OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 4 November 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 4 November 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
29th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Claire Baker (Mid Scotland and Fife) (Lab)
Jeremy Balfour (Lothian) (Ind)
Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Pam Duncan-Glancy (Glasgow) (Lab)
Murdo Fraser (Mid Scotland and Fife) (Con)
Rhoda Grant (Highlands and Islands) (Lab)
Daniel Johnson (Edinburgh Southern) (Lab)
Fulton MacGregor (Coatbridge and Chryston) (SNP)
Liam McArthur (Orkney Islands) (LD)
Stuart McMillan (Greenock and Inverclyde) (SNP)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 4 November 2025

[The Convener opened the meeting at 09:00]

Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 2

The Convener (Clare Haughey): Good morning, and welcome to the 29th meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies from Paul Sweeney, and Jackie Baillie joins us as a substitute.

Our first and only agenda item is consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill at stage 2. As convener, I do not intend for us to go beyond the debate on amendment 226 today, which is the debate on the group on vulnerable adults.

I will briefly explain the procedure that we will be following during the proceedings for anyone who is watching the meeting. Members should have a copy of the bill, the marshalled list and the groupings. Those documents are available on the bill's web page on the Scottish Parliament's website. I will call each amendment individually in the order that is on the marshalled list. The member who lodged the amendment should either move it or say "not moved" when it is called. If the member does not move it, any other member present may do so. The groupings document sets out the amendments in the order in which they will be debated.

There will be one debate on each group of amendments. In each debate, I will call the member who lodged the first amendment in the group to move and speak to that amendment and to speak to all the other amendments in the group. I will call other members with amendments in the group to speak to, but not move, their amendments, and to speak to other amendments in the group if they wish. I will then call any other members who wish to speak in the debate. Members who wish to speak should indicate that by catching my or the clerk's attention. I will then call the member in charge of the bill, if he has not already spoken in the debate.

Finally, I will call the member who moved the first amendment in the group to wind up and to either press the amendment or seek to withdraw it. If the amendment is pressed, I will put the question on it. If a member seeks to withdraw an amendment after it has been moved and debated, I will ask whether any member present objects. If there is an objection, I will immediately put the question on the amendment. Later amendments in the group will not be debated again. If they are moved, I will put the question on them straight away.

If there is a division, only committee members are entitled to vote. Voting is done by a show of hands. It is important that members keep their hands raised clearly until the clerk has recorded their names. If there is a tie, I must exercise a casting vote. The committee is also required to consider and decide on each section and schedule of the bill and the long title. I will put the question on each of those provisions at the appropriate point.

Section 1 agreed to.

Section 2—Terminal illness

The Convener: Amendment 143, in the name of Jeremy Balfour, is grouped with amendments 4, 144, 24, 73, 26 and 84.

Jeremy Balfour (Lothian) (Ind): Good morning, convener, members of the committee and other members. Thank you for having us at the meeting to discuss some very important amendments. I will speak to amendments 143 and 144.

First, with regard to amendment 143, as the bill stands, the definition of "terminally ill" is extraordinarily broad. It would include individuals who could live not for weeks or months but for years. People who are managing long-term conditions, those who are receiving treatment that stabilises their illness, and people who still have meaningful time ahead of them would all fall within the scope of the bill as it is currently drafted. I do not think that that is what members of the Parliament or, indeed, more importantly, members of the public would imagine when they hear the phrase "assisted dying". They would think of someone who is in the final stages of their life or who is perhaps days or weeks from death, not someone who still has years to live but is facing difficulty, fear or despair.

If the law is to mean anything, the definition must be clear as the bill proceeds and if it ultimately becomes an act; otherwise, future generations risk the reach of assisted suicide expanding far beyond what advocates publicly claim to intend, and what the member in charge has publicly stated.

This amendment seeks to restore that clarity. It would define "terminally ill" as a condition that,

"in the opinion of two independent registered medical practitioners ... can reasonably be expected to result in the person's death within three months."

That is not a technical tightening; it is a moral safeguard. It ensures that, if the Parliament chooses to go down this path, it does so honestly, with the legislation restricted to those who are truly at the end of life and not those who yet have years of life, love and care ahead of them. By supporting the amendment, members will protect the integrity of the bill's purpose, and they will protect vulnerable people from a profound expansion of what assisted suicide could mean in Scotland. If we cannot agree on that limit—if we cannot even confine assisted suicide to those who are imminently dying—we must ask ourselves what kind of law we are truly making.

With regard to amendment 144, there is, as I said, an alarmingly broad definition in the bill. I have written to the Presiding Officer and to you, convener, about legal issues around that, and I await responses from both of you. However, as the bill is written at the moment, the door to assisted suicide is open for people who have many years—decades—of life ahead of them. As I said, that is not what people think of when they hear the phrase "assisted suicide". They think of someone who is in the final stages of terminal illness, not someone who is living with mental illness, disability or poverty. Yet, as written, the bill risks crossing that line. It risks sending a message that assisted suicide could be open to someone like me, who is struggling with disability. It opens it to those who are struggling with disadvantage or despair. That is a profound moral error and a betrayal of the very people who need our care and solidarity.

My amendment seeks to put that right. It makes it clear that a person cannot be deemed eligible for assisted suicide if their primary reason for seeking it is a non-terminal condition, such as an eating disorder, an intellectual disability, a mood or anxiety disorder, receipt of disability benefits, loneliness, financial hardship or unsuitable housing. At the same time, the amendment recognises that people may live with those conditions alongside a genuine terminal illness. It therefore would not automatically exclude people with non-terminal conditions from being eligible; it would require only that the driving cause of a request is truly a terminal condition. We heard at stage 1 from members across the chamber that that is what they were seeking to do. The amendment is not about narrowing choice but about protecting meaning and, perhaps most importantly, protecting the most vulnerable in our society.

The amendment would ensure that assisted suicide is not even inadvertently offered as a substitute for care, community or hope. If the state begins to respond to suffering not with support but with death, we will cross the line of the compassionate society that we all want to be part of. I believe that we should not cross that line. This amendment asks us to hold that line with clarity, conscience and compassion.

I move amendment 143.

The Convener: I point out to the committee that, due to pre-emption, if amendment 143 is agreed to, I cannot call amendments 4 and 144, and, if amendment 26 is agreed to, I cannot call amendment 84 or amendment 222, which is in the group on eligibility to be provided with assistance.

Daniel Johnson (Edinburgh Southern) (Lab): At the outset, I state that I broadly agree with much of what Jeremy Balfour has set out. To my mind, the debate has been marked by two substantial features both for those who are advocating for the bill and for those who are speaking against it, in that we all want to provide dignity and empowerment for those who are in the final stages of their lives and who may well be suffering from conditions and diseases that leave them in an intolerable situation. On the other hand, we also want to ensure that we do not foster a culture in which people feel as though they are under pressure to end their life or that there is an expectation that they do so in certain circumstances, particularly when that involves things such as mental illness, disability and other such issues, as Jeremy Balfour has set out. That is why I think that the definition of terminal illness is so important.

I understand that definitions are always difficult and I understand the reasons why the definition in the bill was arrived at but, to my mind, the key point is that the bill's provisions must be used only when a person's death is imminent and expected. If I were to put it glibly, in a sense, we all have a terminal and progressive condition, but the immediateness of it is relative. That is why I think that it is important to include some sort of time boundary, not just for clarity but to prevent judicial expansion, which we have all been very concerned about, based on situations in other countries. I think that there is an inherent issue with the accuracy and effectiveness of time limits. The point is not necessarily about the accuracy of a prognosis; it is about clarity on the immediacy of the likelihood of a person's death and whether that is a reasonable expectation. Including a time boundary could provide absolute clarity that the likelihood of a person's death has some immediacy, so that the time period is counted not in years or decades but in weeks or months.

Jeremy Balfour's amendment 143 sets out the time boundary as three months, which I think is probably too short. If we are leaving these decisions to be made only when death is very proximate, that could preclude people from making a decision as calmly and in as informed a way as possible, although I think that three months would

be better than no time limit. If my amendment 4 is pre-empted, I will understand. Whether the committee decides on a timeframe of three months or six months, we need a time limitation in order to set out clearly that there should be the expectation of the likelihood of a person's death being imminent.

Liam McArthur (Orkney Islands) (LD): Good morning, convener. I thank all members who have lodged amendments to the bill at stage 2. The breadth of the amendments will allow most of the substantive issues that the committee wrestled with at stage 1 to be debated at stage 2, which is the purpose of the process.

I thank Jeremy Balfour and Daniel Johnson for setting out the rationale for their amendments and I agree with much of what they have said. In other jurisdictions, we see that people are accessing the choice that the bill would enable at the end of their life, but I understand why we are having the debate.

Before I touch on the amendments that have been spoken to, I will first address my amendments. My amendment 24 clarifies that,

"For the avoidance of any doubt, a person is not"

to be considered as meeting the definition of terminal illness as set out in section 2

"only because they have a disability or a mental disorder (or both)."

That does not, however, prevent a person from meeting the requirements as set out in section 2 from being regarded as a terminally ill person.

Amendment 26 is consequential and tidies up drafting.

I noted the concerns that were raised at stage 1 about the potential risk of a person with a disability or a mental disorder being assessed as meeting the definition of terminal illness as set out in section 2. I am clear that the bill, supported by its accompanying documents, does not permit a person to be assessed as being terminally ill for the purposes of the bill only because they have a disability, a mental disorder or both.

However, in order to provide further reassurance of policy intent and on the meaning of section 2, and to further inform any future guidance on and the practical operation of the act, I have lodged amendment 24. It is not a change of policy but it will remove any doubt. I remain of the view that, if it is their wish, a person must not be prevented from requesting assistance to end their own life because of a disability or a mental disorder, if they meet the requirements as set out in the bill and are assessed as being eligible.

Jackie Baillie's amendment 73 relates to the amendments that I have lodged in this grouping. Amendment 73 and consequential amendment 84 duplicate the part of my amendment 24 that relates to mental disorder but do not include the part about disability. I am therefore supportive of the principle of Jackie Baillie's amendments, but I ask her not to move them, and I ask that the committee supports amendment 24, given its application to mental disorder and disability.

09:15

I turn to Jeremy Balfour's amendment 143, which, as the convener said, pre-empts amendments 144 and 4. The first two parts of the amendment, which relate to the diagnosis of an

"irreversible and actively progressive disease, illness or condition"

for which

"no treatment is available that could reasonably be expected to prevent death or lead to recovery",

are already provided for in section 2. On the proposal that terminal illness should be defined as a person being considered to have three months or less to live, as the committee heard during stage 1, there are risks in including a timeframe for a prognosis of death.

Jeremy Balfour: To some extent, amendment 143 is a probing amendment. Does the member recognise that, in the social security legislation that the Parliament passed in the previous session, six months was included in the definition of terminal illness to be used if someone wants to get benefits more quickly? Would you want to set any time limit, if an amendment were lodged at stage 3, or would you see there being no time limit at all?

Liam McArthur: I thank Jeremy Balfour for that, and for clarification that amendment 143 is more of a probing amendment. As I say, it is important that we have this discussion, because it is a live debate. As I will touch on shortly, similar prognosis periods are applied in other jurisdictions.

Although a prognosis period of six months was initially proposed for the Social Security (Scotland) Act 2018, Parliament's view was that, because of the practical difficulties with that, it would be more appropriate to set no timeframe.

Many who gave evidence to the committee at stage 1 took that view, noting how difficult it can be for a professional to estimate with any confidence how long a terminally ill patient has to live. That will depend on the condition. The committee's stage 1 report concluded:

"on balance, the Committee recognises the rationale ... for not including a prognostic timescale in the definition of terminal illness set out in the Bill and for arguing that it is ultimately better to leave determination of whether or not an

individual meets that specific eligibility criterion to clinical judgement."

Daniel Johnson: Will the member accept my point that, in principle, rather than necessarily establishing an accurate prognosis, setting a time limit is about trying to set a time boundary around the immediacy of the expectation of the end of life? Does he imagine that such time bands would at least have to feature in guidance so that we do not run the risk of expansion? In other words, how does one judge that immediacy if we do not put it in the bill or guidance?

Liam McArthur: As I say, other jurisdictions operate using prognostic periods and issues appear to be manageable within that context. Nevertheless, the argument is about establishing with any certainty the accurate time of anticipated death. It is an issue that the committee heard about in evidence, and it took the view that it did in its stage 1 report.

Pam Duncan-Glancy (Glasgow) (Lab): I am listening carefully to the points that are being made. The point in amendment 24 about a person not being terminally ill only because they are disabled relates to Daniel Johnson's point about timescales. I would argue that, without a timescale in the bill, it will be difficult to separate the difference between being terminal and being a disabled person under the amendment that the member has lodged. Does the member accept that, in most circumstances, anyone who is terminally ill is also considered to be disabled, and the two things are inextricably linked?

Liam McArthur: I do not happen to agree with that. As I go through and respond to the amendments, the rationale for that might become clearer.

Amendments 143 and 144 offer alternative options. The former suggests a prognosis period of three months. As well as my general concerns about setting a prognosis period, I add that there are no examples from around the world of a three-month prognosis timeframe. Not only would it risk eligible adults being unable to access the choice in time, it would risk—as I think Daniel Johnson rightly pointed out—placing pressure on them to make a hurried decision. I know that Mr Balfour would not wish for that to happen.

A six-month period, as suggested by amendment 144, is certainly more realistic, albeit that I offer the same general reservations about setting a timescale for prognosis. Amendment 144 also proposes adding, for the avoidance of doubt, that a person should not be considered terminally ill if their

"condition can be controlled or substantially slowed down by medical intervention".

I remind colleagues—this perhaps addresses some of what Pam Duncan-Glancy was saying—that the definition that is set out in the bill states that

"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."

I remain of the view that the definition of terminal illness as set out in the bill is appropriate and captures the appropriate cohort of people.

Pam Duncan-Glancy: Will the member take an intervention?

Liam McArthur: I am going to make a little more progress, Ms Duncan-Glancy.

Adding terms such as "substantially slowed down" is likely only to add to confusion.

Although I am sympathetic to the provision in amendment 144 that states that,

"For the avoidance of doubt, a person is not terminally ill if ... their illness is a consequence of voluntarily stopping eating and drinking",

I believe that that is already covered in the existing definition. Indeed, it was not raised with the committee at stage 1.

Daniel Johnson's amendment 4 similarly seeks to define terminal illness by reference to a six-month time period. I know from my discussions with him that he was keen to open up a debate on that, and I think that he has been successful in doing that.

As I have said, other jurisdictions generally operate with prognosis periods of six months, albeit that there are often slightly longer prognosis periods for neurological conditions. It is therefore entirely right that we are having this discussion. I have set out my concerns about how that might work in practice, but I am interested to hear the debate on it and to see where Parliament eventually lands.

I am happy to work with colleagues ahead of stage 3 on workable amendments that might deliver the intention, but it was important to put on record why I opted for the approach in the bill. I think that it is consistent with decisions that Parliament has taken previously on similar issues. I will listen to what colleagues have to say and, as I said, I am open to having further discussions about this.

Jackie Baillie (Dumbarton) (Lab): Amendments 73 and 84—amendment 84 is consequential—are to make it clear that a person is not considered terminally ill solely because they have a mental disorder.

Amendment 73 reflects the position of the Royal College of Psychiatrists in Scotland that mental

disorders such as anorexia nervosa should not be classified as terminal conditions under the bill. It provides clarity and reassurance that the bill does not open the door to assisted dying for individuals whose suffering arises from mental illness alone. I believe that that safeguard is vital to prevent misinterpretation and to uphold the integrity of the bill's intent, which is focused on those with a qualifying terminal physical illness.

I heard Liam McArthur's earlier comments and, as amendment 24 captures the intent of my amendment, I will not move amendment 73.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising national health service general practitioner and chair of the medical advisory group on the bill.

I would like to say a number of things regarding the amendments in this group. On Jeremy Balfour's comments, I think that we in Parliament should be cognisant that it is not up to us to tell people what meaningful life is or to tell people who are living their life what quality of life means, because it is different for everyone. One person's quality of life is not the same as another's. If somebody feels that their quality of life is bad, that they are not getting what they need and that they would like to go through the assisted dying process, we should not be saying, "No, that is not right—you could still live a bit longer, even though you are very unhappy with your quality of life."

Pam Duncan-Glancy: I understand Sandesh Gulhane's background in the area, so I know that he will be aware of all the significant research that shows that non-disabled people's opinion on disabled people's quality of life differs hugely from disabled people's opinion on their own quality of life, and that that difference means that the bill could pose a risk.

Sandesh Gulhane: Pam Duncan-Glancy has the opportunity to lodge an amendment that says that people with disabilities cannot access assisted dying. I would not support such an amendment, because I think that individuals, disabled or not, get to make decisions on their own quality of life and on how they want their life to continue—or, if they are diagnosed with a terminal illness, to say, "I am not prepared to continue with what has happened to me and the issues that this terminal illness has created." That could be at any stage.

Jeremy Balfour: I am interested to explore that a wee bit, because the member is saying that someone could say, "My life is no longer meaningful because I have been diagnosed with something," even if that person has X number of years to live. For example, motor neurone disease is a cruel, horrible disease, but the prognosis can be very short, or someone can end up with a Stephen Hawking situation where they live for 40 years. If someone is diagnosed with MND and they say after day 2 of that diagnosis, "My life is no longer meaningful," would the member be open to them being allowed assisted suicide if the bill goes ahead?

Sandesh Gulhane: I start by saying that this is not assisted suicide. This is assisted dying, as the bill puts it, but Mr Balfour has called it assisted suicide multiple times. That is a way of being very emotive, but I do not think that it is correct.

If somebody is diagnosed with motor neurone disease, we do not know what stage they are diagnosed at. They could be diagnosed at a critically horrible stage where they are struggling to breathe and it is a late diagnosis. Day 2 of that diagnosis is very different from day 2 of a diagnosis that is made when they are right at the start of the journey.

It is important that we, as parliamentarians, do not tell the people what meaningful life is.

Liam McArthur: I think that Sandesh Gulhane is right to point to the importance of autonomy, but does he also agree that the safeguards in the bill would require discussions to take place around the prognosis and the alternative treatment and care options that may be available in order to understand the rationale and the reason why an individual has come to the decision to make such a request?

Suicide rates among the terminally ill are running at twice the national average and more, so we have to question whether having the safeguards in the bill will provide protections that are not there at the moment. I do not see any proposals coming forward that would see them applied more routinely, but having those open discussions is far more supportive of those who may be vulnerable and need assistance in whatever form.

Sandesh Gulhane: I agree with that—I would go as far as saying that that was literally the next thing that I was going to say. I absolutely agree with everything that has just been said.

I cannot support a period of three months; it is far too short. I am sympathetic to Mr Johnson's suggested period of six months, but I do not think that I will support that, because I feel that it is up to the individual to make the decision. I hope that we can agree to amendment 24 and take forward that change in definition. I would agree with Jackie Baillie's amendments, too, but everything is in amendment 24.

09:30

Patrick Harvie (Glasgow) (Green): First, I have a brief comment on Liam McArthur and Jackie

Baillie's amendments. I agree with Liam McArthur that the meaning that is captured in the amendments is already included in the bill, but there is clearly a desire for some additional clarity, which I do not have a problem with. Liam McArthur's formulation is slightly preferable, so I will support amendment 24.

On the specific argument about a prognosis, part of my worry is that we will end up placing an unbearable pressure on clinicians, who must make finely balanced judgments. There is also a potential risk that individuals who make a request could, in certain circumstances, have their access to the rights set out in the bill subject to challenge.

If we lived in a world where prognosis was a simple calculation—it was correct or incorrect—such a time limit would be workable. We do not live in such a world, and the judgments that are required to give a prognosis are not precise. One thing that we should be keen to avoid, if the bill passes and becomes legislation, is individuals—professionals involved in the process or people who seek to access the right to assistance—ending up with their circumstances subject to challenge and query and their rights essentially blocked by those who seek to challenge such judgments, which, by definition, cannot be precise.

Daniel Johnson: I understand the member's point—you do not lodge an amendment that proposes a time boundary without thinking about such things. On the other hand, the principle is that we want the right to be exercised by people whose death is imminent. Jeremy Balfour put that in terms of weeks or months. How do we capture that correctly unless we insert a time boundary? Is there another way to capture it? We are not setting an absolute threshold; we are literally just capturing the sense that the right is to be exercised by people whose death is very likely to be in the coming weeks and months rather than years away.

Patrick Harvie: The most important thing that we should bear in mind is that that is how people are overwhelmingly likely to use the right to seek assistance. The idea that somebody would seek assistance and say, "I want help to end my life," two days after a diagnosis is a bit of a straw-man argument. It is highly unlikely for somebody to be in such a scenario after two days.

As Liam McArthur said, a range of other safeguards are in place. Discussions and conversations will have to happen with the patient and other professionals, some of which will likely be strengthened as we debate other groups of amendments at stage 2 that will ensure that the conversations happen in a sensitive and understanding manner. Principally, the decision and the judgment need to be driven by the individual. It is about giving people a degree of control.

I am not convinced by the time boundary amendments. As the member might be aware, I was not on the committee for the stage 1 inquiry and have joined the committee since then. However, I think that the committee got the judgment right in its stage 1 report in suggesting that a time-bound prognosis should not be required, so I will not support those amendments.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): From the outset, my position is that I support Liam McArthur's amendment 24, because it will allow us to put in place some more safeguards around the definition of terminal illness. In countries where such a definition is applied, we see, as Patrick Harvie just set out, that those who seek an assisted death do so at the later stages of a terminal illness.

I turn to amendment 143, which Mr Balfour has said is more of a probing amendment. If we use three months as the timeline, such a short prognosis will put people who are terminally ill in the difficult position of making a hurried decision, instead of being able to take time to consider all their circumstances.

On Daniel Johnson's amendment on a six-month prognosis, I would defer to the committee's stage 1 report, which set out our understanding of why a prognostic timeframe can be particularly difficult. I understand members' desire to explore the issue but, at this stage, I would not be supportive of that. That is not to say that I will not change my position as we go forward, but clinicians who make decisions that affect access to benefits sometimes feel under undue pressure to make an assessment of a prognostic timeframe. That can also lead to a situation in which, although there is no clear prognosis, people are given a time limit that might not be realistic. We are starting to funnel people down a path.

Pam Duncan-Glancy: I recognise the member's commitment to and support for the bill. If there was no time limit, what would be the difference between a person living as a disabled person and a terminally ill person?

Elena Whitham: We have heard from Liam McArthur about the differences. I agree that people who are terminally ill will, by definition, probably be considered to be disabled, too. However, Liam McArthur's amendment 24, which excludes people who have only a disability or a mental health condition, would put in further safeguards.

At stage 1, clinicians and practitioners from Australia warned us about the limitations and difficulties of the six-month prognostic timeframe, which, as set out by Liam McArthur, specifically

excluded some people who had neurological conditions.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): Elena Whitham said that she is not minded to support a six-month prognosis at this stage but indicated that, as the debate goes on, she could be persuaded otherwise. I point out that the next group of amendments, on eligibility, gives her the opportunity to do just that, because it contains an amendment on a six-month prognosis. I draw members' attention to that, because there are two ways of approaching the issue, and they are not mutually exclusive.

Daniel Johnson's amendment 4 would change the definition of terminal illness, and there is merit in that. We can also change the qualifying criteria, which is what my amendments in the next group seek to do. For the purposes of the debate on amendment 4 in this group, I should put on record paragraph 32 of the policy memorandum, which states:

> "It is not the intention that people suffering from a progressive disease/illness/condition which is not at an advanced stage but may be expected to cause their death (but which they may live with for many months/years) would be able to access assisted dying."

That seeks to strike a balance, but that balance does not appear in the bill. Daniel Johnson's amendment 4 seeks to strike that balance in the bill.

There is a disconnect between the policy memorandum and what is contained in the bill. I will say more when I speak to my amendments in the next group.

The Convener: I call Jeremy Balfour to wind up. I remind members that, if amendment 143 is agreed to, I cannot call amendments 4 and 144, due to pre-emption.

Jeremy Balfour: This has been a really helpful debate, although contributions from members have probably raised more concerns for me. There are some contradictions in what we are hearing. If we accept that prognosis is flawed, how can we ever offer assisted suicide? Prognosis is open to debate. I understand that it is difficult for general practitioners and other doctors to give people an accurate prognosis.

Liam McArthur: I hear what Jeremy Balfour is saying in relation to the prognosis period, but I think that that uncertainty exists—we would find few, if any, health professionals who would not acknowledge it—and is a factor in decisions that are taken about many types of treatment over which we seem comfortable in allowing medical health professionals to use their best judgment in coming to a decision.

I think that Patrick Harvie's point was that placing further undue pressure on them to come up with an accurate timeframe of diagnosis, which is particularly challenging in some conditions, is not in the interests of the health professionals nor of the patients who may be vulnerable and may have questions about the options that are available to them.

Jeremy Balfour: I accept that, and I am sure that Liam McArthur has spoken to many people in the medical profession who feel very uncomfortable about this bill, because they will be asked to make decisions. At the moment, when it comes to prognosis, they are making decisions about what future treatment might be wanted, rather than saying, "Do you want to end your life?" That is a very different position to put general practitioners in.

As many know, my older brother is a GP, and he tells me a story. Many years ago, somebody came into his surgery. He did the usual tests and things. The person said, "How long do I have to live?", and he replied, "Probably six to eight months." However, last week, he was still playing golf with that person.

The situation is therefore very open, and I understand that it is very difficult to put time limits on a prognosis, but we are having to make law not just for the next two or three years but the future. Unless we have clear interpretation and clarity in the bill, we are open to judicial creep. That is a concern.

Daniel Johnson: I wonder whether Jeremy Balfour might agree with me in that, although I understand the contention that precise prognosis is very difficult and is a matter of judgment, the reverse is also true: we are asking medical practitioners to interpret what we mean by the terms, as they currently stand, of "terminal" and "progressive". Without putting the definitions in the bill, we are leaving them open to interpretation either by practitioners or by the people whom we ask to draw up regulation and guidance. In a sense, we are not avoiding that decision; we are simply pushing it to different places and, potentially, leaving it more open.

I understand that prognosis is not precise, and I wonder whether the member agrees with me. I am concerned by some of the notions shared this morning that, without any attempt to define immediacy, assisted dying could be exercised by people who may have years to live. I understand that time may be an imperfect way of defining immediacy, but it is a way of defining it. We potentially run into real risks of exactly the expansion that Jeremy Balfour has just set out.

Jeremy Balfour: I absolutely agree—and I was coming on to that.

In his contribution about whether someone's life is meaningful, Sandesh Gulhane seemed to say that, if I have an early diagnosis but take the view that my life is no longer meaningful, the process can start. I accept that people would have to go through discussions and all that, but I am deeply worried that, as a society, we are saying to somebody that, although they can have years to live with the appropriate treatment, we will open the door for them. The disabled community will be very concerned by what we have heard this morning from some members of the committee. We are opening a door, maybe not next year or the year after but in years down the line, for disabled people to face extreme pressure from society.

On reflection, I think that Daniel Johnson's amendment 4, which suggests a six-month timeframe, is appropriate for the committee to look at. For that reason, I ask the committee to support Daniel Johnson's amendment and I seek to withdraw amendment 143.

Amendment 143, by agreement, withdrawn.

09:45

Amendment 4 moved—[Daniel Johnson].

The Convener: The question is, that amendment 4 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Gulhane, Sandesh (Glasgow) (Con)

The Convener: The result of the division is: For 2, Against 7, Abstentions 1.

Amendment 4 disagreed to.

Amendment 144 moved—[Jeremy Balfour].

The Convener: The question is, that amendment 144 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

Against

Baillie, Jackie (Dumbarton) (Lab)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 0, Against 10, Abstentions 0.

Amendment 144 disagreed to.

Amendment 24 moved—[Liam McArthur]—and agreed to.

Amendment 73 not moved.

Section 2, as amended, agreed to.

Section 3—Eligibility

The Convener: Amendment 83, in the name of Bob Doris, is grouped with amendments 145, 25, 219, 146, 147, 221, 222, 2, 152, 227, 228, 97, 108, 30, 3, 168, 119, 31, 207, 1, and 215. I remind members that amendment 222 is pre-empted by amendment 26, as previously debated in the group "Definition of terminal illness". The following amendments are direct alternatives: amendments 2 and 152; amendments 3 and 168; and amendments 1 and 215. For each pair, both amendments can be moved and decided on, and the text of whichever is last agreed to will appear in the bill.

Bob Doris: Amendment 83 and consequential amendments 97, 108 and 119 more clearly and tightly define the population of people who might be deemed eligible for assisted dying and bring the definition closer to the stated policy intention of the bill.

The definition that is used in the bill is imprecise, which I believe was well illustrated by the first grouping. Key terms in the definition, such as "advanced" and "progressive", do not have accepted standard definitions. There are multiple ways to define premature mortality. Using the definition in the bill to determine eligibility for assisted dying is therefore likely to result in a lack of clarity for the public and for medical practitioners who are tasked with assessing eligibility.

We have already heard from members about the challenge that medical professionals will have, irrespective of what shape the bill takes should it eventually come on to the statute book. The combination of an imprecise definition and the application of the individual judgment of the assessing medical practitioner will likely lead to inconsistencies in who is deemed eligible.

The policy memorandum, which I have already referred to, states:

> "It is not the intention that people suffering from a progressive disease/illness/condition which is not at an advanced stage but may be expected to cause their death (but which they may live with for many months/years) would be able to access assisted dying."

The definition in the bill is very different from the one that is in the policy memorandum and, as I said during the discussion on the previous group, I believe that there is a disconnect. The current definition is not an effective way to identify a narrow group of people who are near the end of their life. As drafted, the definition would likely include some people who would otherwise live for a considerable period.

The definition in the bill is not precise enough, which will lead to confusion and a variation in interpretation. That could mean that people with years to live are deemed eligible—that is pretty clear—which is at odds with the policy memorandum that I have read out. My amendments would qualify the definition in section 2 by adding an additional paragraph to section 3(1) on eligibility. That is a bit different from Daniel Johnson's amendment in the previous group, because we are not creating a new definition of terminal illness, but we are saying that there are additional criteria to meet to access assisted dying. That is a variance from the amendment in the previous group that the committee did not agree to.

Sandesh Gulhane: We have already spoken about the difficulty, so I will not repeat that. If somebody has been diagnosed with a condition and they are struggling to breathe, they are having interminable anxiety, they are suffering, there is nothing that can be done for them palliatively to alleviate them and they have decided at that stage that they have no quality of life and they want to access assisted dying, without a six-month prognosis—if they have, say, a year left to live—we are leaving that person to suffer. I wonder what Mr Doris would say to such an individual.

Bob Doris: I would say to any individual—whether they are very supportive of Mr McArthur's intentions with this legislation or whether they are deeply concerned—that the Parliament needs to make legislation for everyone in society. Whether the bill goes on to the statute books or not, there will be many people who are deeply disappointed, worried and concerned. I do not envy Mr Gulhane's committee's challenge. It must take a balanced approach to find the correct legislative position on this. There are no easy answers, and I do not pretend that there are.

My proposed addition to the list of criteria in section 3(1) would have the effect that a person is eligible to be lawfully provided with assistance to end their own life only if they have a prognosis of six months or less to live. As we have heard from other members, I, too, do not pretend that any of this is easy, and it is clear that there are challenges regarding any timeframe for a prognosis. However, I firmly believe that having a timeframe is preferable to leaving the matter completely open ended.

Daniel Johnson: I wonder whether Bob Doris would agree with me on this. There are two points here: one is the principle, and one concerns the technical drafting. On the principle, as he has pointed out, the policy memorandum seems to suggest that the bill is about providing a possibility for people for whom death is very near or imminent. That is different from the technicalities of how we capture that. However, it is important to establish whether we want to capture that immediacy in the bill itself or leave it to further regulation and guidance. Does the member agree with me that, even if the committee rejects the technicalities of what has been drafted, we need some understanding of whether members accept the principle?

Bob Doris: I agree with Mr Johnson—I was about to make a similar point. Those who believe that the definition and the eligibility criteria need to be refined further will, I hope, back amendment 83 and its consequential amendments in the group, and look to work ahead of stage 3 to do just that. However, it is only right that, in refining the definition and those criteria, we do so from a perspective of having greater, and not fewer, safeguards.

I will say one more thing in relation to my set of amendments in this group. In the debate on a previous group, it was mentioned that Social Security Scotland is taking away the requirement for a six-month prognosis in order to fast-track benefits, but that is, by and large, a significantly different matter. It was done for fast-tracking to ensure that people got the highest rate of award and that there were no reviews, and that payment could be backdated up to 26 weeks from the application date, in order to get as much money into people's pockets as quickly as possible, in a non-stigmatising way, to support them with their life. In contrast, the bill is about assisting people to die, so there is a very different set of circumstances in relation to the six-month rule. It is important to put that on the record.

With regard to other amendments in this group, I will touch on issues around palliative care in relation to Rhoda Grant's amendment 25 and Brian Whittle's amendment 145, and issues around social care in relation to Pam Duncan-Glancy's amendment 219. I have amendments on similar issues in later groups, with regard to assessment of a terminally ill adult, which I hope

that committee members will support at that point. More generally, I am content that it is desirable to enhance safeguards in such ways as I think the members I have mentioned seek to do, and I look forward to hearing the contributions from colleagues.

I move amendment 83.

Brian Whittle (South Scotland) (Con): I have been listening intently to other members speaking to previous amendments. One concern—this relates to one of my amendments, which I am about to come to—is about the definition of quality of life. I think that quality of life is a moveable feast, and having one interpretation of quality of life at a particular moment in time does not necessarily mean that that quality of life will remain poor. I have a relative who would, at one point, have suggested that their quality of life was extremely poor and would have wanted to end their own life. However, 15 years later, that person is a grandparent and has a great quality of life. I am concerned that we would consider an individual's quality of life, or their perception of that, at a certain moment in time as being relevant to whether they can access assisted dying.

My amendment 145, which is related to that issue, is on inequality of access to palliative care and the ability of palliative care to improve somebody's quality of life towards the end of life. We know that access to palliative care in this country is incredibly unequal, especially in more deprived areas. My concern is that, if we do not put in place some sort of safeguard around a right to what we define as a basic level of palliative care, assisted dying may become a preferred option for patients because of the lack of suitable and deliverable palliative care.

10:00

Sandesh Gulhane: I feel that an individual has a right to say no. At the moment, I would love for every patient of mine who has a terminal illness or pain or a problem and who needs palliative care to be able to access it. I love the people who do palliative care—they do great work. However, a lot of patients say, "No, I don't want that," and it should be up to the individual to make that choice.

I am very sympathetic to your amendment, and I wonder whether you could perhaps change the wording to say that a palliative care support plan should be discussed with the individual. If they would like a plan, they absolutely should have one, but if they say no, despite best practice, it is their right to do so.

Brian Whittle: I agree that individuals should have the right to say no to palliative care, but in order for them to be able to say no, palliative care has to be on offer in the first place. That is what I am trying to set out here. If somebody decides that they want to go down the route of assisted dying, they should be able to say no to palliative care, but they can say no only if it is available.

Amendment 145 would allow the Scottish Government to produce a definition of minimum standards of palliative care for those who want to access assisted dying. I do not see how we can do without that, because the bill's impact would become incredibly unequal if there are those who can and those who cannot access palliative care. We need to ensure that there is a fully costed palliative care support plan to ensure that that is deliverable.

I have engaged extensively with those in the third sector on amendment 145, and I understand that they are, in some cases, hesitant that such a requirement may become a barrier to accessing palliative care. However, I would say that access to an acceptable level of deliverable palliative care is not just important but crucial in relation to the bill.

Amendment 207 is consequential to amendment 145.

Rhoda Grant (Highlands and Islands) (Lab): I will speak to my amendments 25, 30 and 31. Amendment 25 would ensure that, in order to be eligible for assisted dying, a person must first

"have an anticipatory care plan ... which includes ... palliative care".

Amendments 30 and 31 are consequential. Amendment 30 would include a statement to that effect in the assessment statement, and amendment 31 would include a statement to that effect in the second declaration.

It is important to put on record that I do not support the bill, and I have concerns that, should it become law, people will opt for assisted dying due to a fear of having little support at the end of their lives. Amendment 25 would ensure that they have in place an anticipatory care plan that includes a palliative care plan. That would empower people who are coming towards the end of their lives to plan ahead and to ensure that they have control over the care that they will receive at the end of their lives. If they choose to go ahead with assisted dying, they will, at the very least, have had all the options explained to them and laid out in detail.

I also believe that these amendments would ensure that those who fear the future and what may lie ahead will have information about that and will have input into the care that they receive. That would mean that every decision is informed, and no one should feel pressure to access assisted dying for fear of how they may die without the full knowledge of an anticipatory care plan.

Sandesh Gulhane: Will the member take an intervention?

Rhoda Grant: I will—I had actually just finished.

Sandesh Gulhane: I did not want to interrupt your flow.

There is very low uptake of anticipatory care plans among the general public. I would love everyone to have an anticipatory care plan, power of attorney and a will in place; that would be great, and it would be good practice for everyone. Again, however, it is an individual's right to choose not to have that, no matter how good it would be for them.

Does Rhoda Grant agree that, in section 7(1)(a)(iii), the bill places a duty on registered medical professionals during the first declaration to discuss

"any palliative or other care available"

to such individuals, and that forcing them into something, despite having had a discussion about what could be available to them, might be a barrier?

Rhoda Grant: I see my amendments as providing better protection. I have personal knowledge from looking at end-of-life care for relatives and from representing constituents who are in that position. I know that it is incredibly difficult to get a proper palliative care plan in place. I have had constituents who simply cannot get one, despite crying out for it and wanting it in place. I also know, from personal experience, that getting such a plan to hang together is very difficult. That, at the end of life, would cause fear to people about what lies ahead of them. At least if a plan is laid out and they know that that is what they are going to get towards the end of their life, they can make an informed decision about what they want to do. At the moment, a right to palliative care does not exist. My amendments would at least provide such a plan for people towards the end of life.

Pam Duncan-Glancy: It will come as no surprise to anyone, nor will it make any front page, that I do not support the legislation. People know that. However, I want to use this opportunity to raise some of the concerns that have been raised by disabled people and others, and to seek to strengthen the bill so that, if the Parliament decides to support it, it contains safeguards. That is what I am seeking to do.

Amendments 219, 221 and 222 make provision about eligibility for assistance but with an expanded definition of "appropriate social care". Amendment 219 specifies that a person is eligible for assistance under the legislation only if they

"have accessed appropriate social care relevant to their terminal illness".

In drafting the amendments, I had wanted the provision not to be quite so narrow as

"relevant to their terminal illness",

because some people might need social care that falls outwith that, but I was told that the bill was too narrowly drawn to be able to do that. Therefore, I do not think that this is the safest bill as it stands, and I do not think that the amendment will make it safe for disabled people, for example, who access social care on a regular basis—or try to but are unable to get it. However, the amendment is important within the confines and the scope of the legislation.

Amendment 221 specifies that:

"a person is ineligible to be lawfully provided with assistance to end their own life if they have been—

(a) unable to access appropriate social care relevant to their terminal illness, and

(b) on a waiting list for such social care for a continuous period exceeding 6 weeks prior to making a request for assistance in accordance with the provisions of this Act."

The amendment is important because all the members around this table know the experience of our constituents and how difficult it is for them to access any form of social care and, indeed, because of the points that have just been made about the social care that is required in a palliative care approach. It is very important that we do not create a situation in Scotland where such intolerable circumstances have arisen in someone's life for them to assess that their quality of life is such that they cannot continue because they have not been able to access a crucial aspect of independent living, which is social care. The amendment is therefore essential.

Amendment 222 sets out a definition of "appropriate social care", which includes but is not limited to

"care provided in accordance with each risk category of the national eligibility criteria".

Again, members around the table will be well aware that a number of our constituents are struggling to access any social care that is not just literally life-and-limb care. Most local authorities are operating an eligibility system that says that individuals can access social care only if there is a "substantial risk" to life as a result of their condition. We have to bear in mind that the bar between whether life is tolerable or intolerable cannot just be that an individual is at substantial risk of dying if they do not get social care. That is why we need to consider the broadest possible definition, and it is why I have lodged amendment 224.

I stress to members that, even with my amendments, because of the narrow scope of the bill on assisted suicide we are only talking about people who are eligible in this context. We are not able to discuss or amend the bill to address social care in general, which I think is needed in order to prevent the everyday or internalised ableism that comes with being unable to access social care on a daily basis, and which can build into a feeling that life is intolerable. That also relates to the third grouping of amendments, on coercion. It is the sort of thing that could encourage people to end their lives. The amendments are narrowly drawn, but they are important.

Amendments 227 and 228 make provision about the assessment that the medical practitioner must undertake to ensure that the person has been offered and provided with appropriate advice and support. When many people are diagnosed with an illness, be that illness terminal or otherwise, there is a sense of loss. I was diagnosed with my illness when I was 18 months old, too young to directly experience any sense of loss, but I know that my parents did, and I know that the people who were around my parents felt that sense of loss. We need to ensure that we are creating a society around people that provides them with the level of support required and signposts them to the services that may exist to make their life tolerable, even at the end.

Particularly given the conversation that we have had on the previous grouping, on timescales, my argument remains that, if we do not sort out some of the structures—the systemic inequality that can come from the fact that social care does not exist for many disabled people to allow them to live their life equal to others—we are creating a circumstance where choice is not equal and we are not taking control of our own lives. The state is taking control of our lives and, I can say as a disabled person, it has been doing so for decades, because we rely so much on those systems. My amendments seek to operate within the constraints of the scope of the bill, and I am doing the best that I can, but they will not address some of the issues on coercion.

I also wish to talk briefly about the amendments where we have another opportunity—and I encourage members to take it—to consider including a time limit of six months. I turn to the arguments that have been made previously by many members, including Jeremy Balfour, Daniel Johnson and, more recently, Bob Doris, on the question of premature illness. I say what I am about to say not because I am looking for the tiniest violin in the world, or because I am trying to pull at members' heartstrings, but because I am trying to set out the real dangers. I therefore encourage committee members to vote for the amendments that include a timescale.

On the definition in the proposed legislation, the policy memorandum says:

> "the member decided to focus on whether a registered medical practitioner considers a person to have an advanced and progressive illness".

I was diagnosed with juvenile idiopathic arthritis when I was 18 months old. I am now 44 years old, and there is not a medical practitioner in this country who would not consider my condition to be "advanced and progressive". It is not something that I am going to recover from, and that has been proven time and again. I therefore meet those criteria. Yes, as a result of some aspects of my medical condition, it could cause my premature death.

As the bill stands, it has no protections. I do not think that it is intended to cover me—and I am not saying this to make it sound like I think that it is—but the fact is that it does. Without having the six-month time limit, we are opening up the bill to cover any advanced and progressive condition, and I have already made the point about most of the people concerned being disabled people.

I am asking the committee to take the opportunity now to put in the safeguard with some of the amendments. People know that I will still have some concerns, but the six-month time limit is incredibly important. Without it, how do we draw the line between allowing someone like me to choose this option—to take my own life because things have got so intolerable, because my social care has fallen apart, my house is not accessible or I cannot get public transport, or because of all the things that make life very difficult for disabled people—and not? I encourage members to think very carefully, please, about how they vote on the six-month time limit amendments in the group.

Jeremy Balfour: I fully support the amendments in the group that have been discussed so far.

At the heart of the bill lies an interesting assumption, which is that every individual has the capacity to make a decision about life and death. However, I would argue that, both within law and within practice, that assumption is not true. Capacity is not constant. It can fluctuate with illness, medication, fear, depression or external pressures, as we have heard from Brian Whittle and, very powerfully, from Pam Duncan-Glancy, but the bill begins with the presumption that everyone is capable of giving fully informed consent to their death.

10:15

That is an extraordinary presumption to make in law, and a dangerous one too. When the decision is irreversible—when it involves the deliberate ending of life—we must hold ourselves to the

highest possible evidential standard. Anything less would be a profound failure of our duty to protect those whose vulnerability may be obvious to others, even if it is not obvious to themselves.

Amendment 146 strengthens that safeguard. It reverses the default presumption so that an individual must be presumed not to have capacity unless it can be proven on the basis of clear evidence that they do. It also sets a higher bar to "beyond reasonable doubt", which is clearly understood by lawyers and, I think, most people in the public. It also defines what true capacity means in that context: that someone has a full understanding of the nature and consequences of the decision, an awareness of all available care, treatment and palliative options, and the ability to communicate the decision and the reasoning behind it clearly and voluntarily.

Amendment 146 says exactly what Mr McArthur and others have said that they want to be in the bill. As Pam Duncan-Glancy clearly articulated, for many people with disability, life could become almost not worth living if their care package was taken away or reduced. I could imagine a situation where I had no family, the care package was cut and I could not get dressed in the morning—would I want to continue living, being housebound in my pyjamas 24/7? That is why we have to think very carefully about Pam Duncan-Glancy's amendments.

Let me be clear that the amendment is not about creating obstacles; it is about ensuring integrity. It ensures that only those who truly comprehend the gravity of what they are deciding can do so. If we are to legislate on life and death, let us at least do it with humility and humanity that recognises how fragile human judgment can be and how permanent death always is.

I move to amendment 147. We have had a lot of discussion around the terminology and what I believe is the vagueness in it. As I said, I believe that that could lead to including people who have not had the appropriate treatment. There is a real risk that we could include people suffering from anorexia nervosa, as Jackie Baillie pointed out, which is a severe and life-threatening mental illness, but one from which recovery is possible. I believe that to treat such a person as terminally ill is not compassionate, but the opposite.

When someone's judgment is clouded by an illness that distorts their relationship with life and death, surely our duty as a Parliament and society is not to confirm that despair but to offer hope, treatment and care. If the bill's wording allows those who can recover to access assisted suicide, it fails in its most basic moral duty—to protect life when life can still be saved.

My amendments would ensure that that cannot happen. They make clear that an illness cannot be classed as terminal if it can be controlled or substantially slowed by medical intervention such that death is not reasonably expected within six months. They also specify that an illness cannot be considered terminal if it is a result of

"voluntarily stopping eating and drinking."

Those are not minor technicalities; they are essential safeguards, particularly for those battling anorexia, to ensure that the Parliament does not, however unintentionally, create a legal pathway for suicide among people who could otherwise be treated, supported and restored to health and often live very fulfilling lives. Any law that touches on life and death must draw its boundaries with precision and compassion.

Daniel Johnson: I am very sympathetic to the member's points about anorexia nervosa, and I think that we need to put safeguards in place in that respect. That said, I wonder whether there are technical problems with the reference to

"voluntarily stopping eating and drinking",

given that there are a number of conditions, including digestive ones, that might result in people not being able to eat or drink and being required to use enteral feeding, have percutaneous endoscopic gastrostomy tubes and so on. I wonder whether the way in which the member has captured that issue might have unintended consequences.

Jeremy Balfour: If the committee—and the member—is willing in principle to accept what I have said, and members feel that there is just a technical drafting issue that needs to be tidied up, I am happy to look at that. I am interested to know whether that is the member's view or whether he is opposed to the amendment in principle, which I think is a different issue.

I conclude by saying that my amendments ask us to protect the vulnerable, to defend hope and to ensure that no one's darkest moment is mistaken for their final one.

Sandesh Gulhane: I want to start by saying how deeply concerned I am about Jeremy Balfour's amendment 146 and the idea of an individual being presumed not to have capacity. If someone is diagnosed with a terminal—or very serious—medical condition, am I to say, "You can't make any decisions about your treatment going forward, because you have been diagnosed with cancer and therefore do not have capacity. I need to prove that you have capacity first"? If so, I think that that is wrong. We cannot have a presumption that somebody cannot have capacity—the presumption needs to be that people do have capacity.

The convention is that doctors will look at a person's capacity when they speak to them and bring to bear their judgment as to whether or not they have it. If necessary, they will then take that further and say, "I am concerned about the capacity this person has—or hasn't—got." Putting that the other way round is deeply concerning. I do not want to go into the other amendments in the group; that is the one that I really wanted to speak to, because it is of great concern to me.

My amendment 2 is very simple. I just think that 16 is a bit too young. We have a problem in Scotland with defining what an adult is; I know that there is another amendment that seeks to change the age to 25. I believe that an adult is somebody who is 18 years old, and I believe that, at that point, they have the right to decide on their medical treatment and whether to accept or refuse treatment. They have the right to go to a pub and drink legally; they have the right to smoke; they have the right to do a lot of things. In the majority of cases, they are no longer at school.

On balance, I think that that is the right age to—

Daniel Johnson: Will the member give way?

Sandesh Gulhane: Absolutely.

Daniel Johnson: I think that the member might be referring to my amendments in a later group, which would alter the age to 25. I hear what he is saying, but I wonder whether he thinks that there is a discussion to be had about the issue. He talks about rights but, earlier in his contribution, he talked about capacity, too. There is an increasing body of evidence on cognitive development and neurodevelopment that shows that people's attitudes and ability to make decisions—that is, their cognitive ability—do not fully mature until the age of 25. If capacity is a central issue, there is at least a discussion to be had about the age limit to be set, because we absolutely want to ensure that people are exercising this right with the fullest of capacity. Does the member accept that those are the parameters of this debate?

Sandesh Gulhane: Capacity is an individual matter. When it comes to medical interventions, there are 13-year-olds who can make a decision based on their particular ability to do so. It is different for everyone, and every person will be a case in point. I just think that the vast majority of people at 18 do have that full capacity and are able to make their own decisions.

I do not know whether members agree, but I said earlier that we need to start to think about, in the majority of cases, the question of what an adult is. Yes, development does go on in a person's brain until the age of 25, but I do not believe that 25 is the right age, because plenty of 18-year-olds have the ability to make informed decisions. I think that that is the most important thing.

Claire Baker (Mid Scotland and Fife) (Lab): Amendment 152 asks the committee to consider the appropriate age for people to be included in the bill. My understanding is that Liam McArthur has indicated that he supports raising the age to 18, but my amendment aligns the bill with comparable policy, which considers the cognitive maturity of young people.

The Scottish Sentencing Council, whose framework the Scottish Government accepts, states clearly that

"the brain does not fully mature until ... the age of 25".

This scientific and psychological understanding guides how we treat culpability for crime, by recognising that young adults might not yet possess full emotional and cognitive maturity. There are a number of different landmark ages at which responsibilities and obligations are extended to young people, but I ask members to consider whether, if the principle of maturity at 25 is accepted when determining responsibility for wrongdoing, it should also apply when considering a decision that is far more permanent—indeed, one that would end one's own life.

Raising the age to 25 aligns the bill with the same evidence-based understanding of brain development that already shapes our justice system. By applying an age of 16 or 18, we would be permitting individuals to make an irreversible choice during a period when their decision-making faculties are still developing. Surely, if we believe that a person under the age of 25 might not yet be fully capable of assessing long-term consequences when committing a crime, we must apply that same caution when it comes to their choosing to end their own life through an assisted suicide.

My amendment is about ensuring consistency, protecting the vulnerable and acting with the same moral seriousness across all areas of law.

Liam McArthur: First, I thank all members for setting out the rationale for their amendments. I have great sympathy with the motivation in every instance; I am particularly grateful to those who are opposed to the bill but who are seeking to strengthen it—in this case, in relation to eligibility.

I have not lodged any amendments in this group, but I will address those that have been lodged. I note that amendment 222, in the name of Pam Duncan-Glancy, is pre-empted by amendment 26 in the previous group on definition of terminal illness, and that amendments 2, 3 and 1 in the name of Sandesh Gulhane are direct alternatives to Claire Baker's amendments 152,

168 and 215. I will return to those amendments shortly.

On Bob Doris's amendments 83, 108, 119 and 97, for which he gave us a spoiler alert in the discussion on the previous group, I stated in relation to that group that I have concerns about adding a period of life expectancy to a terminal illness definition, and I have similar concerns about amending eligibility requirements so that someone must be

"reasonably expected to die within six months".

I will not repeat what I have already said, but I note that the Australian Capital Territory, having learned from other states in Australia and elsewhere, has chosen not to set a fixed timeframe for eligibility. Instead, it requires that a person's condition be

"advanced, progressive and expected to cause death",

focusing on the reality of end of life rather than an arbitrary time limit. We see there the evidence of who is accessing this, and the point in their prognosis at which they are accessing it.

That is borne out by the research that the committee heard about by Professor Ben Colburn at the University of Glasgow, which should allay some of the concerns about disproportionate vulnerability or the extent to which those with a disability will access that choice.

Bob Doris: Will the member give way?

10:30

Liam McArthur: I will in a second, Mr Doris.

In an intervention on Sandesh Gulhane, I recognised that the bill would put in place safeguards that do not exist at present. Those are in relation to access to an assisted death and more widely to those who are vulnerable, who may have a terminal illness and who, at the moment, are being left without support or the opportunity to discuss their concerns and the situation in which they find themselves.

I am happy to take the intervention. I think that it was from Bob Doris—or was it from Daniel Johnson?

Daniel Johnson: Bob was first.

Bob Doris: You are very popular this morning, Mr McArthur. I get the issues with having a timeframe in relation to prognosis. However, would Mr McArthur also accept that there are significant issues with having no timeframe at all and that wording such as "advanced", "progressive", "unable to recover" and

"reasonably be expected to cause their premature death"

could also all be seen to be very broad brush strokes? Where does the member sit between the open, broad-brush-stroke approach that is in the bill and the efforts to be more narrow and specific in the various amendments that we are discussing today, including my set of amendments in the group?

Liam McArthur: I do not know whether Daniel Johnson wants to make a similar intervention on the back of that point. If so, I can try to address both interventions.

Daniel Johnson: My intervention is further to that point. I echo the questions that Bob Doris just raised and will add to them. As it stands, from the member's understanding, what would prevent someone with a decade or more to live from exercising their rights under the bill? That question follows on from the very powerful point that Pam Duncan-Glancy made.

Liam McArthur: To some extent, we need to detach ourselves from the rationale for why somebody would seek to make a request of that nature—it would be very individual to that individual. We need to ensure that the safeguards protect the vulnerable. The safeguards would allow interventions to be made that, as I said to Sandesh Gulhane, are not being made at the moment. Therefore, they would make the situation for many with a terminal illness safer than it is at present.

I acknowledge the fact that there are jurisdictions that have prognostic periods in their legislation. I also acknowledge that, in many instances, those prognostic periods have gone through a review period that has presumably satisfied legislators that, whether they provide an additional safeguard or not, they are not inhibiting those who meet the eligibility criteria from accessing that choice. However, as I said, I also point to jurisdictions that do not have prognostic periods, the reasons why they do not and the evidence of who is accessing assisted dying in those jurisdictions, which bears out the point that it is very much those who are at the end of life and with advanced progressive—

Jeremy Balfour: Will the member take an intervention?

Liam McArthur: I will in a second, Mr Balfour. The assumption is that, in those jurisdictions, when someone receives a terminal diagnosis, the immediate reaction is to seek to make the choice of an assisted death. That is simply not borne out by the evidence of who is accessing it, when they are accessing it and for what reasons.

Jeremy Balfour: I am just looking for clarification. In principle, as the bill stands, if someone got a terminal diagnosis and had maybe 10 years to live, would you be content for that

individual to go through the process—I appreciate that they would have to go through the safeguards—and then for the assisted suicide to take place?

Liam McArthur: Again, I reject the reference to "assisted suicide". We can have a debate at another point about the difference between the mental state of someone who is seeking to take their own life and someone with a terminal illness who is seeking to take control over that process.

What I have said, and what is set out in the bill as it stands, is that this relates to someone with an "advanced and progressive" condition. Although I understand the argument for setting a prognostic timeframe—and I welcome the fact that we are having this debate—the committee concluded from the evidence that it took that doing so would be problematic. On that basis, I do not support the amendments on that, and I urge Bob Doris not to press them.

On amendments 145 and 207 by Brian Whittle and amendments 25, 30 and 31 by Rhoda Grant, I fully support the principle of a terminally ill adult having available information and options explained to them and having in place appropriate care plans—including for palliative care, where appropriate—if they wish. That is why section 7(1) would require the assessing doctors to explain and discuss the person's diagnosis and prognosis, available treatment, palliative and other care options, and the assisted dying process and the substance that would be used. It is also why I lodged amendment 29, which aims to ensure that palliative care discussions include available hospice care, symptom management and psychological support.

As Sandesh Gulhane suggested in his intervention, greater use of advance care plans would be welcome and would help to increase the likelihood of people having their wishes respected, but it is important that such plans remain voluntary. I am therefore not supportive of adding to the eligibility criteria in the ways that are proposed in the amendments, which would include a person having an anticipatory care plan or a palliative care plan in place. Doing so would risk adding a barrier to a terminally ill adult who is otherwise deemed eligible being able to access assistance because, for example, they did not want such a plan or did not wish to have palliative care, which can be a matter of personal choice.

Brian Whittle: I am very grateful to you for taking my intervention. Surely you would accept that, in order to make the choice not to accept palliative care, an individual has to be given the option of palliative care in the first place. You and every other member here are aware of the inequality of access to palliative care. We have talked about how quality of life can be greatly enhanced by palliative care. Not having access to palliative care much reduces quality of life. The decision to access assisted dying has to be a decision of equality. Not having access to palliative care creates a real problem with the bill.

Liam McArthur: Thank you for the intervention. You make a strong point, which also came through strongly in the evidence that the committee heard. The committee heard from witnesses who were involved in the process in Victoria, Australia that engagement with palliative care has improved as a result of the change in the law there. Although palliative care discussions are not taking place as routinely as they might, ultimately, the decision about whether to have palliative care and, indeed, any other treatment, has to rest with the individual—that is, with the patient. We need to address areas where access to palliative care is not what it should be, although that cannot be addressed through the bill. Nevertheless, it needs to be a decision for the individual as to whether they access palliative care or have a palliative care plan. However, they absolutely need to be made aware of the options that are available in relation to palliative care—that is why I lodged amendment 29.

Rhoda Grant: My amendments say that there should be a palliative care plan. They do not insist that the person take up that palliative care; they are simply about having a plan for palliative care. Discussing palliative care is totally different. A lot of my constituents have discussions about palliative care. Often, they are told, "What you want to happen won't happen, because we don't have the ability to do that." However, having a plan in place is a guarantee to somebody that what they want will happen. Putting a plan in place gives them a choice, rather than their simply having a discussion and being told, "It's unlikely to happen for you".

Liam McArthur: I get the point that you are making. Ideally, one would want people to have as much advance planning, including in terms of palliative care, as possible. However, making such plans part of the eligibility criteria is highly problematic, for some of the reasons that I have touched on. I will come on to address those in more detail. Making such plans part of the eligibility criteria could result in a terminally ill adult, who would otherwise be eligible but has a short time to live, dying before such a plan could be put in place.

The Scottish Government has also highlighted the chief medical officer's confirmation of a

"change in terminology from 'anticipatory care planning' to 'future care planning'",

while noting—and I agree—the following:

"The process of developing a future care plan should be holistic and person-led, with a focus on shared decision-making. As such, setting out that a person must have a plan in place which must include a plan for palliative care in order for them to be eligible for an assisted death goes strongly against this person-led ethos, given that some people may not want palliative care for a number of reasons."

Regarding Pam Duncan-Glancy's amendments 219, 221, 222 and 228, I fully support people with terminal illnesses having full access to social care. However, I am concerned about adding a requirement for a person to have such care in place in order to meet the eligibility criteria for assistance. I do not agree that a person should be ineligible for an assisted death if they have not accessed social care or if they have been on a waiting list to access social care for six continuous months. Adding such a requirement risks adding a barrier to a terminally ill adult who is otherwise deemed eligible to access assistance.

Regarding Ms Duncan-Glancy's amendment 227—

Pam Duncan-Glancy: Will the member take an intervention?

Liam McArthur: Briefly, yes.

Pam Duncan-Glancy: Forgive me—I thought that you had reached the end of discussing my amendments.

I am not sure that I fully follow the argument about access to social care not having been offered, or, indeed, the previous argument about palliative care. I do not understand why the requirement would create an additional barrier, unless the member admits that social care and palliative care are in such a poor state in Scotland that the timescales involved would be difficult and the money involved prohibitive.

Liam McArthur: The difficulty is in making eligibility contingent on a person having a care plan in place or having access to social care or palliative care. Ultimately, that needs to be a decision for the individual.

Regarding Ms Duncan-Glancy's amendment 227, I support people with a terminal illness having access to appropriate advice and support about living with their illness. I urge the committee to support the amendment.

In relation to amendment 146, in the name of Jeremy Balfour, the committee will be aware that the law in Scotland generally presumes that adults are capable of making personal decisions for themselves. The starting point is a presumption of capacity that can be overturned only if there is medical evidence to the contrary. The amendment appears to reverse that, with capacity to be proven, not assumed. I am not sure that Mr Balfour would support such an approach in other circumstances. Consistency with the principles and approach that we take in other areas is important, not least in reducing the risk of confusion but also in respecting the rights of individuals. Mr Balfour takes that enormously seriously and has a strong track record in defending such rights.

Given the complexity and finality of the decision in question, two doctors have to be satisfied that the ability to make the decision is not affected in any way. That is one of the essential safeguards and protections in the bill. Specifically, the bill sets out that, to have capacity to request an assisted death, the person must not be

"suffering from any mental disorder which might affect the making of the request"

and must be

"capable of—

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

(ii) making a decision to make the request,

(iii) communicating the decision,

(iv) understanding the decision, and

(v) retaining memory of the decision."

That the person who wishes to access assisted dying fully understands the decision that they are making, in all its complexities, is therefore a precondition under the bill's requirements. The bill adopts the established test for capacity that doctors currently apply, which is set out in mental health legislation, and applies it in the assisted dying context.

I note that amendments 146 and 147 appear to present alternative options. On amendment 147, I am not persuaded that capacity should be tied to the person's reasons for seeking an assisted death, as provided for in the amendment. It could muddy the waters by introducing subjective elements to an objective process, which risks making it difficult for health professionals to carry out assessments. It also potentially discourages open conversations between doctors and their patients.

I support amendments 1, 2 and 3 in the name of Sandesh Gulhane and ask the committee to support them. I am on record as supporting a change in the minimum age of eligibility from 16 to 18. Members will be aware of why I set the age that is contained in the bill at 16. In the interests of time, I will not rehash those reasons.

Claire Baker: Will the member take an intervention?

Liam McArthur: I will take a brief one.

10:45

Claire Baker: My intervention is about age. The Scottish Sentencing Council's research highlights that young people

"are generally less able to exercise good judgement when making decisions",

that they

"are more vulnerable to negative influences such as peer pressure and exploitative relationships"

and that they

"may take more risks".

The research seems relevant to the decision that the committee will have to make about age. The decisions that young people can make when they are 16 or 18—for example, about getting married, starting smoking or drinking alcohol—are all reversible; they can get divorced, give up smoking or become teetotal. However, what we are talking about is not a reversible decision. I caution members on whether to accept that allowing such a decision to be made at 16 or 18 is appropriate.

Liam McArthur: I will turn to Claire Baker's amendments shortly. I fully understand her point. It is problematic in that it could open up the prospect of raising the age at which we allow a whole host of things to happen and for capacity to be assumed in young adults, to a level that I think we would find it difficult to justify in other areas. There are other ways of addressing some of the concerns that Claire Baker has raised, which I will come to in a second.

Sandesh Gulhane: On good judgment, peer pressure and taking more risks, I was a doctor at the age of 24. Does that mean that it would have been okay for me to make a decision about other people's lives, but not mine?

Liam McArthur: A point has been made by Claire Baker, and Sandesh Gulhane has also made his point. I support the age being raised to 18 and urge the committee to do likewise.

On the age threshold that Claire Baker proposes, which was pre-empted by Daniel Johnson's earlier intervention, I am not persuaded by the case that has been made to raise the age to 25, as provided for in amendments 152, 168 and 215. In other jurisdictions with similar legislation, 18 is typically the age at which someone becomes eligible. During stage 1 evidence, many of the witnesses appeared to consider 18 as the appropriate age of eligibility. Claire Baker has clearly set out the Sentencing Council's views and I am conscious of Children's Hospices Across Scotland's concerns, following my interactions with the charity over the past few years on issues pertaining to young adults who are under the age of 25. I believe that those issues will be better addressed through training, which we will discuss in subsequent groups, and by ensuring the involvement of relevant medical and other professionals. Again, those provisions are contained in other amendments.

I urge the committee to back the amendments in the name of Sandesh Gulhane, and I encourage Claire Baker not to press her amendments to a vote.

Bob Doris: The debate has been quite lengthy. In summing up, my amendments throughout the legislation have been lodged in partnership with the umbrella organisation, the Scottish Partnership for Palliative Care; it provides the secretariat for the cross-party group on palliative care, which I convene. The partnership organisation has surveyed its members in detail. Although each individual organisation will have its own views on assisted dying, the partnership has no view and is not aligned. It believes that, on balance, the amendments in my name would put reasonable safeguards in place.

I put on record, as have other members, that my view is that the bill should not proceed, but I take seriously my responsibility as a member of the Scottish Parliament. Irrespective of my personal view on the legislation, I believe that I should make it as robust as possible, which has inspired my amendments that we will be looking at over the next few weeks.

I will not say any more about my set of amendments, as I think that the point about the need for a prognosis with a timescale, versus a completely open-ended approach, has been well made. I think that the member who is in charge of the bill is wrestling with that, as are committee members, and I am sure that the Parliament will return to that issue at stage 3.

Clearly, I would rather that committee members supported my amendments at stage 2. It is important to put on record that the amendments do not directly secure any service or right to palliative care support plans, anticipatory or future care plans, or a right to palliative care. Moreover, just because there is a palliative care support plan, that does not mean that there is the resource to deliver it.

Dr Gulhane mentioned issues relating to anticipatory care planning. I know very well that one of the main issues is the reluctance of family members and care staff to talk about such planning. There is a cultural reticence to do so. That makes it all the more important that we ensure that people who seek assisted dying can make an informed choice. If a person is seeking to take that route, there is no time to back away and for someone else to say, "Look, here's what palliative care could do for you. Let's look at this to make an informed choice."

Brian Whittle: Rhoda Grant and I have made the point—quite strongly, I think—that we are not forcing people into palliative care or into social care. However, the important point—the key element—is that, in order to make an informed choice and to provide an even choice, palliative care must be available.

Bob Doris: We are in danger of agreeing, Mr Whittle. That is the point that I was coming on to make.

However, the caveat that I would add is that the amendments do not guarantee any of that. They guarantee that a palliative care support plan would be offered, but whether the resource would be found to deliver that plan is another matter. They could guarantee that an anticipatory care plan or a future care plan was sought to be drafted, but the individual might or might not comply with that. That would tick another box, but it would not guarantee the delivery of anything.

Even if palliative care is a right, guaranteeing its delivery is outwith the scope of the bill. Later we will return to the issue of why the bill might not be able to provide the safeguards that some people would like.

Elena Whitham: I wonder what your thoughts are on section 7, which places a duty on registered medical practitioners, during the first declaration, to discuss palliative care and any other care that might be available to that individual. That would allow the individual to make an informed decision about any palliative care plans or future care planning that could be made. That is a safeguard; that will be discussed at that point. However, if you were to tie that to eligibility criteria, that person would not have the autonomy to say, for example, that they did not want those plans to be made. Indeed, when timeframes are really short, that might preclude somebody from accessing the supports that are available under the bill.

Bob Doris: I say to Elena Whitham that the point about short timescales brings us back to prognosis issues. The member in charge of the bill and the committee are not really compelled by the arguments on including a timescale for a prognosis of death and fast-tracking the process.

I have later amendments on palliative care. I do not believe that there are safeguards on such care in the bill currently. Having a general discussion on palliative care is not a sufficient safeguard and—

Liam McArthur: Will Bob Doris take an intervention?

Bob Doris: I will take an intervention in a little while. The bill must be more robust, and I have a series of amendments that would have that effect. However, I agree with Elena Whitham that the provisions in section 7 are a good starting point for building in some of the safeguards that I would like to see.

Liam McArthur: As the chair of the cross-party group on palliative care, Bob Doris will be aware that the debate on such care was nothing like as prominent as it has been since I announced my intention to introduce the bill. That bears out the evidence that the committee heard from witnesses in Australia that, as a result of the conversations and the safeguards that are in place on assisted dying, engagement with palliative care improves. Simply asserting that there is a zero-sum game here would be inappropriate and is not borne out by the evidence.

Elena Whitham made the point that discussions on palliative care need to be voluntary. Tying that to the requirement for there to be a plan—whether it is an anticipatory care plan or a palliative care plan—runs the risk that someone who would be eligible under the criteria would be unable to access the choice that they wish to make.

Bob Doris: I respectfully say to Mr McArthur that I do not agree with how that has been framed. In the stage 1 debate, I raised the issue of palliative care, as many other members did. At the subsequent meeting of the cross-party group on palliative care, I did not see members rushing to the CPG to declare their absolute support for how we expand all that. That simply did not happen.

Talking about assisted dying has caused many members to suddenly realise that we should be talking openly and honestly—perhaps on a cross-party basis—about the fact that much more has to happen on palliative care, including discussing how it should be resourced and the choices that we have to make as a Parliament and as parties within that Parliament. All that has been raised because the bill has been introduced, but it should never have been thus, Mr McArthur; we should all have been interested in palliative care, which has merits in its own right, irrespective of whether there is a bill on assisted dying. However, I absolutely acknowledge that talking about this issue is shining a light on palliative care. Passage of the bill is not required to secure additional funding for such care, but I acknowledge Mr McArthur's point.

The final thing that I will say, given that Jeremy Balfour's amendments in this group relate to vulnerabilities and capacity, is that, later, we will consider a group about vulnerable adults, at which time we can look more at coercion, vulnerabilities and individuals who are at risk. That might be a more appropriate point to have that conversation on a more rounded basis. I have no other reflections.

The Convener: Mr Doris, are you pressing or withdrawing your amendment?

Bob Doris: I press amendment 83.

The Convener: The question is, that amendment 83 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Gulhane, Sandesh (Glasgow) (Con)

The Convener: The result of the division is: For 2, Against 7, Abstentions 1.

Amendment 83 disagreed to.

Amendment 145 moved—[Brian Whittle].

The Convener: The question is, that amendment 145 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 2, Against 8, Abstentions 0.

Amendment 145 disagreed to.

Amendment 25 moved—[Rhoda Grant].

The Convener: The question is, that amendment 25 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 2, Against 8, Abstentions 0.

Amendment 25 disagreed to.

Amendment 219 moved—[Pam Duncan-Glancy].

The Convener: The question is, that amendment 219 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 2, Against 8, Abstentions 0.

Amendment 219 disagreed to.

Amendment 146 not moved.

Amendment 147 moved—[Jeremy Balfour].

The Convener: The question is, that amendment 147 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

Against

Baillie, Jackie (Dumbarton) (Lab)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 0, Against 10, Abstentions 0.

Amendment 147 disagreed to.

The Convener: I now suspend the meeting for a 10-minute comfort break.

11:02

Meeting suspended.

11:13

On resuming—

The Convener: Amendment 220, in the name of Pam Duncan-Glancy, is grouped with amendments 223, 85 to 87, 12, 13, 161, 104, 237, 105, 238, 162, 107, 112, 164, 118, 120, 169, 172, 174, 124, 42, 43, 210, 139, 216, 217 and 140. I point out that amendment 12 is pre-empted by amendment 88, which is to be debated in the group on assessments of the terminally ill adult.

Pam Duncan-Glancy: Amendments 220, 223, 237 and 238 would ensure that requests for assistance to end life under the Assisted Dying for Terminally Ill Adults (Scotland) Bill are entirely self-initiated by the terminally ill adult and are made without any encouragement, suggestion or inducement from medical professionals, practitioners or other professionals involved in their care.

Amendment 220 is in reference to eligibility, amendment 223 is in reference to the person's first declaration, amendment 237 is in reference to the statement by the co-ordinating registered medical practitioner and amendment 238 is in reference to the statement by the independent registered medical practitioner.

The notion of coercion has been discussed and debated at length in other jurisdictions, particularly in relation to gender-based violence. By definition, it is difficult to detect coercion but, nonetheless, it is incredibly important that, when we are considering legislation that allows someone to take their own life, we ensure as best we can that it is absolutely watertight that the people whose job it is to support a person to live do not take any part in suggesting that that person may end their life.

11:15

I want to speak for a moment about the wider coercion that I highlighted in the stage 1 debate—and I note that the amendments in Stuart McMillan's name seek to look at some of these same issues of pressure and societal coercion. We live in a society where choice for disabled people—and by definition, therefore, people who are eligible under the bill for assistance to take their own lives—is not equal. Disabled people do not have the same choices as other people. They cannot get out of bed in the morning whenever they decide to do so; often, somebody else makes that decision, because it is all to do with the timings that suit the professionals around them. I am not saying that to critique the incredible social care professionals who support us, day in, day out; I am just recognising that there is a substantial element of control from other people in the lives of disabled people—and, indeed, the lives of terminally ill people. For reasons that I have rehearsed previously, the two aspects are difficult to unlink.

It is also the case that we live in a society in which disabled people's lives, and the lives of people who have lost certain functions, are not valued in the same way as those of people who have those functions. She will not mind me using this example, but the incredible Paralympian Tanni Grey-Thompson, in a debate in the House of Lords, said that she was incontinent, and then talked about people saying, "I would rather die than be incontinent." She had to face that in the House of Lords, and she said, "Well, I lead a very open and enjoyable life."

We have already heard this from other members, but the fact is that, although everybody's understanding of quality of life can be quite different, there is very much an understanding that disabled people's lives are often valued less than non-disabled people's lives. Often the loss of function, whatever it might be, can become something that people inherently fear. I fear it; I do not have a lot of function, but the very little function that I do have I would be scared to lose.

That loss can really be internalised. When people around us start to think that not being able to get out of bed on your own in the morning, not being able to shower yourself, not being able to take yourself to the toilet or not being able to feed yourself is a life not worth living, people who, by definition, have a terminal illness, or any other illness, can find themselves internalising that and thinking, "What is my life worth if I can't do that? Other people do not think that that's a life worth living."

That sort of societal and everyday ableism exists and is a real danger in the context in which we are bringing in this piece of legislation. Disabled people are less likely to work. We are more likely to live in homes that are inaccessible; indeed, about 10,000 of us in Scotland are stuck in our own homes, because we cannot get into and out of them. Many disabled people—one in four—cannot access the palliative care that they need. High numbers of disabled people cannot access social care, because of the costs associated with

it; high numbers of them do not access it because of the recruitment crisis; and many do not access it because the eligibility criteria determine that they are not able to do so. We are operating a system in Scotland in which we are literally providing life-and-limb care and support to a large majority of disabled people. In that context, the notion of choice and control is very difficult for a disabled person.

Therefore, my amendments seek to take out some elements of what coercion could be. They will not be able to address all of the issue, and I ask members to think carefully about that, particularly when listening to Stuart McMillan's argument, which I am sure will be powerful, on the points around pressure and societal coercion.

It is those areas that really worry me about the bill. Unless we fundamentally change social care, unless we fundamentally change healthcare, unless we fundamentally change our housing system and unless we can get to a system that does not oppress or discriminate against large swathes of society, the context in which we are bringing in the bill will be very dangerous. The amendments that I have lodged in this group seek to try to protect at least some small part of this; I would have lodged other amendments dealing with the broader aspects of what I am talking about, but I was told that they were not within the scope of the bill. I ask members to reflect on that comment.

For the time being, I think that amendments 220, 223, 237 and 238 will provide some, if not all, of the safeguards that are needed in the legislation, and I ask, and encourage, committee members to support them.

I move amendment 220.

Bob Doris: Amendment 139 in my name and the various consequential amendments in this group seek to address concerns about a deficiency in the current definition of coercion in the bill. Coercion in the bill is framed as something that is done by a person, whereas the current professional standard that is demanded by the General Medical Council guidance requires practitioners to consider other indirect coercive factors. It is important to the Scottish Partnership for Palliative Care that that be put clearly on the face of the bill.

There is broad agreement that the assessment of coercion is central to safeguards in the bill, and the definition of coercion to be used is central to the effectiveness of any assessment. The bill's own policy memorandum, which I have already mentioned, refers to the relevant GMC guidance as key to assessing coercion, but the bill itself currently uses a weakened definition. I cannot see any good reason why the accepted professional standard should be weakened in the context of a life-and-death decision relating to assisted dying.

Therefore, amendment 139 and consequential amendments seek to place in the bill a definition of coercion that complies with current regulatory and professional standards. Practitioners assessing coercion under the revised definition will be clearly directed and able to consider the wide range of coercive factors that we know might lead some people to wish to hasten their death.

I will mention one or two of those factors, although I think that Pam Duncan-Glancy has illustrated very clearly what they might well be, as will other members with amendments in this group. For example, a person might feel that they are a burden to others, and there are also the financial pressures that they might be under. I know from my own lived experience that older people with frailty often feel that they are a burden; in the last year of her life in a care home, my mother in her more lucid moments—she had vascular dementia—would tell me, "Son, get yourself home. Why are you here?" She was worried about me and my work commitments and worried that she was being a burden on me. Before that, while they were still in the family home, my mother and father would dissuade me from visiting them, because they thought that I was busy at my work and what, really, was there for me to go down and visit them. They had a view of themselves, and a view of me, that made them feel like a burden. That is just a personal experience that I would share with the committee.

Jeremy Balfour: Will the member reflect on the fact that, if the bill becomes an act, it will be there for generations to come? This kind of attitude can build up not necessarily in some direct way but through television programmes, newspapers and social media. It might not be absolutely at the heart of what society thinks at the moment, but we could see, over a five or 10-year period, that sort of pressure building on vulnerable individuals, due to things that are reflected in society more widely.

Bob Doris: I suppose that my answer to that would be "Possibly". My general comment to your intervention is that we have to ease burdens in society, challenge the idea of someone who has ill health or a terminal condition or who is old and frail feeling like a burden in the first place, and say that their life is valued, irrespective of all that. A pathway to easing that burden would not be assisted dying but supporting them better as an equal member of society as best we can.

My only amendment in this group that might not be considered as consequential on amendment 139 is amendment 140, which adds to the bill the definition of "voluntarily" as meaning

"not having been coerced or pressured."

The bill would otherwise be silent on the definition of "voluntarily". However, the definition makes it clear that an act is not voluntary if coercion or pressure is present. That is important, given that that distinction is not always clear in the bill when the word "voluntarily" is used.

For instance, section 6(2)(c), on medical practitioner assessments, states that a declaration must be made "voluntarily" and must not have "been coerced or pressured". Something cannot be voluntary if there is coercion or pressure, and therefore, in my view, we have to define the term "voluntarily" in the bill. It is important to make it clear that a person cannot act voluntarily if they have been pressured or coerced, and I hope that amendment 140 clarifies that.

I have no other comments to make on this group of amendments.

Patrick Harvie: Will the member take an intervention at this point?

Bob Doris: Yes.

Patrick Harvie: I did not want to interrupt in the middle, but I hope that Bob Doris could say a little more about what seem to me to be subjective issues in the definition, in particular about coercion including being

"unduly influenced ... by ... the person's own beliefs about themselves".

We are all very conscious that we are discussing a subject on which people in society have profoundly different values. There will be people around this table with very different values on how we make decisions in our own lives. Legislation of this kind needs to reflect and respect the fact that people have a right to make decisions in line with their own values, not in line with the values that are imposed on them by society. Can the member tell me what the difference is between legitimately making a decision in a way that is reasonably influenced by my beliefs about myself and what would be considered coercion by being unduly influenced by my beliefs about myself? It feels to me to be a subjective and difficult-to-define area.

Bob Doris: I answer that in two ways. The first relates to Mr Balfour's intervention earlier. Someone who may be a confident, enabled individual could get a terminal diagnosis, and everything that follows from that could lead to that person having less self-worth. That should not be so, Mr Harvie, but that could happen. They could have adult family members with caring roles for their primary care needs. They may think that they are a burden on those individuals, and their view of their own self-worth may be impacted by that. That is an anecdotal potential example, which I probably should not give, because that is not the intention of amendment 139. The intention of the amendment is to be consistent with how the medical profession and the General Medical Council define coercion. That is not my view in relation to how coercion should be defined. A definition exists in all other areas, and it seems to be remiss not to have it in this area of life and death.

I absolutely accept Mr Harvie's point that it would be better to understand that a bit more. I agree with him, but I ask the rhetorical question of why we would use the GMC definition of coercion for everything else but not use it on assisted dying. My amendment would simply make sure that we are consistent in our approach.

Emma Harper (South Scotland) (SNP): Good morning. I have been listening carefully, and I appreciate colleagues' thoughtful and respectful contributions so far. My amendments 12 and 13 are directly linked. Amendment 12 allows the introduction of amendment 13. My amendments seek to allow registered medical practitioners to consult other health and social care professionals, such as nurses, carers and social workers, when assessing whether a person has made a declaration voluntarily and without coercion.

I remind colleagues that I am still a registered nurse. The proposal was informed by engagement over summer recess with constituents and medical professionals working in end-of-life and palliative care. I met the Royal College of Nursing over the summer, and again recently, and I met the Scottish Association of Social Work. The medical professionals raised concerns that non-medical professionals often have more frequent and meaningful contact with individuals nearing the end of life and may be better placed to detect subtle signs of coercion or distress. I acknowledge what Bob Doris said about people feeling that they are a burden.

Originally, my amendments aimed to strengthen safeguards and promote a multidisciplinary approach, ensuring that assessments are thorough and person centred. Acknowledgement was made of concerns around the wording, particularly regarding the liability, responsibility and training of professionals, such as registered nurses, to be accountable for assessing coercion, whether overt or subtle. I am aware of the potential cost implications in that approach.

My amendments are therefore presented as probing amendments, and I am willing to work with the member in charge ahead of stage 3 to redefine the language or change it if necessary.

Pam Duncan-Glancy: Will the member take an intervention on that?

Emma Harper: I think so—I had finished.

The Convener: If it can be brief, Ms Duncan-Glancy.

Pam Duncan-Glancy: Forgive me—I had not realised that Ms Harper was just concluding. Can she say something about the types of costs and say in which part of amendment 13 she can see any scope for a reduction in costs?

11:30

Emma Harper: It has been pointed out to me that, because of the requirement to train health professionals—whether they are carers, registered nurses or any other people who are entering someone's home—they would need to be provided with education. I do not know the direct costs, but I understand that that would potentially cause a cost burden under the member's bill. I am happy for amendments 12 and 13 to be probing amendments for discussion and to hear what the member has to say about the issue.

Brian Whittle: I welcome Pam Duncan-Glancy's amendment 220, which she spoke to very powerfully. I also commend the work that Tanni Grey-Thompson has done—having sought her advice, I know that she is a powerful advocate on this issue.

I would welcome engagement across parties and, more importantly, from the Scottish Government at stage 3. I recognise that the Government is neutral but that does not mean that it cannot advise on operational challenges that the amendments could cause. Arguably, by failing to engage, the Government would in effect be acting against the bill. If the bill is going to be the best that it can be, it must be deliverable, and the Government needs to advise on whether it would not be deliverable.

I declare my position: I have not decided what my position will be at stage 3. In considering all the amendments, I am seeking to make the bill the best piece of legislation that it can possibly be.

I have lodged my amendments in this group because of my concern that an individual who may have a moral or personal reason to oppose the decision of the person who has made an assisted dying declaration could use the police or court system to delay the process through a protracted investigation resulting from an allegation of coercion. Amendments 161, 164, 169, 172 and 174 create a mechanism for review that is independent of the medical profession, for use in cases where people who are close to the patient—that would be family, named friends or carers—suspect or allege coercion.

I have tried to model my approach on a similar independent assessment model for organ donation, which has a 10-day reporting time. Amendment 162 says that reports should be referred to the medical professional or police where appropriate; amendment 210 gives the Scottish ministers flexible powers to create the model. The mechanism is triggered only when those close to the patient express that concern. The 10-day reporting time is also included in an effort to not prolong the suffering of the person who wishes to access assisted dying.

The driving force behind the amendments was the realisation that, as the bill stands, if somebody tries to access assisted dying and there is an objection from a relative or close friend, they could be wrapped up in a legal court case because the police would be duty bound to investigate any such allegations. We all recognise the length of time that that can take—by which time, the person who has tried to access assisted dying may be unable to comply with the rules and regulations or may have passed away. The amendments are about trying to protect the person who wishes to access assisted dying and make sure that they do not suffer excessively.

Liam McArthur: I echo Brian Whittle's comments on the Scottish Government's engagement in the process. My conversations with the Scottish Government have been constructive throughout but, for the reasons that Brian Whittle indicates, notwithstanding its neutrality, there are issues about the operability of the legislation on which members across the Parliament would welcome the Scottish Government's views—now, and certainly ahead of and during stage 3. That is important.

I will start by addressing my amendments, before I address the amendments that colleagues have lodged. My amendment 42 extends the section 21 offence to cover the day of death when the co-ordinating registered medical practitioner or authorised health professional provides the substance to the person. There is no change to the penalty that is set out in section 21(2). Amendment 43 is a drafting consequential.

Section 21 makes it an offence to coerce or pressure a terminally ill adult into making a first or second declaration. Amendment 42 adds a new offence of coercing or pressuring a terminally ill adult into the act of using an approved substance. The bill as introduced requires the co-ordinating registered medical practitioner or authorised health professional who is providing the substance to the person on the day of the intended assisted death to be satisfied that the person is not being coerced before providing the substance; however, coercion at that point is not covered by the offence in section 21. Therefore, the amendment ensures, in a situation in which a person has not been coerced or pressured into making a first or second declaration but is subsequently coerced into self-

administering the substance, or if coercion is suspected on the day, that that is made an offence. If coercion is discovered after the terminally ill adult has died and it can be shown that the person was coerced into using the substance, the offence will remain prosecutable. That may also trigger a homicide investigation. The amendment will further strengthen the safeguards in the bill and bring it more closely in line with the Westminster bill as it stands.

Turning to the other amendments in the group, on Pam Duncan-Glancy's amendments 220 and 223, I am content that my bill has safeguards in place to ensure that a person who is seeking an assisted death has not been unduly influenced. I am also concerned that her amendments may make doctors hesitant about discussing assisted dying with their patients, thereby limiting the information that is available. I note that the British Medical Association has been unequivocal on that, stating:

"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."

On amendments 237 and 238, my bill provides that the co-ordinating registered medical professional's statement must set out that the person made the declaration voluntarily and is not being coerced or pressured by any other person into making those decisions. I am not convinced that there would be value in adding another similar statement.

Pam Duncan-Glancy: Can the member set out what aspects of his bill he thinks would safeguard against the coercion that could be experienced by disabled people?

Liam McArthur: I think that I have explained that the conversations that would be had as part of the assessment of the rationale for why a request has been made are not happening at the moment. Therefore, the bill would not only provide protections but extend them far more widely to those who are currently left vulnerable.

Moving on to amendments 85 to 87, 104, 105, 107, 112, 118, 120, 124, 139 and 140, lodged by Bob Doris, I consider that personal choice and autonomy is at the heart of the bill, which provides appropriate and proportional safeguards, while allowing those who wish to have assistance to be able to access it in a reasonable time and within a reasonable framework. It is fundamental that a terminally ill adult makes the choice to request assistance themselves without coercion or pressure by another person. The bill clearly provides for that and makes it an offence to coerce or pressure a person into requesting assistance and, as I have said, I have also lodged an amendment that adds the offence of coercing or pressuring a person into using an approved substance.

However, I am very wary about widening the current definition of coercion or pressure from some form of illegitimate influence being brought to bear by another person, to something that is done by the person themselves, societal expectations, or by the health and social care system, as opposed to individuals within the system or in the state. I am concerned that defining coercion and pressure in such a way would risk introducing new definitions of legal terms, which would create confusion and make the detection of coercion or pressure and the prosecution of offences in the bill more difficult.

I understand what the member is getting at with those amendments and I understand that there are various factors that may express a person's vulnerable status and situation, which would potentially make them prone to influence and could affect their decision making. However, I believe that retaining the need for coercion or pressure to be an act that is done by another person, supported by the offences in the bill and the ability for other health, social care and social work professionals to input into the assessment process, is the best way to proceed.

Bob Doris: Will the member give way?

Liam McArthur: Yes—briefly.

Bob Doris: Clearly, I am disappointed that Liam McArthur is not persuaded by the need for consistency and using the GMC definition of coercion, which is mentioned in the member's policy memorandum but does not appear in the bill. My amendment 139 seeks to place that in the bill. Will Mr McArthur outline to me what is wrong with the GMC definition of coercion? It seems to be suitable for almost all other areas.

Liam McArthur: I would respond to that by saying that there is nothing wrong with that guidance. It is consistent with the approach that is taken in the bill. The discussions that my team and I have had with the Scottish Partnership for Palliative Care on that have yet to determine where that difference is. I will continue those discussions with the SPPC and, indeed, with Bob Doris to establish whether more can be done. However, as yet, I have not seen the evidence that shows the disconnect between the definition in the bill and the GMC guidance. As Mr Doris acknowledges, the policy memorandum refers to that guidance.

I turn to Emma Harper's amendment 12. I support the assessing medical practitioner being required to make inquiries of those who are providing or have provided health or social care to the person. I consider that that should include social work services as well, if they think that that

would be helpful, and their having the option to make inquiries of health, social care and social work professionals on any matter that is relevant to an assessment that they are making. That includes input that might be helpful from people who are providing or have provided care to the person and will know them to an extent and might have seen them interact with family and friends on matters where coercion might be relevant.

I note that amendment 12 is pre-empted by amendment 88 in group 10, on assessments of the terminally ill adult. I consider that that potential input should include social work services, which amendment 12 does not. I also consider that it should extend beyond being limited to matters of coercion.

My amendment 69 seeks to require assessing registered medical practitioners to make inquiries of health, social care and social work professionals who have provided care to the person, if they consider that appropriate. It would also allow those assessing practitioners to seek input from those professionals on any relevant matter at the assessing stage. That would include seeking input on potential or suspected coercion.

Those same points apply to Emma Harper's amendment 13. Although I am grateful to her for lodging her amendments and enabling this debate to take place, I ask her not to move them and for the committee to support my amendment 69. If further work needs to be done ahead of stage 3, I am happy to work with Emma Harper on that.

With regard to Brian Whittle's amendments 161, 162, 172 and 210, and amendments 164, 169 and 174, it is fundamental that a terminally ill adult makes the choice about requesting assistance themselves without coercion or pressure being put on them by another person. The bill is clear on that, provides for it and makes it an offence to coerce or pressure a person into requesting assistance.

Given that the co-ordinating registered medical practitioner and independent registered medical practitioner will already be assessing for signs of coercion, I question whether a further assessment by an independent assessor is necessary.

Brian Whittle: Will the member give way?

Liam McArthur: In a second, Mr Whittle. I would be concerned that that might create undue delays and prolong the suffering of the person who is seeking assisted death, particularly given that the proposed period of 10 working days following the assessment before the report is produced might pass with no additional protection being provided.

Brian Whittle: The whole point of my amendments is to try to counter a family member potentially facing a moral issue when someone has made a decision to access assisted dying. Even though it is the medical professional's job to establish whether there has been any coercion, if someone makes an accusation of coercion, it is the police's legal responsibility to investigate that. That is the problem that I am trying to alleviate.

It does not matter whether the medical professionals decide that no coercion has taken place; if somebody says that it has, there is a legal responsibility to investigate that. That is the bit that would take the time and potentially impact the person who is seeking assisted dying.

11:45

Liam McArthur: I thank Brian Whittle for that further clarification. From the discussions that I have had with him, I understand his motivation, which is entirely constructive in intent. My concern is still that that process is likely to delay any decision being taken forward and to allow opportunities for family members—who, as he rightly says, might have their own strong views—to express their views on the decision that the individual is proposing to take. In relation to coercion, during stage 1 evidence, the committee heard from witnesses in Australia that, almost without exception, coercion is applied in trying to influence an individual out of making the decision. Unfortunately, the process—however well-motivated it may be—runs the risk of allowing that to be given effect. I do not think that that is in the interests of the patient, their family members or health professionals more generally. Again, I am happy to work with Brian Whittle to see whether there are ways to tease that out further ahead of stage 3.

I turn to Stuart McMillan's amendments 216 and 217—I recognise that I am speaking before he has had a chance to present them, so I will bear that in mind and invite him to come in if needs be. Other amendments also seek to define "coercion" and "pressure". My understanding is that the terms are well understood, both in the medical profession and by the courts, and do not require definition in the bill. The committee heard at stage 1 about the existence of guidance from the General Medical Council on the issue of coercion. There appeared to be general consensus among expert witnesses—and it was acknowledged in the committee's stage 1 report—that cases of explicit coercive behaviour should be relatively straightforward to detect. However, I recognise some of the issues that have been raised in the context of these amendments. As I said in response to Bob Doris's intervention, my bill is consistent with the GMC guidance. If more needs to be done in that area, I am happy to work on that ahead of stage 3.

Of course, there might be cases that are not straightforward, which is why the bill also allows for the Scottish ministers to prepare and publish guidance on such matters. That is also why I have lodged amendments to allow ministers to regulate for the training that a "coordinating registered medical practitioner" and an "independent registered medical practitioner" should have in order to fulfil those roles. Those powers would be in addition to those that are already given to ministers under the bill to regulate for qualifications and experience. On that basis, I encourage Mr McMillan not to move his amendments, and, if he does, I encourage the committee not to support them.

Stuart McMillan (Greenock and Inverclyde) (SNP): A main point that has come up in my discussions with constituents and organisations over the past four years has been about coercion. Notwithstanding Mr McArthur's comments a moment ago—he may come in if he wishes to—about terms being well defined and well recognised and about the guidance, I lodged my amendments 216 and 217 to try to have something in the bill that would give the wider public a full understanding of the situation. We all recognise that although this is—technically—a normal bill going through the parliamentary process, the subject matter is not normal subject matter.

A point that has come up a number of times in discussions is that the smallest hint of disapproval from a loved one—the quiet suggestion that an individual is a burden, or even the unspoken weight of financial or emotional strain—can influence a person's decision in ways that are almost impossible to measure. Bob Doris spoke powerfully about the aspect of feeling like a burden. If coercion or pressure goes undetected, people may die—not because they wish to but because they feel that they ought to. Amendments 216 and 217 would address the gap by introducing clear definitions of coercion and pressure in section 29.

Liam McArthur: I appreciate Mr McMillan's setting out the rationale for his amendments, which do not come as a surprise, as he and others have raised the issue before. Does he accept the points that Bob Doris made about the guidance from the GMC, which includes a firmly established process for assessing coercion? We need to make sure that the bill aligns with that. I believe that it does, but if further work needs to be done to allow that to happen, I am happy to take that forward.

Adopting a different approach is likely only to create uncertainty and confusion and to make prosecutions of offences more problematic. That is not in the interests of patients, their families or the health professionals who we are asking to operate the system.

Stuart McMillan: I appreciate the points that Liam McArthur makes. My amendments may seem unnecessary and, to judge by Mr McArthur's points, potentially confusing from a legal perspective. However, I think that they are very much worthy of being discussed at stage 2. If they were not acceptable to Mr McArthur—the committee could decide on them later—I would be content not to move them and to work with Mr McArthur on something else for stage 3.

Because of the subject matter, this is more than just a normal bill. I genuinely believe that having social consensus will be extremely important if the bill is passed at stage 3 and becomes an act of Parliament.

Bob Doris: I appreciate the exchange between Mr McMillan and Mr McArthur. It is important that Mr McArthur says that he wants to align with the GMC guidance as it is. If Mr McMillan decides not to move his amendments, one solution would be to put the GMC guidance—we all agree that it is the correct guidance—in the bill in order to give the certainty that is required, rather than finding a workaround. If the definition exists, why not put it in the bill and apply it?

Liam McArthur: Will Mr McMillan take an intervention?

Stuart McMillan: I am happy to take Mr McArthur's intervention.

Liam McArthur: I am using you as an intermediary between me and Mr Doris. The approach needs to be consistent with the GMC guidance. Consistency across other areas of healthcare is important in reducing the scope for confusion or uncertainty, so I am happy to look at that. Putting guidance in the bill seems potentially problematic, but I am happy to work with Mr Doris and Mr McMillan on how to express that better, if that is felt to be necessary.

I am sure that that guidance will be updated as understanding of coercion develops. Putting it in the bill might be problematic, but I understand Bob Doris's and Stuart McMillan's points, and I am happy to work with them ahead of stage 3.

Stuart McMillan: I appreciate that, Mr McArthur. Social consensus will be extremely important if the bill becomes an act of Parliament. As a consequence, we need a wider understanding of exactly what the act would say. The reason for lodging my amendments in the first place was so that the public—not solely those in the medical profession—can have that wider understanding. I am content not to move my amendments if we can work together on something else going forward.

Pam Duncan-Glancy: If I had not thought—wrongly—that Bob Doris's amendments 139 and 140 were in another group, I would have said at the outset that I think that they are incredibly important. Together with Stuart McMillan's amendments 216 and 217, they get to the heart of some of the concerns that disabled people have about the internalised ableism in society. I have to say that a rejection of them, a rejection of any definition of coercion and a rejection of any other process to determine that coercion is taking place, including that in Brian Whittle's amendments, would be quite concerning. I hope that the committee will therefore support some of the amendments on that.

I draw the committee's attention to the evidence from the Royal College of General Practitioners Scotland, which challenged the assumption that discussions about assisted dying could take place at regular GP appointments. It said:

"This is a complex process, morally and emotionally, involving considerable time for technical assessment of capacity and coercion which can be challenging. We do not believe that this work can or should be incorporated into an already very busy and stressed service, without potential detriment to patient care"

That is an important reflection from front-line professionals for us to bear in mind. When we are considering the definition of coercion, the clearer we can be in the legislation, the better.

The committee is grappling with two aspects. One is the definition of coercion. There are several options available to the committee in the amendments. Some of them include the broader aspects, which I think are essential to include, and some of them are more narrow but nonetheless still define coercion. Given what the Royal College of General Practitioners said about the ability of professionals to reach such a difficult decision without clarity in legislation, I would like to think that committee members will support the amendments.

I will comment briefly on the point that amendment 13 might not be moved at this stage because of concern about training health professionals and the cost of that. Concern about the cost of training health professionals on the legislation is legitimate. For people to be able to do this work, not only will they have to have time to do it but they will have to be trained to do it. There is a question whether we should bear the brunt of that cost. Training will cost money. I would like to think that, if the bill is to include the safeguard that such professionals will be able to make such decisions, surely they will have the appropriate training. Even if my colleague Emma Harper does not press amendment 13 at stage 2, I would like to think that something similar will be lodged at stage 3, regardless of the cost.

I press amendment 220.

The Convener: The question is, that amendment 220 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Haughey, Clare (Rutherglen) (SNP)
Whittle, Brian (South Scotland) (Con)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 3, Against 7, Abstentions 0.

Amendment 220 disagreed to.

Amendment 221 moved—[Pam Duncan-Glancy].

The Convener: The question is, that amendment 221 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

Abstentions

Baillie, Jackie (Dumbarton) (Lab)

The Convener: The result of the division is: For 0, Against 9, Abstentions 1.

Amendment 221 disagreed to.

The Convener: Amendment 26, in the name of Liam McArthur, has already been debated with amendment 143. I remind members that, if amendment 26 is agreed to, I cannot call amendments 84 and 222.

Amendment 26 moved—[Liam McArthur]—and agreed to.

Section 3, as amended, agreed to.

After section 3

12:00

The Convener: Amendment 148, in the name of Murdo Fraser, is grouped with amendments 62, 128, 256, 257, 208, 63, 138, 277, 141 and 142.

Murdo Fraser (Mid Scotland and Fife) (Con): I have two amendments in this group—amendment 148 and amendment 208, which is consequential to amendment 148.

Amendment 148 seeks to establish a new statutory designated agency, which would be responsible for administering and overseeing the entire assisted dying process under the legislation. The agency's duties would include managing declarations, co-ordinating medical assessments, authorising practitioners, arranging assistance, maintaining records and reporting. The designated agency would operate independently of the NHS, with its powers, governance and procedures further defined by Scottish ministers through regulations. Functions performed by medical practitioners in the process would generally be under the agency's authority or delegation.

Amendment 148 would address one of the deepest contradictions in the bill—the expectation that assisted suicide will be carried out within the framework of our national health service. The NHS was founded, in the aftermath of the second world war, with a singular moral purpose, which was to preserve and protect life—without distinction. It was a national affirmation that every life, regardless of age, ability or circumstance, was worth saving. To ask that same institution now to facilitate the deliberate ending of life would be to abandon that founding principle. Doing so would blur the moral and professional boundaries on which public trust in the NHS depends. Patients turn to doctors and nurses in the belief that their sole purpose is to heal, comfort and preserve life. If the state asked them also to provide the means to end life, that trust would be fundamentally—and perhaps irreparably—weakened.

Sandesh Gulhane: The Abortion Act 1967 allows the NHS to perform abortions. That is contrary to the point that you made about preserving life. Would you suggest that the 1967 act contravenes the point of the NHS?

Murdo Fraser: I suggest that the purpose of the 1967 act was to protect the lives of mothers, who, in many cases, were potentially at risk from continuing with a pregnancy. I understand the point that Dr Gulhane is making, but I am not sure that it is salient to the argument that I am making.

My amendment 148 seeks to establish a statutory independent body that would be responsible for administering the functions of the act. That body would be separate from the NHS and would oversee all aspects of the process: receiving and recording declarations, co-ordinating assessments, authorising practitioners, arranging for the provision of the approved substance, maintaining compliance, and reporting outcomes. In creating an independent agency, we would make a clear moral distinction between a service that was dedicated to preserving life and a mechanism that was authorised by the state to end it.

The Convener: I want to be absolutely clear about what Mr Fraser is proposing. He is proposing a body that would not be part of the NHS or be under the remit of NHS Scotland but that would be a separate body that was tasked purely with implementing, should it pass, the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Murdo Fraser: Yes—that is correct. That is the purpose of amendment 148.

The Convener: Thank you for that clarification.

Murdo Fraser: Amendment 148 would create a new stand-alone body, regulated by Scottish ministers, that would have the responsibility for conducting assisted death.

I believe that, in creating an independent agency, we would create a clear moral distinction between the NHS and a new body that was established with a different purpose, which would be to end life. I do not believe that the NHS should be asked to bear the burden of bringing in assisted dying.

I urge members to support amendment 148 in order to protect the integrity of our health service and the trust on which it rests.

I move amendment 148.

Jackie Baillie: Amendments 62 and 63 were lodged after discussion with CHAS—Children's Hospices Across Scotland—which runs Robin house children's hospice, in my constituency. The bill does not contain any details of the regulation, scrutiny or inspection of organisations that would provide an assisted dying service, nor of the reporting on the processes that they would operate. All of that happens in other types of care, so this would represent an unprecedented lack of regulation and scrutiny.

The requirement for regulatory arrangements needs to be made explicit in the bill, because we all want to ensure patient safety, and the quality of the service is a paramount consideration. Healthcare Improvement Scotland and the Care Inspectorate already ensure that non-NHS services are run by fit and proper people. They already have statutory powers to secure patient safety and significant experience of regulating the

provision of social care and healthcare outwith the NHS. They are also accountable. To be clear, the amendments would not in any way prevent an assisted death in a person's home; they would simply ensure that the organisation supporting that, if it was not an NHS service or a GP practice, met all the standards and was safe.

Sandesh Gulhane: Will you clarify that point? Are you proposing that the assisted dying not be part of the NHS and thus, as Murdo Fraser has suggested, that we have a regulatory body for that?

Jackie Baillie: No, I am not proposing a separate regulatory body; I am leaning into the current arrangements, and I am allowing for the circumstance that assisted dying might not be entirely delivered by the NHS, which is the case in other countries. It is a belt-and-braces approach that aims to make sure that we have the right regime in place, so that we are satisfied with the levels of scrutiny and regulation. I hope that that is clear.

Amendment 62 would allow the Scottish Government to bring forward regulations to prevent an assisted death from taking place in certain settings—for example, in care accommodation for people aged under 18, in a care service that is used primarily by children, in a drug and alcohol rehabilitation centre, in supported accommodation for people with mental health illnesses or in a women's aid refuge. Those are all registered care settings, but providing assisted dying in them would clearly not be appropriate.

I also anticipate that the regulatory framework could make situations in which a person is asked to undertake an assisted death in a public place or outdoors a sensitive issue. The Scottish Government should bring forward the details in due course through secondary legislation. I also anticipate that secondary legislation will clarify whether the service can be provided privately on a for-profit basis. There are already legislative prohibitions on other types of care providers—for example, adoption agencies—operating for profit in Scotland.

In summary, the amendments are about ensuring that we have the right safeguards in place, that we allow only reputable and regulated organisations to be involved, and that a standard is set, that there is oversight of it and that we align that standard to existing bodies such as Healthcare Improvement Scotland and the Care Inspectorate, with which we are all familiar. I hope that members can support amendments 62 and 63, which provide for affirmative regulations.

Bob Doris: My amendment 128 and consequential amendments 138, 141 and 142 would require the Scottish Government to produce regulations about the regulation and oversight of persons who would carry out assisted dying under the bill. The purpose of that is to ensure the safety and wellbeing of the people who are provided with assisted dying. Such regulations should include the regulation of settings in which assisted dying may or may not take place, regulations determining and making provision for the role of Healthcare Improvement Scotland and the Care Inspectorate in regulation and scrutiny, and provisions for a process through which to raise concerns about the provision of assisted dying to a person.

The bill is silent on institutional responsibilities for the delivery of assisted dying; it merely permits practitioners to provide assisted dying in certain circumstances. Even the most basic organisational model setting out duties and responsibilities is missing. That is something that the Scottish Partnership for Palliative Care has concerns about, and I agree with it.

The bill contains no requirements that the provision of assisted dying should be subject to any system of regulation or scrutiny. Although assisted dying might take place in the NHS, it might also take place in the private or third sector, as Jackie Baillie indicated. Either way, surely there is a need to provide powers to scrutinise and regulate a life-and-death activity such as assisted dying.

The bill makes no provision for a process by which people might raise concerns about the provision of assisted dying to a person. It is likely that, from time to time, people might wish to raise a concern about the assisted dying process and the provision of assisted dying to a person in a specific instance—or, indeed, to raise concerns about the role of any organisation that is facilitating assisted dying more generally.

The bill should make provision for such a process. My amendments seek powers that would enable the Scottish Government to establish a system of scrutiny and regulation of assisted dying and to establish a process by which people could raise a concern about specific instances of assisted dying processes and provision. That process would be established in regulations under the affirmative procedure, which would have to come into force before other provisions in the act could be implemented.

Patrick Harvie: I am curious about the part of Bob Doris's amendment that refers to regulations making provision about

"the type of settings or premises where functions under this Act"

can take place. That seems to be a very broad definition. There is a legitimate discussion that we might have about whether there ought to be

regulations on the settings or premises in which the final action under the bill—the provision of an approved substance and its use by an individual—should take place and about whether that should be defined. However, it seems to me that it is quite broad to say that there should be regulations on the settings and premises for any functions performed under the act, including record keeping and the recording of statements, for example. Will Bob Doris explain why he has taken a very broad approach to that aspect?

Bob Doris: I thank Patrick Harvie for that insightful intervention. I note that the bill takes quite a broad, permissive attitude in relation to where assisted dying can take place as long as the relevant procedures are followed. Therefore, I seek to bring in regulations that might decide whether it is or is not appropriate for a place to carry out such functions, even if there were to be a stand-alone body. It is important to consider whether an NHS facility or a care home that is run by the public sector could be used. We must also consider anything that might come up in relation to what best practice would look like and whether the process should be inspected when an institution is involved.

My amendment 128 is deliberately broad, Mr Harvie, and, having listened to what you said, I think that that remains the right approach. I will certainly move the amendment. However, given that it is so broad, I might hope to persuade the committee to agree to it at this stage by perhaps suggesting that there should be a super-affirmative process rather than an affirmative process, in order to get full buy-in and ensure that we look through all the possible permutations. As I said, the amendment is deliberately broad because the provisions in the bill are deliberately permissive. One complements—or counterbalances—the other in my view.

I will say a little about the other amendments in the group, particularly Murdo Fraser's amendment 148, which seeks to set up a designated statutory body outwith the NHS that would be responsible for pretty much all aspects of assisted dying. We have heard some of the rationale for that body from Mr Fraser. As we go forward, we will have to tease out whether the NHS would still have a role and what the inspection and oversight of that body would look like, as well as whether NHS staff and buildings could still be used on a contractual basis. Much more information is required on that amendment. We also need to know how concerns could be raised regarding the operation of the new body's functions and its carrying out of its responsibilities.

12:15

Jackie Baillie's amendment 62 appears to have a similar policy intent to my amendment 128. It would require the Scottish Government to make regulations about the provision of assisted dying when that takes place outwith the NHS, including in relation to a role for Healthcare Improvement Scotland and the Care Inspectorate. Unlike Ms Baillie's amendment, mine would make explicit provision for the raising of concerns, if I have captured that correctly. However, there appear to be no pre-emptions, so it appears that committee members do not need to choose between our amendments.

I will turn to Fulton MacGregor's amendment 256. Actually, I will not progress to that at the moment, Pr—convener; I nearly upgraded you to Presiding Officer—but will rest my comments there, because of the time.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Good afternoon, folks. Amendments 256, 257 and 277 have been lodged with the support of the Scottish Association of Social Work and, of course, the help of the legislation team—what would we do without it in such situations? I put on record my thanks to both.

The amendments are about ensuring that, if the Parliament chooses to legislate in this area, the practical delivery of assisted dying services is fully integrated with Scotland's existing health and social care framework, using the structures that already exist to manage and oversee sensitive health functions rather than creating a new, stand-alone system.

I think that all members who are here will agree that the bill, by its very nature, demands clarity, accountability and public confidence in how it would operate in practice. My amendments in the group are intended to provide that.

Amendment 256 would make a small but important technical change to the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014—that is easy for me to say. That set of regulations lists the functions of health boards that are included in local integration schemes—the partnership arrangements between health boards and local authorities that underpin how healthcare and social care are jointly delivered in Scotland. By adding the bill to that list, the amendment would ensure that any functions that health boards have under the bill were automatically captured within the existing integration framework. That means that the planning, oversight and reporting of any assisted dying service would take place within the same governance structures as other key health and social care services and would be subject to the same accountability mechanisms and local

partnership scrutiny. That is important, because it would help to ensure that there was no fragmentation or confusion about who was responsible for delivering or overseeing those services. The amendment would situate them firmly within the public system, in which clear lines of responsibility and accountability already exist.

Amendment 257 would build on that by requiring each health board to establish a specialist assisted dying service for its area. Again, that is about consistency and quality of provision across Scotland. It would ensure that, wherever a person might live, a defined and accountable service would be in place to support individuals, co-ordinate with local partners and ensure that the requirements of the act were applied safely and consistently.

Sandesh Gulhane: How do you envisage the NHS working and functioning to provide an assisted dying service without amendment 257? Does that need to be in the bill? Would it not happen anyway?

Fulton MacGregor: The member might be interested to know that amendment 257 is strongly supported by the Royal College of Nursing, which states that it supports the requirement for each health board to set up specialist assisted dying services to deliver the functions of the act. He might also be interested to note that the Royal College of General Practitioners also strongly supports amendment 257, given its background. Those are two very strong endorsements.

Pam Duncan-Glancy: I genuinely understand Fulton MacGregor's intention, particularly in relation to amendment 257, given the points that I made on the record earlier about the Royal College of GPs. However, does he worry that having such a duty around assisted dying under the Public Bodies (Joint Working) (Scotland) Act 2014 would mean that there would be a lot of scrambling for funding with the other services that are also subject to that act? It could mean that some money would be moved from social care services to services that assist people to die.

Fulton MacGregor: The member raises a great point. If the bill becomes law, those decisions will need to be made by the Government and health boards in collaboration, as happens for other services. That is a good point well made.

The model also recognises the importance of choice for staff. I know that the committee has looked at that. The development of a single dedicated service would ensure that those who worked in it had actively chosen to do so, meaning that any staff who had a conscientious objection to assisted dying would not be placed in a position in which they felt pressured to participate, whether due to workplace expectations or out of a sense of duty to the people they were supporting.

At the same time, subsection (2) in amendment 257 would give the Scottish ministers the ability to "make further provision" by regulation about how such services were to be delivered. That would ensure that detailed operational guidance could evolve as needed, subject to parliamentary scrutiny. It could, perhaps, take into account how things were operating in practice, as Pam Duncan-Glancy mentioned.

Amendment 277 is a straightforward consequential provision that would simply add the regulation-making power under subsection (3) in amendment 257 to the bill's main list of regulation-making powers. It is a tidy-up measure to make sure that all the delegated powers are properly captured.

Taken together, my amendments are not about altering the principles of the bill but about ensuring that, if the bill proceeds, delivery is effective, transparent and safely governed. They build on the model of partnership and integration that Scotland has spent years developing across health and social care, and they recognise that issues of life, death and wellbeing cannot be neatly separated between services that require collaboration, consistency and compassion. By placing assisted dying services within the existing framework, we can help to ensure that oversight is robust, that the public can have confidence that the law will be implemented, and that those who work in the system are properly supported. The measures in the amendments are proportionate, practical and responsible, and they are designed to strengthen the bill's administrative foundations while maintaining the focus on dignity, safety and accountability that it has always had at its heart. I hope that members will support my amendments today.

Liam McArthur: I agree with Fulton MacGregor's final sentiment about the way in which we must embed the service. That is crucial. I thank other colleagues for setting out the rationale for their amendments.

Turning to Murdo Fraser's amendment 148 and the issue of the administration and regulation of assisted dying services, the bill does not expressly establish a system within the NHS. It provides for a process with roles for health, social care and social work professionals; Public Health Scotland also has a role in data gathering and reporting.

My view throughout the process has been that assisted dying services under the bill should be provided predominantly through the NHS, although I can envisage that there might be scope for them to be provided in some private settings as well. I am concerned that the implications of the

approach proposed by Mr Fraser would potentially exacerbate inequalities in access and disrupt existing pathways for treatment and care at a point when the individual is least able to cope with that.

In relation to that point on amendment 148 and its consequential amendment 208, I note the Scottish Government's concerns about competence and about the possible duplication of the roles of Public Health Scotland and the Scottish ministers.

To some extent, that concern also applies to Jackie Baillie's amendment 62 on the provision of assistance outwith the NHS. Amendment 63, which is consequential to that, proposes that the related regulations be subject to the affirmative procedure. I listened to the comments that Jackie Baillie made and her response to the interventions. I am reassured that she does not seek to set up a service outwith the NHS. The points that she makes about regulation are fair and reasonable. They lead me back to the point that Brian Whittle made earlier: this is one of those areas where engagement with the Scottish Government on the operability of the system would be welcome, especially ahead of and during stage 3. I am committed to such engagement and am happy to work with Jackie Baillie on those provisions and others that may relate to similar issues.

Patrick Harvie: So that I can be clear about what the member is saying—is he saying that he does not support the amendments from Jackie Baillie at this point but that he is willing to explore the issues further? Is he resisting the amendments or is he ambivalent about them?

Liam McArthur: I am never ambivalent, Patrick Harvie—you will know that.

I am reluctant to support the amendments as they are framed, but Jackie Baillie raised some reasonable points in relation to the regulation of services, particularly those outwith the NHS. Fulton MacGregor spoke about embedding the service within the NHS and for that to have protocols and all the rest of it. That is the most appropriate route to proceed along. However, as I said, Jackie Baillie's points about services that are outwith the NHS are reasonably and fairly made.

I turn to Bob Doris's amendment 128, and note that amendment 138 is a consequential amendment that seeks to ensure that related regulations are subject to the affirmative procedure—or possibly, given his earlier comments, bumped up to super-affirmative procedure. I am keen to ensure the safety and welfare of anyone who is seeking assistance under the bill's provisions, and I believe that the bill includes safeguards to ensure that that happens.

I note that health professionals who choose to participate in assisted dying are already regulated by the General Medical Council, which provides robust oversight. I acknowledge that there are already mechanisms for raising concerns about health and social work professionals, and I would be concerned about setting up dual-running processes, which would only add confusion.

I am not persuaded of the need for or appropriateness of ministers being required to create an exhaustive list of places where assisted dying can take place, for many of the reasons that Patrick Harvie alluded to in his intervention.

With regard to subsection (3) in amendment 128, I remind the committee that there are already established mechanisms for raising those concerns.

In relation to the linked amendments 141 and 142, I have serious reservations about the commencement of the substantive provisions of the bill being subject to the regulations that are provided for in amendment 128. I believe that, as with other amendments that seek to prevent the act from being properly implemented, that risks an unacceptable delay for those who wish to have and need assistance being able to request it.

Pam Duncan-Glancy: Will the member take an intervention on that point?

Liam McArthur: Yes—briefly.

Pam Duncan-Glancy: I understand the member's view, but surely it is not an unacceptable delay but a necessary delay to have in place those regulations before the act commences.

Liam McArthur: There are a number of areas in which provisions are contingent on other things happening. I would be very cautious about proceeding on that basis. I am sure that we will have debates about that in future groups, but I have set out my concerns in relation to that point.

Pam Duncan-Glancy: Is the member suggesting that he would support the provisions of the act being operated in an unregulated way?

Liam McArthur: I am saying that there is plenty of scope in the bill for instructing or requiring ministers to introduce secondary legislation, and for them to work with healthcare and other relevant stakeholders in doing so, and for requiring professional bodies and others to introduce guidance. I think that the public and we as parliamentarians would expect that to take place in a timely fashion and allow the bill to proceed. I would be reluctant to link the provisions, as set out in amendment 128, to commencement of the bill.

Bob Doris: Will the member give way?

Jeremy Balfour: Will the member take a quick intervention on that point?

Liam McArthur: I will give way—very briefly—to Bob Doris.

Bob Doris: Primarily, I want to reassure Mr McArthur, notwithstanding his lack of support for my set of amendments, that the commencement order was not intended to cause any undue delay. Those were not wrecking amendments in the slightest. The underlying principle that I adhere to here is that we should decide what regulation looks like and bring it into force before assisted dying begins. Therefore, it is a sequential amendment rather than a blocking amendment. That is an important point to make.

Liam McArthur: I thank Bob Doris for making that point. That was not the implication of my remarks, but it is very helpful that he set that out, and I take that point in the spirit in which it was made.

Jeremy Balfour: Will the member give way?

Liam McArthur: I am afraid that I am going to proceed, Mr Balfour.

The Scottish Government has identified potential legislative competence issues. I am aware that the Scottish Government is working with the United Kingdom Government to ensure the full operation of the bill, should it be passed. Although the Cabinet Secretary for Health and Social Care is not here to update us on those discussions, it is important to acknowledge the issues that those amendments raise.

Amendment 256 seeks to amend the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 by adding the assisted dying for terminally ill adults legislation to its schedules. I am supportive of that amendment.

On amendment 257, I have always taken the view—I think that it was reiterated by Sandesh Gulhane earlier—that it is for the healthcare sector to determine how to manage the assisted dying process within the parameters of the bill. Fulton MacGregor acknowledged that in his remarks. Therefore, my feeling is that it should be left to the health and care sector to determine whether it would be appropriate for each health board to set up a specialist assisted dying process.

Amendment 257 mandates that every health board set up a service, while amendment 256 mandates joint working with the local authority. I wonder whether the amendments are proportionate and not overly restrictive. I understand absolutely what Fulton MacGregor is driving at and the reasons why the RCN and others wanted the amendments to be lodged and want them to be agreed to. There are certainly examples in other jurisdictions in which provision is mandated in similar ways, which, ostensibly, is to ensure access. I am happy to work with Mr MacGregor ahead of stage 3 to see whether something more proportionate might be achievable.

12:30

Amendment 277 is a consequential amendment to ensure that—

Fulton MacGregor: This intervention is to ask for clarity. Are you saying that you support amendment 256 but you want to work with me on amendment 257? Is that correct?

Liam McArthur: That is correct.

Fulton MacGregor: That just helps me to decide whether I will move the amendment.

Liam McArthur: I will certainly support amendment 256. As I said, there is an issue about proportionality with amendment 257. There are examples of similar provisions in other jurisdictions for reasons to do with guaranteeing access. I am more persuaded of the rationale for allowing those who are in the sector to develop the model. My evidence to the committee at stage 1 acknowledged that the service will look and feel different in different parts of the country because of the circumstances that each area will need to deal with. That is already happening daily in health and care.

I understand the motivation behind amendment 257 and I understand why the RCN and others seek that provision. As it stands, the amendment may be disproportionate, but I would certainly be happy to work with Fulton MacGregor ahead of stage 3 to see whether something can be worked up that might address those concerns.

Murdo Fraser: I thank colleagues who commented on my amendments. I am grateful to Bob Doris for his comments; he made a reasonable point about the additional detail that might be required. Should amendment 148 be successful at stage 2, there would be an opportunity to address some of those concerns with amendments at stage 3.

There is an important point of principle in relation to the correct placing of an assisted dying service and whether it should be within the NHS. I am aware that there are many practitioners in the NHS who are deeply uncomfortable with the concept that the NHS, which they joined to save and preserve life, would have, as part of it, a service that is committed to helping people to end their lives. There would be many in the NHS who would be much more comfortable if there were to be a separate, stand-alone service providing

assisted dying, rather than it being part of the NHS.

I remind members, as I am sure that they are aware, that the Dignitas service that operates in Switzerland—which people in this country sometimes avail themselves of—operates not in the public health sphere but as a private service. Therefore, there is precedent for services to be provided in different ways elsewhere. The amendment provides an important point of principle. For that reason, I press amendment 148.

The Convener: The question is, that amendment 148 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

Against

Baillie, Jackie (Dumbarton) (Lab)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 0, Against 9, Abstentions 1.

Amendment 148 disagreed to.

Section 4—Request for assistance: first declaration

The Convener: Amendment 149, in the name of Murdo Fraser, is grouped with amendments 150, 165 to 167, 32, 170, 171 and 45. If amendment 32 is agreed to, I cannot call amendment 170 due to pre-emption.

Murdo Fraser: My amendments in this group seek to replace previous provisions on proxy signing and limit the signing of declarations under the bill to the declarant or, where the declarant is physically unable to sign, to a notary public acting as a proxy.

The notary public must verify identity, ensure comprehension and voluntariness, affix their notarial seal and record their involvement in the person's medical records. Those safeguards aim to ensure the integrity, authenticity and legality of the declaration process.

I should declare a partial interest in that I am a member of the Law Society of Scotland. I used to be a notary public but, because I do not have a practising certificate, I no longer hold that office. I can therefore reassure members that this is not a job creation scheme for notaries public.

The amendment intends to address a fundamental weakness in the bill, which is the dangerously low threshold that it sets for proxy signing. Under the bill as it stands, a declaration to end one's life can be signed on an individual's behalf without the involvement of a notary public or any equivalent legal safeguard. That might be acceptable in routine matters of administration, but not in a matter of life and death.

Sandesh Gulhane: How many notaries public do we have in Scotland who are readily available?

Murdo Fraser: I cannot give an exact number, but all practising solicitors who hold a practising certificate are routinely notaries public. If the member checks how many solicitors there are in Scotland, he will find that, invariably, all solicitors are notaries public.

Across Scots law, for an act that has serious legal consequences, such as the signing off of an affidavit, it is standard practice to require the oversight of a notary public. However, the bill, which deals with the very serious matter of ending a human life, demands far less. That is a profound inconsistency and it presents an unacceptable risk. Amendment 149 would therefore ensure that the highest legal standard is applied to the most serious of decisions. When a declaration is made under the bill, it must be signed by the individual himself or herself, or when that is physically impossible, by a notary public acting as proxy. That notary would be required to verify the person's identity, confirm the person's understanding, affix their official seal and ensure that their involvement was recorded in the individual's medical records.

These safeguards are not bureaucratic obstacles: they are protections against coercion, conviction and abuse, and they uphold the principle that, when the state authorises the ending of a life, the process must meet the highest conceivable standard of legal integrity.

Patrick Harvie: I hope that we would all agree that, if legislation of this kind is passed, we should try to avoid, as much as possible, individuals incurring any financial cost. Will there be a financial cost involved in notaries public providing such a service? If so, how do we expect that it will be met?

Murdo Fraser: That would have to be agreed as the procedures for assisted dying are progressed. Generally speaking, notaries public are private individuals who operate in firms of solicitors and they would normally make a charge for witnessing documents. In my experience, that would not be a large charge. It would tend to be a

modest charge, but the cost would have to be borne in mind.

The amendment would put in an important safeguard to ensure that there are additional protections in the event that someone is using a proxy as opposed to signing on their own behalf.

I move amendment 149.

Liam McArthur: I start by thanking Murdo Fraser for setting out the rationale for his amendments in this group, and for his declaration of interest, which I take in good faith.

The bill requires the signing of a first and second declaration form by a terminally ill adult to be witnessed and signed by the co-ordinating regulated medical professional and another person, which, for the second declaration, cannot be the other regulated medical professional who assessed the eligibility of the person.

Following discussions with the Law Society, which had concerns—to some extent, along the lines of those of Murdo Fraser—about the way in which that provision was framed in the bill, and the potential implication of creating a relationship between solicitors and individuals, I lodged amendment 32, which changes the definition of who can be a proxy.

It replaces the definition in the bill with a definition that requires the terminally ill adult to have known the proxy for at least two years or for the proxy definition to be specified by Scottish ministers in regulations. Amendment 45 sets out that that would be subject to the negative procedure.

Schedule 5 sets out who is disqualified from being a proxy. That includes family members, those who would benefit financially from the person's death, and a medical professional who has treated the person for the terminal illness. The conditions in schedule 5 remain and should therefore be read with this amendment.

I note that amendment 32 would pre-empt Mr Fraser's amendment 170. In relation to that amendment, the proxy role should not be limited to a notary public. Doing so might risk making it difficult for a terminally ill adult to engage such a person, who might be needed urgently and at short notice, which could add to a terminally ill person's stress and anxiety.

Amendment 45 is consequential and it ensures that the regulations that the Scottish ministers make are subject to the negative procedure.

I will discuss the other amendments in the group together. The role of the independent witness to the signing of the forms, in addition to the co-ordinating regulated medical professional, is just that—to witness the signing by a terminally ill adult. I see no reason why a notary public should also be required to witness as set out by the other amendments in the group. As I have said, we need to ensure proportionality and that safeguards are not simply barriers to eligible adults accessing the choice to which they should be entitled under the legislation. I therefore urge Mr Fraser not to press amendment 149, but, if he does so, I urge the committee not to support it.

The Convener: I call Murdo Fraser to wind up and to indicate whether he wishes to withdraw or to press amendment 149.

Murdo Fraser: I am grateful to Mr McArthur for setting out his arguments. I reiterate that my amendments apply only in the event of an individual appointing a proxy. There is a need for an additional safeguard in that circumstance but not when somebody is declaring on their own behalf.

On that basis, I press amendment 149.

The Convener: The question is, that amendment 149 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Whittle, Brian (South Scotland) (Con)

Against

Baillie, Jackie (Dumbarton) (Lab)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 1, Against 9, Abstentions 0.

Amendment 149 disagreed to.

Amendment 150 not moved.

Amendment 223 moved—[Pam Duncan-Glancy].

The Convener: The question is, that amendment 223 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)

Against

FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)

Haughey, Clare (Rutherglen) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 1, Against 8, Abstentions 1.

Amendment 223 disagreed to.

The Convener: As we are coming to a new group of amendments on a different section, I propose that we end our meeting today and return next Tuesday for further consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill. That concludes our meeting.

Meeting closed at 12:44.

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