Death Certification and Medical Review legislation. The requirement on the certifying doctor in that legislation is as stated in the GMC Guidance.

It is worth noting that Kim Leadbetter's Bill currently being considered in Westminster states that the cause of death should be entered as 'Assisted Death'.

Liam MacArthur kindly responded to me in detail that advice he received was that because Health is devolved and this Bill was separate from that in Westminster there was no conflict. It is still my professional opinion that this remains a complication for the Bill, able to be challenged in the courts and leaving doctors and registrars in a vulnerable position.

Best wishes

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

---

## **Correspondence 23 (email + letter)**

### ***Email***

From: Marie McNair MSP <Marie.McNair.MSP@Parliament.scot>  
Sent: 16 January 2026 14:42  
To: Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
Subject: (Case Ref: **[redacted S.38(1)(b)]**)

Dear Cabinet Secretary

Please find attached letter of which I would value a response.

Regards

Marie A McNair

Marie A McNair MSP  
Member of the Scottish Parliament  
Clydebank & Milngavie Constituency

### ***Letter***

16th January 2026

Ref: **[redacted S.38(1)(b)]**

Neil Gray MSP  
Cabinet Secretary for Health and Social Care  
The Scottish Government  
St Andrew's House  
Regent Road  
EDINBURGH  
EH1 3DG

Dear Cabinet Secretary

### **Assisted Dying for Terminally Ill Adults (Scotland) Bill**

I have recently had contact from representatives of St Margaret of Scotland Hospice in Clydebank.

The Hospice has raised concerns about what the ramifications for the Hospice would be if they do not implement any directive re Assisted Dying which would go against their beliefs, core values and on moral grounds, should the Assisted Dying Bill pass at Stage 3. This includes possible cuts to their funding and across the Hospice sector.

The Hospice also requests a meeting with yourself and officials to discuss this matter.

I would be most grateful if you could consider the above and provide comment.

Yours faithfully

Marie A McNair MSP  
Member of the Scottish Parliament  
Clydebank and Milngavie Constituency

---

## Correspondence 24 (email)

**From:** [redacted S.38(1)(b)]

**Sent:** 28 January 2026 19:05

**To:** Swinney J (John), MSP <John.Swinney.msp@parliament.scot>

**Subject:** Please read this, I humbly ask of you

Dear First Minister,

I trust you are well.

My name is [redacted S.38(1)(b)] and I am writing to you to discuss your Assisted Dying legislation.

As you can see from my email address, [redacted S.38(1)(b)]. I am a disabled man, and I suffer from [redacted S.38(1)(b)] although I do manage to live a semi-independent life. Much of this is only possible through the support of the Scottish government: I thank you kindly for all this.

The current government decision on Assisted Dying does not allow for mentally disabled people to make a deliberate decision to end their life. I think this is unfair and I would ask you to reconsider your position on this matter, please.

It was put to me several years ago that mental disability is worse than physical disability: there are no crutches to carry me, no drugs that can cure me and that is why the torture is ongoing and without definite end.

My life, and no doubt others too, is consistently painful. There is no break in my suffering, and the management of my condition is only temporary, so the maintenance is never ending.

Forgive me for this blunt point, as a dog would be treated better than a human being who is suffering unnecessarily.

I'm [redacted S.38(1)(b)] years old. I'm a recovering alcoholic addict and my life is trauma filled. To make matters worse no one confirms what I've endured and I am regularly gaslit. [redacted S.38(1)(b)] That said, it's unlikely that I will ever get a job. An honest man knowledgeable about Human Resources recently explained the reality for individuals like me. You can imagine.

I regularly generate ideas which are potentially profitable although no one ever listens to me simply because I have a condition. I was conned out of my intellectual property twenty-eight years ago and no one believes me, except for my mentor, [redacted S.38(1)(b)] .

Before I was diagnosed with this condition there was also a person who effectively confessed to a serious crime: no one listens because of my disability. (I spoke with a retired QC, and a retired sergeant, there is not enough evidence to proceed.)

My only option is to travel abroad to Belgium; they are the only country in the world where I might be accommodated. It costs at least £15k and even then, there's no guarantee.

I beg you to have a heart. Many suffer and it's needless.

Please help me.

Thank you,

[redacted S.38(1)(b)]

---

## Correspondence 25 (email + attachment)

### *Email*

**From:** [redacted S.38(1)(b)] On Behalf Of Minto J (Jenni), MSP  
**Sent:** 04 February 2026 11:34  
**To:** Minister for Public Health and Women's Health  
**Subject:** FW: Association for Palliative Medicine briefing regarding TIA Scotland Bill

**From:** [redacted S.38(1)(b)]  
**Sent:** 04 February 2026 11:26  
**To:** Minto J (Jenni), MSP <Jenni.Minto.MSP@Parliament.scot>  
**Subject:** Association for Palliative Medicine briefing regarding TIA Scotland Bill

**CAUTION:** *This e-mail originated from outside of The Scottish Parliament. Do not click links or open attachments unless you recognise the sender and know the content is safe.*

Dear Jenni Minto,

This is regarding the ongoing debate on the Terminal Adults (End of Life) Scotland Bill (aka Assisted Dying Bill). I am writing from the Association for Palliative Medicine of Great Britain and Ireland (APM).

We have prepared an updated detailed briefing document specifically for you, which we have attached for your consideration (or through this link - <https://apmonline.org/wp-content/uploads/Scotlandapmletterfeb26-final.pdf>) It outlines the key evidence on this critical matter, drawing upon our members' extensive and relevant clinical experience and warns of the new danger of large areas previously deemed essential now having been deferred with no vote.

We would be greatly honoured if you would take the time to review this material

Yours sincerely,

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]

### **Attachment**

Dear Scottish Member of Parliament,

**Re: Assisted Dying for Terminally Ill Adults (Scotland) Bill 2024 – Serious Critical Clinical Concerns**

We write as the professional body representing over 1,400 palliative medicine specialists across Great Britain and Ireland to express our profound and escalating

professional concerns regarding the Assisted Dying for Terminally Ill Adults (Scotland) Bill. We are deeply concerned that legislation in its present and now amended form is clinically unsafe, inequitable and unworkable

- **Inadequate Safeguards endanger patients**  
Lives are at risk through flawed prognostication, risk of coercion, no mental health assessment, no requirement for suffering, and patients rationale for AD can be feeling a burden or financial pressure.,.
- **Protect Palliative Care**  
With critical workforce shortages across Scotland, inequitable access to palliative care, predominantly charitably funded services, assisted dying must not become a default option.
- **Equity before expansion**  
Every patient deserves equitable access to high-quality palliative care before considering assisted dying - this must be guaranteed first.
- **Removal of Essential Governance Protections**  
It is now evident that critical provisions concerning professional regulation and conscientious objection will be omitted from the final Bill (Here). This means MSPs are being asked to approve legislation without the very safeguards they initially deemed necessary for safe implementation. The decision on these safeguards has been deferred to Westminster. There is now no guarantee that healthcare professionals will have the right to conscientiously object to involvement in AD without penalty, nor is there provision to protect patients from doctors suggesting assisted dying to them unprompted when they meet the eligibility criteria. For our full statement of serious concern see Here.

**We urge you to review:**

- Serious Clinical Concern regarding removal of essential clinical safeguards Jan 2026 (Here)
- Twenty-one Key Questions for MSPs to consider regarding the Scotland Bill – updated Feb 26 (Here)
- Assisted Dying MythBusters updated Jan 2026 (Here)
- A video by Dr Kath Mannix outlining what happens during ordinary dying (Here)
- The APM Scotland 2022 Assisted Dying Survey (Here)
- 

Our 2022 survey indicates that 75% of Scottish palliative care specialists would be unwilling to participate in the assisted dying process, with 43% indicating they would consider resigning if required to do so. The protection of professional conscience is not a peripheral issue but a cornerstone of ethical medical practice.

In matters of life and death, the threshold for safety must be unassailable. The current proposals fall demonstrably short of this standard, exposing vulnerable people to risks we cannot undo, while the palliative care they need remains inequitable and often unavailable. Until these profound concerns are meaningfully addressed, moving forwards with assisted dying in Scotland would risk normalising irreversible decisions borne from unequal access to care and not genuine choice. We urge extreme caution: dying people need investment in care and support, not legislation that could compound existing inequities.

Sincerely,

**Executive of the Association for Palliative Medicine**

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

---

## **Correspondence 26 (email + letter)**

### ***Email***

**From:** [redacted S.38(1)(b)]

**Sent:** 04 February 2026 11:40

**To:** Cabinet Secretary for Health & Social Care 2024

**Cc:** [redacted S.38(1)(b)]; McArthur L (Liam), MSP ; Lord Advocate ; Health, Social Care and Sport ; enquiries@ukgovscotland.gov.uk

**Subject:** BMA Scotland letter - Section 104 orders to ADTIA (Scotland) Bill

Please find attached a letter from [redacted S.38(1)(b)] BMA Scotland's Scottish Council, on our concerns on the section 104 orders on provisions in the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

If you require any additional information please don't hesitate to let me know.

Kind regards,

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

**BMA Scotland**

T: [redacted S.38(1)(b)] | M: [redacted S.38(1)(b)] | E: [redacted S.38(1)(b)]

14 Queen Street, Edinburgh, EH2 1LL

### ***Letter***

Mr Neil Gray MSP

Cabinet Secretary for health and social care

Scottish Government

**\*\*by email\*\***

## **Section 104 order for Assisted Dying for Terminally Ill Adults (Scotland) Bill**

Dear Cabinet Secretary

Since 2021 the BMA has taken a position of neutrality on whether the law should be changed on assisted dying. We have however, sought to engage with legislation across the UK and Crown dependencies, to ensure that any legislation that is passed, is the best and safest it can be, not only for our members who may choose to engage or not engage with any new service, but also for patients.

At stage two of Liam McArthur MSP's Assisted Dying for Terminally Ill Adults (Scotland) Bill, BMA Scotland worked with various MSPs and other health organisations to lodge amendments to provide protection from detriment and discrimination and allow for a genuine choice about participation in any newly

created service. This included amendments on the creation of an opt-in model, no duty to participate and no detriment should a health care professional choose to or not to participate. These amendments allowed for doctors to understand the scope of their involvement, and their options in how they could choose to interact with any new service created, should this legislation pass.

In your letter to the Convenor of the Health, Social Care and Sport Committee, dated 16th December 2025, you outlined the areas under consideration for a potential section 104 order. As I am sure you will appreciate many of our members are now raising concerns about what this means for the provisions that we worked hard to have included in the Bill; and should the Bill pass, what it would mean for doctors who would require these very important protections and safeguards. Further it would be helpful to understand the Scottish Government's rationale for seeking a section 104 order as opposed to a section 30 order which, as we understand, would have allowed the Scottish Parliament to make provisions for these issues within the Bill itself.

Given the Scottish Government's decision to request a section 104 order, we appreciate these provisions on regulation of health professions and employment, and industrial relations must now be provided through a different mechanism. As we approach stage 3, therefore, it is vital that trade unions and professional bodies have clarity on the specific areas affected by the need for a section 104 order; understand exactly what provisions will be removed from the Bill at stage 3; and have assurances about when and how they will be reinstated. This information needs to be shared as soon as possible alongside drafts of the provisions as they would be passed in the section 104 order, and crucially with additional assurances from the UK Government that this will happen in a timely fashion should the Assisted Dying for Terminally Ill adults (Scotland) Bill pass. Removal of provisions on regulation of health professionals and employment and industrial relations, without a clear timeline and transparent plan for inclusion via a section 104, will lead to confusion and uncertainty for the medical profession.

As the Bill has progressed through the Scottish Parliament there has been a disappointing lack of technical oversight from the Scottish Government. Whilst we appreciate this is a Member's Bill, it is the job of government to ensure that any Bill is technically sound and pragmatically workable, should it pass. This Bill in particular, which would create a service in an already, and understandably, heavily regulated sector, requires support and oversight. We are now asking you directly for you and your team to work to provide more technical assistance to this Bill at stage 3.

We would be more than happy to meet with you to discuss our concerns.

Yours sincerely,

**[redacted S.38(1)(b)]**

**[redacted S.38(1)(b)]** BMA Scotland's Scottish Council

cc Liam McArthur MSP

cc Clare Haughey MSP, Convenor of the Scottish Parliament's Health, Social Care  
and Sport Committee  
cc Patricia Ferguson MP, Chair of the UK Parliament's Scottish Affairs Committee  
cc Secretary of State for Scotland the Rt. Hon. Douglas Alexander MP  
cc Lord Advocate Rt. Hon. Dorothy Bain KC

---

## Correspondence 27 (email)

From: [redacted S.38(1)(b)]

Sent: 12 February 2026 15:13

To: Cabinet Secretary for Health & Social Care 2024

Subject: The Right to Die

Dear Sir,

I sincerely believe that the option of an assisted death should be the right of every individual wanting to avoid or end incurable suffering. My belief is strengthened by my own experience of recurring episodes of severe pain for over fifty years.

I am [redacted S.38(1)(b)] and have known bouts of severe headache for most of my life. The condition began in my early teens and lasted until my late sixties. Episodes usually lasted 1 to 3 hours, although they could last longer. The frequency of these episodes was varied and unpredictable.

In the [redacted S.38(1)(b)] I was referred [redacted S.38(1)(b)]. Their diagnosis was that I was suffering from [redacted S.38(1)(b)], a condition for which there was (and probably still is) neither cure nor treatment. Painkillers had no discernible effect.

Brain Research UK describe cluster headache as follows:

“Cluster headache is a rare headache disorder characterised by recurring bouts of excruciating headaches on one side of the head. The pain is overwhelming, with cluster headache described as one of the most painful conditions known to man.

Most patients have '*episodic*' cluster headache - with bouts (or '*clusters*') of pain that last between 4 and 12 weeks once a year. They may then be headache-free until the following year. A small number of patients do not have these pain-free intervals and are said to have '*chronic*' cluster headache<sup>(1)</sup>.

Around 65,000 people in the UK suffer from cluster headache. But whilst rare, cluster headache is enormously debilitating. Those affected are rendered incapable of functioning normally or maintaining daily life during these bouts of headache.”

<sup>(1)</sup> My cluster headache was of the chronic type

Not once during the fifty plus years I suffered from chronic cluster headache did I wish to die. I knew that each episode would end and that I could then resume normal life until the next unpredictable episode. However, had the condition ever become unremitting, I would most certainly have wished for an assisted death. The same would apply to any possible future diagnosis that I was suffering from a terminal medical condition resulting in continuous pain prior to death.

Fortunately, I never felt sorry for myself and remained optimistic. I continued and completed my academic studies to postgraduate level. Happily, my chosen profession allowed me to work around episodes.

I firmly believe that everyone having the mental capacity to make their own decision should have the right to seek an assisted death under defined circumstances. Anyone other than the individual seeking an assisted death should be unable to influence, alter or rescind the recorded authorisation of that individual.

Yours faithfully,

**[redacted S.38(1)(b)]**

---

## Correspondence 28 (email + letter)

### *Email*

**From:** [redacted S.38(1)(b)]

**Sent:** 18 February 2026 11:34

**To:** Cabinet Secretary for Health & Social Care 2024

**Cc:** Central Correspondence Unit

**Subject:** Letter from [redacted S.38(1)(b)] Royal College of Physicians of Edinburgh.

Dear Cabinet Secretary,

Please find enclosed a letter from [redacted S.38(1)(b)] the Royal College of Physicians of Edinburgh regarding the Assisted Dying for Terminally Ill Adults (ADTIA) Bill.

Kind regards,

Douglas.

[redacted S.38(1)(b)]

[redacted S.38(1)(b)]

Royal College of Physicians of Edinburgh  
11 Queen Street, Edinburgh, EH2 1JQ  
T: [redacted S.38(1)(b)]  
E: [redacted S.38(1)(b)]  
W: rcpe.ac.uk



ROYAL  
COLLEGE of  
PHYSICIANS of  
EDINBURGH

### *Letter*

Neil Gray MSP  
Cabinet Secretary for Health and Social Care  
The Scottish Government  
St Andrews House  
Edinburgh  
EH1 3DG

Sent by email: CabSecHSC@gov.scot

Dear Neil,

### **Assisted Dying for Terminally Ill Adults (ADTIA) Bill**

As you will know the RCPE has no position on the Assisted Dying for Terminally Ill Adults (ADTIA) Bill and neither supports nor opposes its introduction in Scotland.

We appreciate the complexities of competence surrounding the ADTIA Bill and note that whilst the presiding officer initially regarded all provisions of the Bill as being within the legislative competence of the Scottish Parliament, the current view of the Scottish Government, and indeed the Bill's sponsor, Mr Liam McArthur, are that some provisions are not and will require to be managed by Section 30 and Section 104 orders respectively. As such, collaborative working with the UK Government would be necessary were the Bill to pass in Holyrood at Stage 3.

Clearly this situation has raised concern amongst some members of the profession – essentially there is concern that MSPs will not be able to give adequate scrutiny to the parts of the Bill that are removed, that subsequent scrutiny of those parts will be based at Westminster not Holyrood, and that an interim period of legal uncertainty would exist - the Bill having been passed in Scotland, but the requisite protections for doctors in relation to conscientious objection, the use of lethal substances, and patients with regard to unsolicited recommendations of AD would not be in place.

We therefore ask the following.

1. What reassurance can be given that MSPs will indeed scrutinise those parts of the Bill to be removed?
2. What scrutiny will be given to those parts removed and by whom, should the Stage 3 vote pass in Holyrood?
3. At what point would AD in Scotland become legal, with the full protections for doctors and patients implied by the word “legal”, should the Bill pass at Stage 3? Immediately, or only after Section 30 and 104 issues are resolved?

Kind regards,

**[redacted S.38(1)(b)]**

Royal College of Physicians of Edinburgh

---

## Correspondence 29 (email + letter)

### Email

From: Delegated Powers and Law Reform [redacted S.38(1)(b)]  
Sent: 14 January 2026 14:49  
To: Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
Cc: Minister for Parliamentary Business and Veterans <MinisterPBV@gov.scot>; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; Constitution, Europe, External Affairs and Culture [redacted S.38(1)(b)]>  
Subject: Letter regarding the Scotland Act 1998 (Modification of Schedule 5) Order 2026

Dear Cabinet Secretary,

Please find attached a letter from the DPLR Committee. The Committee requests a response by Monday 19 January.

Please let me know if you have any questions.

Kind regards,

[redacted S.38(1)(b)]  
[redacted S.38(1)(b)]



[redacted S.38(1)(b)]  
Delegated Powers and Law Reform Committee  
Comataidh Cumhachdan Tiomnaichte is ath-Leasachadh Lagh

The Scottish Parliament / Pàrlamaid na h-Alba  
Edinburgh EH99 1SP / Dùn Èideann EH99 1SP

### Letter

Available at: <https://www.parliament.scot/-/media/files/committees/delegated-powers-and-law-reform-committee/correspondence/2026/20260114-convener-to-cab-sec-health-s30-order.pdf>

---

**Correspondence 30 (Letter)**

From Stephen Kinnock MP  
Minister of State for Care

39 Victoria Street  
London  
SW1H 0EU

29 July 2025

Dear Neil,

**[redacted S.28(1)]**

Yours sincerely,

STEPHEN KINNOCK

---

## **Correspondence 31 (letter)**

Available at: <https://www.parliament.scot/-/media/files/committees/health-social-care-and-sport-committee/correspondence/2025/20250926-hscs-convener-to-cabinet-secretary-for-health-and-social-care--assisted-dying-for-terminall.pdf>

---

**Correspondence 32 (letter)**

Neil Gray MSP  
Cabinet Secretary for Health and Social Care  
Scottish Government  
St Andrew's House  
Regent Road  
Edinburgh  
EH1 3DG

Via email

16 December 2025

Dear Neil,

**The Assisted Dying for Terminally Ill Adults (Scotland) Bill**

[redacted S.28(1)]

**KIRSTY MCNEILL**

**MP PARLIAMENTARY UNDER-SECRETARY OF STATE FOR SCOTLAND**

---


## Correspondence 33 (email + letter)

Dear [redacted S.38(1)(b)]

Thank you for sight of the earlier letter from the Cabinet Secretary. Please find attached my response and I will ask my office (copied) to follow up with you to establish when the suggested meeting might take place following the lodging deadline for amendments on 29 October and the start of Stage 2 proceedings in the Health & Social Care Committee on 4 November.

Kind regards, Liam

**Liam McArthur MSP**  
**Liberal Democrat, Orkney**

-----  
**Scottish Parliament Edinburgh EH99 1SP**  
**Tel: [redacted S.38(1)(b)] Fax: [redacted S.38(1)(b)]**  
**Constituency Office: 14 Palace Road, Kirkwall, Orkney KW15 1PA**  
**Tel: [redacted S.38(1)(b)] Fax: [redacted S.38(1)(b)]**  
✉ Liam McArthur  Liam McArthur MSP

### *Letter*

Liam McArthur MSP

Neil Gray MSP  
Cabinet Secretary for Health and  
Social Care

20 October 2025

Dear Neil

Thank you for your letter of 16 October 2025, updating me on the actions and decisions that have been taken by the Scottish Government in relation to the Assisted Dying for Terminally Ill Adults (Scotland) Bill, ahead of stage 2 proceedings commencing on Tuesday 4 November.

Many thanks for the update provided on your ongoing discussions with the UK Government, after the Scottish Government put proposals to the UK Government on 8 September 2025 to try and resolve the legislative competence issues with the Bill. Your commitment to continue to provide updates is helpful. I note that a substantive response from the UK Government is expected, and, given the timescales involved, perhaps may be expected in the near future. I expect that an agreement between the two Government's would need be finalised imminently to ensure that any order can be laid and scrutinised within relevant timescales. I would be grateful if you would keep me informed. It would also be helpful if you could share any further details, from the Scottish Government's perspective, about the content of the proposals and timescales of ongoing discussions.

In terms of stage 2 proceedings on the Bill, I note that you state,

“given our neutral position, we will not be preparing or lodging any Scottish Government amendments to the Bill during Stage 2”.

I was disappointed to read that, and would welcome any further explanation you can provide on:

- why this position has been adopted;
- whether the Scottish Government anticipates changing the position ahead of stage 3; and
- the extent to which you believe that the position is consistent with the decision taken by the Parliament to support the general principles of the Bill at stage 1, and the statement made on the Scottish Government’s website concerning the Bill, which states,

“...we consider that we have a duty to assess the technical, legal and deliverability implications of proposed amendments to ensure the Bill is workable in practice, if passed at the Stage 3 vote.”

I welcome and agree with that statement made by the Government, and seek reassurance that the Scottish Government will approach that duty to ensure full workability of all aspects of the Bill responsibly and timeously. Stage 2 provides an opportunity to debate and consider amendments on technical, legal and workability issues, as well as policy issues, and, as you know, is also an opportunity to avoid a busier than may be necessary, or indeed ideal, stage 3 process.

I note your comments regarding the potential for a Financial Resolution likely being required for certain amendments at stage 2, and welcome your commitment to being prepared to lodge such a resolution, if it is required.

Finally, thank you for your offer of a meeting before stage 2 proceedings begin on 4 November. For that meeting to be of most use, it would perhaps be helpful for it to take place after the deadline for amendments for all MSPs has closed on Wednesday 29 October. I would therefore suggest either Friday 31 October, or Monday 3 November, for a meeting if you are able to attend on either of those days.

Yours

Liam McArthur MSP

---

## Correspondence 34 (email + letter)

### *Email*


**From:** [redacted S.38(1)(b)] On Behalf Of McArthur L (Liam), MSP  
**Sent:** 10 December 2025 15:41  
**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
**Cc:** [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)];  
**Subject:** Letter from Liam McArthur to the Cabinet Secretary for Health and Social Care, 10 Dec 2025

Dear Cabinet Secretary,

Please find attached a letter regarding the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Kind regards,  
Liam

**Liam McArthur MSP**  
**Liberal Democrat, Orkney**

-----  
**Scottish Parliament Edinburgh EH99 1SP**  
**Tel:** [redacted S.38(1)(b)] **Fax:** [redacted S.38(1)(b)]  
**Constituency Office: 14 Palace Road, Kirkwall, Orkney KW15 1PA**  
**Tel:** [redacted S.38(1)(b)] **Fax:** [redacted S.38(1)(b)]  
✉ Liam McArthur  Liam McArthur MSP

### *Letter*

Neil Gray MSP  
Cabinet Secretary for Health and Social Care

Liam McArthur

10 December 2025

Dear Neil,

### **Re: Assisted Dying for Terminally Ill Adults (Scotland) Bill**

This letter sets out some of the areas that I consider would require engagement from the Scottish Government, as well as some issues that would greatly benefit from the Scottish Government's involvement and input. This letter also sets out some issues/questions regarding the Scottish Government's liaison with the UK Government on issues of legislative competence.

### **Stage 3**

Following the completion of stage 2 of the Assisted Dying for Terminally Ill Adults (Scotland) Bill, and with stage 3, as I understand it, likely to take place in mid-March 2026, as previously emphasised to you, it is important to allow for the standard functioning of the legislative process that the Scottish Government engages at this point on the following issues:

### **Operation of an assisted dying service**

- A central consideration ahead of stage 3 is how an assisted dying service will operate in Scotland should the Bill be passed, and whether the Scottish Government considers that anything more is needed in terms of Bill provisions to ensure that sufficient arrangements can be made for the effective operation and deliverability of services in practice (within or alongside existing NHS structures and patients' rights frameworks). This has been a key focus for me and other members across Parliament engaging constructively with the stage 2 process. In all other legislation the Scottish Government's function in the legislative process 2 involves developing any amendments that it considers are required to ensure bills can be effectively implemented in practice, drawing on its unique role overseeing the bodies that will deliver legislation. In the interests of ensuring any gaps are identified, would the Scottish Government intend developing any amendments as part of its standard role in the legislative process?
- In addition, the Government would normally, in its role as guardian of the statute book, draft amendments for stage 3 to address any inconsistencies that inadvertently have been created during the course of the stage 2 process. I do not, as you know, consider that such a role impacts on the Scottish Government maintaining a neutral position on the Bill. As an example, the Bill, as amended, now contains section 20A, a duty on the Scottish Ministers to make provision about the provision of assistance outwith the NHS. It would be helpful to understand the Scottish Government's views on this section. I also note that as an amendment seeking to make the related regulations subject to the affirmative procedure was not agreed to, no procedure currently attaches to the regulation making power in this new provision (see the annexe for a list of further drafting issues which should be addressed).
- The Government was engaged at stage 2 to the extent that it posted views on the Scottish Government website on all the non-government amendments considered at stage 2. I sought to feed in the Scottish Government's position during the course of stage 2 to ensure the Committee was considering all the context in voting on amendments, and the Government's views (in the absence of amendments expressing them) are of course important in these decisions. Given the Government has a position, as stated on its website, on numerous amendments likely to be considered again at stage 3, does the Government intend to make associated amendments at stage 3, for example to ensure that assisted dying services can be planned, commissioned and delivered across the whole variety of different settings?
- For comparison, consider sections 41 and 42 of the Westminster Bill as it currently stands. I note that section 41(4), for example, enables the Secretary

of State to add reference to assisted dying services into existing health legislation (specifically to add assisted dying services to the meaning of “health service” under section 1(1) of the NHS Act 2006). Does the Scottish Government consider that my Bill would require something similar? Note also that section 41 of the Westminster Bill as it currently stands makes explicit provision about NHS assisted dying services having to be provided free of charge (considering the breadth of settings in which assisted dying might be provided). I would welcome the Scottish Government’s view on that point.

### **Interaction of the Bill with Westminster Bill if passed**

- As previously highlighted, there will be implementation issues, such as, for example, cross-border issues, that may need to be addressed should the 3 Westminster and Scottish Parliament Bills both pass, and different assisted dying services be provided for in England and Wales and in Scotland. Indeed, consideration would also need to be given should one bill proceed, and one bill fall. These are active considerations for the Government which in no way impacts on its neutral position. It would be helpful to understand what consideration the Scottish Government is giving to what (if anything) may need to be added to the Bill at stage 3 to enable it to address such points if necessary. I would also welcome clarification on whether the Scottish Government has had, or intends to have, any discussions with the UK Government on addressing issues arising from potentially having two different assisted dying regimes in place in parts of the UK.

### **UK Government liaison and legislative competence (Scotland Act Orders)**

I, along with members of my team and supporting officials in the Scottish Parliament, met with Scotland Office officials on 4 December 2025. It was a helpful meeting which reiterated and added detail to some of the points you outlined when we met on 19 November 2025. I understand discussions continue to take place. As the Member in charge of the Bill, I take an utmost interest in ensuring that the safeguards, checks and balances contained in my Bill, and that stakeholders and MSPs voting on my Bill consider crucial (such as section 18 of the Bill), are maintained.

I am conscious that the Scottish Government, in its memorandum of September 2024, considered some of the provisions in my Bill as introduced as possibly being outside of the Scottish Parliament’s legislative competence (sections 4(5)(a), 6(6)(a), 7(2)(c), 15(8) and 18). I am aware that the Bill as amended at stage 2 now contains provisions that the Scottish Government, in its comments, also considered as adding to the legislative competence discussions with the UK Government. I therefore request clarification from the Scottish Government regarding:

- its involvement in the section 104 order discussions;
- which provisions of the Bill, as amended at stage 2, specifically, the Scottish and UK Governments agree should be captured in the order; and
- how it is proposed that the Bill be amended as a result of the planned contents of a section 104 order (and confirmation that the Scottish Government would intend to lead on drafting/lodging any resulting required amendments). In this context, and especially as section 104 orders are not laid before the Scottish Parliament, how will it be ensured that the

aforementioned safeguards, checks and balances in my Bill will be maintained?

Finally, I am aware that the Scottish Government is continuing to consider how it intends to approach stage 3 and engage with me on addressing issues such as those I have set out in this letter, including with regard to identifying and drafting any required amendments. I urge the Scottish Government to work with me ahead of stage 3 to ensure full workability of all aspects of the Bill responsibly and timeously.

I also urge the Scottish Government to consider the extent to which performing its standard role at stage 3, including bringing forward amendments, as guardian of the statute book and the body with ultimate oversight of the delivery of the Bill should it pass, on the matters set out above, is not a departure from its neutral position, rather it is a valuable function required for the Parliament to perform its full function as a legislature.

With that in mind, I would welcome a response from you on these matters as soon as is practicable and a meeting with you early in the new year.

Yours,

Liam McArthur MSP

### **Annexe - Addressing drafting issues as a result of stage 2 amendments**

- In commenting on amendments lodged at stage 2, including some amendments which were passed, the Scottish Government identified a number of drafting issues. For example, the establishment of a new advocacy service (see new sections 14A and 14B of the Bill as amended at stage 2 by amendments 242 and 243), and the added offence of advertising assisted dying (see section 21A of the Bill as amended at stage 2 by amendment 252).

- I am also aware that there are various parts of the Bill which, due to amendments agreed at stage 2, have likely drafting/tidying issues due to duplication and/or workability. It would be helpful to discuss these with the Scottish Government, along with any other such issues identified, and agree an approach as to how best to address them at stage 3. These include:

- Section 7(1)(b)(iii) refers to subsection (4a) but there is no such subsection and the relevant amendment inserting it was not agreed to;
- There appear to be minor drafting errors in sections 14A and 14B;
- Section 15(7A) and (7B) duplicate amendments requiring the recording/reporting of any complications;

- Section 18 – the conscientious objection provision has been removed and replaced with a “not duty to participate directly” provision, but other provisions which hang on conscientious objection were inserted;
- Section 23(3A) makes reference to a subsection “(2)(g)” but section 23(2) has no (2g) as the intended parent amendment (266) was not agreed to;
- Section 28(3)(b) refers to, “regulations under section 15(7B)” – however, the intended parent amendment was not agreed to.

As highlighted in the letter above, does the Scottish Government intend to draft amendments ahead of stage 3 to tackle such issues?

---

**Correspondence 35 (email + letter)**

***Email***



**From:** [redacted S.38(1)(b)] On Behalf Of McArthur L (Liam), MSP  
**Sent:** 11 November 2025 16:53  
**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>  
**Cc:** [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)] >  
**Subject:** Letter from Liam McArthur MSP to the Cabinet Secretary for Health and Social Care

Dear Cabinet Secretary,

Please find attached a response to your letter dated 30 October 2025, which I hope is helpful.

Kind regards, Liam

**Liam McArthur MSP**  
**Liberal Democrat, Orkney**

-----  
**Scottish Parliament Edinburgh EH99 1SP**  
**Tel:** [redacted S.38(1)(b)] **Fax:** [redacted S.38(1)(b)]  
**Constituency Office: 14 Palace Road, Kirkwall, Orkney KW15 1PA**  
**Tel:** [redacted S.38(1)(b)] **Fax:** [redacted S.38(1)(b)]  
 Liam McArthur  Liam McArthur MSP

***Letter***

Neil Gray MSP  
Cabinet Secretary for Health and Social Care

Liam McArthur MSP

11 November 2025

Dear Neil

**Re: Assisted Dying for Terminally Ill Adults (Scotland) Bill**

Thank you for your letter of 30 October 2025, which responded to my letter to you of 20 October 2025.

I note the reasoning you set out for the Scottish Government not lodging any amendments at stage 2, including any technical and/or drafting amendments to aid workability of the legislation - this being explained as being due to the Scottish Government's ongoing neutral position on the Bill.

On a related point, and for your awareness, at today's stage 2 proceedings on the Bill at the Health, Social Care and Sport Committee, Jeremy Balfour MSP asked the Convener, as a point of order, why the Scottish Government was absent, and noted his view that it would have been helpful to have the Scottish Government represented at proceedings, so that it could take part in the debates on amendments and respond to questions being raised by members. I am aware that similar observations were made at the first stage 2 session on 4 November.

I also note your comments on the Scottish Government's approach to stage 3, and note that is still to be determined, and will be considered after the conclusion of stage 2. In coming to a decision, I hope that the Government will carefully consider the duty, which you set out in your letter, "...to the integrity of the statute book to ensure, so far as possible, that the Bill is able to be implemented, including in relation to legislative competence, should it pass the Stage 3 vote."

I would welcome meeting with you after the conclusion of stage 2, and ahead of stage 3, to discuss the Scottish Government's position on the Bill, as amended at stage 2, its approach to stage 3, and how we can best work together to ensure that any non-ethical, technical and practical amendments deemed necessary can best be approached.

In terms of the ongoing discussions between the Scottish Government and the UK Government on matters of legislative competence, you will be aware that since your letter, input has been provided as requested at official level on these matters. You make reference in your letter of 30 October to the "challenging timescales" involved in this process, and given we are now approaching the middle of November, I would welcome a further update from you on the discussions with the UK Government and likely timescales going forward, especially given that expectation are that stage 2 may be completed by the end of this month.

Yours

Liam McArthur MSP

---

**Correspondence 36 (email + letter)**

***Email***

**From:** [redacted S.38(1)(b)] **On Behalf Of** McArthur L (Liam), MSP  
**Sent:** 09 February 2026 12:13  
**To:** Cabinet Secretary for Health & Social Care 2024 <CabSecHSC@gov.scot>;  
[redacted S.38(1)(b)]  
**Cc:** [redacted S.38(1)(b)];[redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]; [redacted S.38(1)(b)]  
**Subject:** Letter from Liam McArthur to the Cabinet Secretary for Health and Social Care

Dear Cabinet Secretary,

Please find attached a response to your letter dated 4 February regarding the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Kind regards, Liam

**Liam McArthur MSP**  
**Liberal Democrat, Orkney**

-----  
**Scottish Parliament Edinburgh EH99 1SP**  
**Tel:** [redacted S.38(1)(b)] **Fax:** [redacted S.38(1)(b)]  
**Constituency Office: 14 Palace Road, Kirkwall, Orkney KW15 1PA**  
**Tel:** [redacted S.38(1)(b)] **Fax:** [redacted S.38(1)(b)]  
Liam McArthur      Liam McArthur MSP

***Letter***

Neil Gray MSP  
Cabinet Secretary for Health and Social Care

Liam McArthur MSP

9 February 2026

Dear Neil

**Re: Assisted Dying for Terminally Ill Adults (Scotland) Bill**

Thank you for your letter of 4 February 2026 setting out various agreements the Scottish Government has made regarding my Assisted Dying for Terminally Ill Adults (Scotland) Bill.

**Section 30 Order**

I note your comments on the Scottish Government's intention to draft and lodge amendments, at stage 3, that are required in consequence of the Section 30 Order. I ask that your officials share drafts of your proposed amendments with me and my team, including my supporting NGBU and Legal Services officials, as soon as possible – given that the expected deadline for you (and I) to lodge amendments is 3 weeks today.

### **Remaining provisions the Scottish Government considers outside of Legislative Competence**

The issue of what the Scottish Government will ask the UK Government to include in the proposed Section 104 Order – when – and what that means for the provisions in the Bill, is obviously of the utmost urgent concern – not just to me, but to all other MSPs as well as all those stakeholders and members of the public with an interest in the Bill.

I am sure you are aware, as I am, of the recent correspondence from key organisations such as the Royal College of Nursing and British Medical Association, and their deep concern about both the content of, and process for, the planned Section 104 Order. I am also concerned, given the nature of the debate on the Section 30 Order last week, that there is a general lack of familiarity amongst MSPs about both the Section 104 process, and how key provisions in the Bill will be reflected in that process and not lost from the policy and provisions of the Bill. This underscores the need for clarity and for these matters to be addressed as a matter of urgency.

Your letter, and the statement from the Minister for Parliamentary Business and Veterans in the Chamber when speaking to the Section 30 Order, suggests that discussions with the UK Government are ongoing. At my most recent meeting with Scotland Office officials, they were clear that they are waiting for the Scottish Government to clearly set out to the UK Government exactly what it is asking for in the Section 104 Order, and why. I would echo those comments – I have yet to see, with 3 weeks remaining until the deadline for amendments closes, and with a final vote on the Bill expected in just 4 weeks' time, any detail or analysis from the Scottish Government relating to the Section 104 Order, including:

- which provisions you think need to be removed from the Bill, and why; and
- which provisions in the Bill you think require amendment – why, and in what specific way.

In addition to matters of content, there are deep concerns, again from both politicians and stakeholders, about how details of what the Section 104 Order will contain – with relevant detailed explanation – will be made public, or at least known to MSPs and all relevant stakeholders, ahead of the final vote on passing the Bill at stage 3.

As I am sure you will understand and expect, it would not be reasonable for me to commit to lodging amendments drafted by the Scottish Government relating to the Section 104 Order until I, and my supporting officials, have seen the details of what is being proposed by the Scottish Government. Of particular interest and concern is Section 18(1) of the Bill. I reserve the right to pursue my own amendments if the

outcome of discussions on the Section 104 process is not concluded to our mutual satisfaction.

I also note your comment about Section 15(1A) – which I note has been made with very little time left ahead of stage 3. I ask that you share your thinking on that with me and my wider team as soon as possible – along with any other similar areas of concern, so that I can give as much time as possible for full consideration.

### **Technical and practical amendments**

Given that the Scottish Government only indicated its decision regarding its intentions at stage 3 late last week, I made the decision earlier last week to ask NGBU/Legal Services to instruct a range of technical/drafting/tidy up/correcting etc. amendments on my behalf from our drafter. I am expecting drafts of all those amendments early this week.

As you may be aware, the drafter working for NGBU, on my behalf, is a PCO drafter – and therefore we are likely to have essentially the same drafting resource working on the same Bill, and, at times, perhaps on essentially identical amendments. Given the very short time left before stage 3, I sincerely hope that both our PCO drafters, and supporting officials on both sides, can work together where appropriate from this point on to maximise efficiency.

With that in mind, I would ask that you share with me and my wider team a list of all amendments you are proposing, and, in return, I would be happy to ask NGBU/Legal Services to share drafts instructed on my behalf.

Again, as set out above, I am sure you would consider it reasonable for my decisions on whether to lodge any such amendments drafted by the Scottish Government to depend on detailed engagement on draft amendments between our officials, and my views on the final proposed draft amendments.

### **Financial critique**

I note your intention to provide the Health, Social Care and Sport Committee with a brief critique of the revised Financial Memorandum. I would be interested to understand more about why the Scottish Government has not produced this at an earlier stage in the process given stage 2 was completed last November. Is the intention to provide costings on the Bill as amended? Amendments at stage 3 are still to be lodged, debated, and disposed of, and could potentially further alter the cost of the Bill, including potentially reducing the likely cost. Any assessment of cost between stages 2 and 3 by the Scottish Government seems to be being produced at a very late stage and would have been of more use much earlier in the process, and will be out of date very soon. I note that at no stage in the process to date (across stages 1 and 2) has the Scottish Government provided any detailed analysis of the costs as estimated in the Financial Memorandum, and that the Government's letters to the lead Committee which did make some comment did not give any detailed explanation as to how the costings provided were arrived at. In that context, I would be grateful for a little more context on the reason for, and specifics of, this work.

## Response to my questions of 10 December 2025

I am very disappointed to note your responses to my questions about issues of deliverability, including adding reference to assisted dying services into existing health legislation. You state that,

“This is not something that I believe the Scottish Government can produce amendments for at this stage, given it strays heavily into the ethical issue of whether or not the NHS should be providing such a service (with particular reference to Murdo Fraser MSP’s stage 2 amendment, which sought to set up an independent body to administer the functions set out in the Bill, given his belief that this should not be a role for the NHS).”

And further in your response, in relation to existing health legislation issues, you state:

“I acknowledge that the provision of assisted dying would not seem to be a matter that falls within the ambit of the National Health Service (Scotland) Act 1978, noting section 1, for example, that refers to the purposes of the health service. However, for the same reasons as I outlined in my response to question 1, I do not believe this is an area that the Scottish Government can produce amendments for given our neutral position.”

The Scottish Government has an accepted and established role as guardian of the statute book in Scotland, with responsibility for ensuring the practical workability and integration of legislation with existing services and Acts of the Scottish Parliament. As I have stated previously, I am not convinced, and would not think I am alone in this, that the Scottish Government has fulfilled that role on this Bill – to the extent that you are now indicating that in some areas it is too late to now do so. This approach appears to compromise the Scottish Government’s position of political neutrality.

I note that the Scottish Government is still considering the duty (introduced in an amendment by Jackie Baillie) on the Scottish Ministers to make provision about the provision of assistance outwith the NHS. This suggests that the Scottish Government has not ruled out seeking to amend the provision. If so, I would be interested in your views on how that sits with the comments on other areas of workability and the stated Scottish Government position of neutrality.

Finally, I note your comments on cross-border issues, and your statement that,

“...both the Scottish and UK Government are maintaining a neutral position on assisted dying, and both governments believe that it is for the respective Parliaments to determine the detail of the final Bills. As such, the Scottish Government has no plan to amend the Bill to address issues arising from potentially having different assisted dying regimes in place in different parts of the UK.”

I agree that it is for Parliament to take a view on proposed amendments, and on the Bill, as amended, as a whole. However, it is my understanding that the UK

Government has worked with those in charge of the Westminster Bill at an earlier and more constructive stage in the process. As I mentioned above, frustration with the Scottish Government's approach and engagement on my Bill is not limited to me, but can now clearly be seen in many of the organisations and their members who would be implementing the assisted dying scheme in Scotland.

Given you have confirmed the Scottish Government's position that it will not bring forward amendments in this area, despite stating that assisted dying, in the Government's view, will not likely be a matter that falls within the ambit of the NHS (Scotland) Act, I will consider whether to instruct my own amendments in this area, to ensure that the Scottish Government has necessary powers to make specific amendments to relevant health legislation. We can perhaps discuss the extent to which you and your officials may be prepared to engage with me and my officials on any such amendments.

I thank you again for your response, and would welcome meeting with you, along with our respective officials, at the earliest opportunity.

Yours,

Liam McArthur

---

**END**