

ASSISTED SUICIDE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

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

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

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

EXPLANATORY NOTES

INTRODUCTION

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

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

SUMMARY AND BACKGROUND TO THE BILL

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

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

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

COMMENTARY ON SECTIONS AND SCHEDULES

Part 1: Lawfulness of assisting suicide

Section 1: No criminal liability for assisting suicide

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

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

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

Section 2: No civil liability for assisting suicide

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

Part 2: Safeguards

Section 3: Essential safeguards

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

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

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

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

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

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

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

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

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

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

Section 7: Cancellation of preliminary declaration and record of cancellation

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

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

Section 8: First request for assistance

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

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

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

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

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

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

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

Section 10: Second request for assistance

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

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

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

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

Section 12: Capacity

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

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

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

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

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

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

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

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

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

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

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

Section 17: The act of suicide: time limit

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

Section 18: Nature of assistance: no euthanasia etc.

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

Section 19: General functions of licensed facilitators

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

Section 20: Reporting to police

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

Section 21: Licensed facilitators: disqualifying relationships and minimum age

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

Section 22: Licensing of facilitators

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

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

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

Section 23: Directions and guidance

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

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

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

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

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

Part 3: Commencement and short title

Section 25: Commencement

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

Schedules

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

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

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

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

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

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

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

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

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

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

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

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

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

FINANCIAL MEMORANDUM

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

Number of likely cases of assisted suicide

8. The population of Scotland is around 5.3 million (2011 Census). In 1997, the Death with Dignity Act (DWDA) was enacted in Oregon, a US state with a population of around 3.9 million in 2012.¹ During the period for which data is available (1998-2012), a total of 1,050 people were prescribed lethal doses of medication under the DWDA, of which 673 (64%) died as a result of taking that medication.² The number of deaths each year has ranged from 16 in 1998 to 77 in 2012, with a general trend of increasing numbers over the period. Taking a mid-range point as the average number of deaths per year – say 50 – and taking account of Oregon's growing population³, this amounts to approximately 14 deaths per million people each year.

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

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

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

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

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

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

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

COSTS ON THE SCOTTISH ADMINISTRATION

Appointment of licensing authority

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

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

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

14. However, some numerical data has been provided by the Scottish Parliament staff who manage the process of appointing individuals to fill posts (e.g. as commissioners) for which the SPCB is responsible under statute. This is only a loose analogy to the appointment of an organisation to fulfil a licensing authority function, but may serve to give a general indication of what is involved. The SPCB process is estimated to account for around 31 hours of the time of a staff member on a pay-scale ranging from approximately £40-48K per annum (i.e. £25-30/hour) – suggesting a mid-range cost of around £850.⁶

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

COSTS ON LOCAL AUTHORITIES

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

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

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

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

NHS/Health Boards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Licensing authorities and facilitators

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

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

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

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

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

Organisations providing palliative care

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

Persons seeking an assisted suicide, and their relatives

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

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

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

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

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

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

Professional bodies

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

MEMBER'S STATEMENT ON LEGISLATIVE COMPETENCE

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

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

PRESIDING OFFICER'S STATEMENT ON LEGISLATIVE COMPETENCE

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

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

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

ASSISTED SUICIDE (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

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