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Health, Social Care and Sport Committee

Tuesday 4 February 2025

Session 6

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ASSISTED DYING FOR TERMINALLY ILL ADULTS (SCOTLAND) BILL: STAGE 1 1

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

4th 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)
*Gillian Mackay (Central Scotland) (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:

Claudia Bennett (Scottish Parliament)
Nick Hawthorne (Scottish Parliament)
Liam McArthur (Orkney Islands) (LD)
Dr Amanda Ward

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 4 February 2025

[The Convener opened the meeting at 10:00]

Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 1

The Convener (Clare Haughey): Good morning, and welcome to the fourth meeting in 2025 of the Health, Social Care and Sport Committee.

The first item on our agenda today is to take evidence as part of the committee's scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill at stage 1 from the member in charge of the bill, Liam McArthur MSP. I welcome Liam McArthur, who is joined by Claudia Bennett, a senior solicitor in legal services at the Scottish Parliament; Nick Hawthorne, who is a senior clerk in the non-Government bills unit of the Scottish Parliament; and Dr Amanda Ward, who is adviser to Liam McArthur.

Before we move to questions, I invite Mr McArthur to make a brief opening statement.

Liam McArthur (Orkney Islands) (LD): Thank you, convener. I apologise for the state of my appearance. When cycling to the Parliament this morning, I hit a pothole and the bike went from under me—that is not an attempt to play the sympathy card with the committee, but it is certainly a reminder of the value of wearing a cycling helmet.

I will start by declaring relevant interests. I receive funding for an additional member of staff from three permissible donors: Friends at the End, Dignity in Dying and the Humanist Society Scotland. That support is currently for one day a week. The Humanist Society Scotland also funded the development, maintenance, domain cost and hosting of a website that I have used to publish materials relating to the bill, and Dignity in Dying paid for the costs associated with my visit to California last year as part of a cross-party delegation of MSPs that met various organisations and individuals in relation to the state's End of Life Option Act. I refer members to my entry in the register of members' interests for further details.

I introduced the Assisted Dying for Terminally Ill Adults (Scotland) Bill in March last year, following the usual member's bill process and supported by the non-Government bills unit. The bill's aim is to allow mentally competent terminally ill adults in Scotland to voluntarily choose to be provided with assistance by health professionals to end their own lives. It sets out eligibility criteria and processes for assessment, all of which contain, I believe, appropriate safeguards. The bill also includes requirements for data gathering, reporting and review.

The bill is the culmination of years of campaigning and work by individuals and organisations, including current and former members of the Parliament. Proposals and bills were previously introduced on the issue by Patrick Harvie, the late Margo MacDonald and Jeremy Purvis. I thank all those who have been involved in seeking a change in the law on this issue and who have supported me.

I am acutely aware of the weight of responsibility that comes with leading a bill on this issue, and of the responsibility that rests on every MSP. We owe it to our constituents—whatever their views—to consider and debate this issue thoroughly and respectfully to ensure that any bill that is passed is appropriate, safe and fit for purpose. I know that that responsibility is one that the committee has taken seriously, and I thank you for your detailed and robust scrutiny to date.

I appreciate that the committee has faced difficulties in taking oral evidence from people who will be most directly affected—that is, those with a terminal illness. However, I know that a large amount of powerful written testimony was received in response to the committee's call for written evidence and in response to my consultation in 2021.

As members will be aware, the fundamental reason why the bill is before the Parliament is a belief in the need to give terminally ill adults more choice and control over their end of life and the means of avoiding the existential pain, suffering and symptoms that are often associated with terminal illness. It is worth emphasising, however, that the bill's provisions will relate to a relatively small number of people each year.

I have paid close attention to the evidence that the committee has received. I have heard the support that has been expressed by many witnesses and I have also listened carefully to the concerns that have been raised by others. I am aware of areas of the bill that have attracted particular focus, such as the age at which assistance can be accessed and how capacity should be defined and assessed. I will continue to listen to views on those points and to consider whether the bill requires amendment.

Another area of focus has been the definition of terminal illness. The bill requires a person to have an illness, disease or condition that is worsening, that will continue to worsen, and that is at an advanced stage. The illness must be one that a person will not recover from and that is expected to result in their early death.

I do not believe that the definition should include reference to a prognosis period, and no strong case has been made for that. I remain confident that the definition gives clear effect to the policy intent, which is to capture terminally ill adults in the final stage of their illness.

I also listened carefully to views about the assessment process, and believe that the safeguards in the bill are sufficiently robust: a person must be deemed eligible by two doctors acting independently, and both doctors will be able to refer to specialists for their views on that particular terminal illness and on capacity. Involving other relevant practitioners, where appropriate, is also an option.

Regarding the end-of-life process, my policy is that the life-ending substance must be self-administered. I acknowledge that there have been some concerns about that but, as the committee has also heard, a variety of options may be available to support self-administration.

In all those areas, the approach that I have taken has been to achieve what I consider to be an appropriate balance between ensuring access to assistance in a timely fashion, within a manageable process, and ensuring that appropriate safeguards are in place to protect people—including those who may be vulnerable—as well as to respect the right of practitioners to choose not to participate.

I do not underestimate the sensitivity of the issue or the significance of making the proposed change. However, as the committee has heard—and given what we know about the experiences of those who endure a bad death despite the best efforts of palliative care or of those who feel forced to take matters into their own hands—doing nothing and keeping the status quo has consequences. We can, and must, do better, and the bill provides us with an historic opportunity to do so. I thank members for their patience and look forward to answering their questions.

The Convener: We will move straight to questions, beginning with Emma Harper.

Emma Harper (South Scotland) (SNP): I have a couple of questions about eligibility criteria and the definition of “terminal illness”. I know that a very similar bill is going through the United Kingdom Parliament at the moment and want to explore the language of terminal illness in Scotland and England. You said that someone must be terminally ill and in the end stage of their illness to be eligible. Concerns have been raised that that is not only about people with a cancer diagnosis but might apply to someone who has a terminal illness such as motor neurone disease or Parkinson’s. People also might be unable to recover from chronic obstructive pulmonary disease, end-stage renal failure or cardiovascular disease, which can be really debilitating. Please give us an overview of the definition of “terminal illness” and how that relates to the bill.

Liam McArthur: My first observation is about the jurisdictions that have a similar model in place for assisted dying, terminal illness and capacity. Broadly speaking, we can see the conditions that patients who access that provision tend to have, and the expectation is that that would be replicated here in Scotland, and I do not think that it would be much different in England and Wales.

As I said in my opening remarks, the expectation is that there would be a requirement for the terminal illness to be advanced and progressive, so that the patient would not recover. I think that medics are used to making that diagnosis and are comfortable with it. There would also be a requirement that the diagnosis would be made by not one but two medical practitioners, which provides an additional safeguard. Over and above that, where there is any dubiety or any question in the mind of either practitioner, there is an option to refer that on to a specialist in that area of medicine.

Regarding the terminal illness diagnosis, conversations with stakeholders and observation of what happens internationally suggest that that might be more about the assessment of capacity, so the onward referral will, again, be an important safeguard and will give confidence that the terminal illness assessment is robust and thorough and that it provides the protections that patients and the wider public would expect.

Emma Harper: Another issue that has come up is the language around someone being “unable to recover” from a condition versus a condition being “untreatable”. The language needs to be very precise. We have had conversations around the bill’s use of “unable to recover”, where treatment options have been explored, agreed on and then not proceeded with.

Tell me about the use of “unable to recover” rather than “untreatable”. Somebody who has an eating disorder, for instance, might consider that they have no option to recover from that, but that is not the case, which I say as a healthcare practitioner—I am still a nurse. How do we make sure that the language of the bill is definitive in referring to a terminal illness as a condition that someone is “unable to recover” from?

Liam McArthur: I have sat in on the oral evidence sessions that the committee has held, and I was encouraged and reassured by the evidence that was taken from the panel that included witnesses from the British Medical Association and the Royal College of General Practitioners. They did not appear to have any concerns about the way in which terminal illness had been defined in the bill; I think that they were comfortable with the way in which that was set out and with the further explanation in the supporting documentation.

However, the question that you raise is one that does crop up. There are clearly many treatments that can be tried and applied, and some might have some benefit in slowing the progression of a terminal illness. Defining “terminally ill” on the basis of a “disease, illness or condition” from which the patient will not recover is important. That separates it out from some of the conditions that have been raised in evidence that, to my mind, would not meet the eligibility criteria, because there are options that would lead to a recovery. Whether the patient chooses to take those options is a matter for the individual patient, but such conditions would not meet the eligibility criteria that are set out in the bill.

Emma Harper: I think that other members will come to capacity, so I will leave it there.

The Convener: Joe FitzPatrick has a supplementary question.

Joe FitzPatrick (Dundee City West) (SNP): I want to ask about age. You decided that 16 would be the relevant age in the bill. There are good arguments for choosing 16 or 18 as that age: 16 is in line with the age of legal capacity in Scotland, whereby 16-year-olds can make decisions about medical procedures and treatments, and 18 is the age at which you are no longer a child under the United Nations Convention on the Rights of the Child. As I said, there are good arguments for both, so I am keen to hear a bit about what you did to come to your decision. What consultation did you do and who did you speak to?

Liam McArthur: You have summed it up well. You can make a strong argument for both 16 and 18, and the rationale for opting for 16 was on the basis of that being the age of adult capacity for making medical decisions. People who are 16 are deemed to have the capacity to make decisions about their treatment. There is a logic for 16; it is a very defensible case.

That said, I have heard the evidence that the committee has taken in relation to the case for 18. In other jurisdictions—whether in Australia or some of the US states—18 is the age at which an assisted death can be accessed, and the Terminally Ill Adults (End of Life) Bill that has been introduced at Westminster has a similar age limit.

It is an area on which I am keen to reflect further should the bill pass at stage 1 and as we look ahead to stage 2. As I say, I have taken cognisance of the evidence that the committee has heard, and the arguments for setting the age level at 18 are persuasive. The reason for opting for 16 is that that is the age at which individuals are deemed to have capacity to make a range of decisions in relation to their care and treatment.

Joe FitzPatrick: Did you have any engagement with young people—16 to 20-year-olds—in coming to that conclusion? Would such engagement need to be done if we were going to change the age in the bill?

10:15

Liam McArthur: There would absolutely need to be further engagement.

I would observe that the Children and Young People’s Commissioner Scotland has taken a close interest in the issue—in fact, successive children’s commissioners have done so and have expressed views. The Scottish Youth Parliament has had campaigns in support of a change in the law over successive sessions of that Parliament. The issue clearly engages younger people. It is often assumed that the issue kicks in solely for people later in life, but that is absolutely not the case.

You will probably see in the written evidence that you have received—I certainly saw it in the response to the consultation that I issued—that young people have very clear personal experience to draw on, often of older family members who have perhaps gone through a bad death, so they feel very invested in this. Therefore, if the age limit was to change, that would need to take account of any concerns that younger people might have.

The only other thing that I would add is that the numbers that are likely to seek to access an assisted death in any given year will be relatively low. I would have said that it would be around 1 per cent of the overall numbers who die in any given year. Therefore, the numbers at the younger end of the age spectrum will be exceptionally low, possibly even zero in a given year. That is not to say that it is not important to take those views into account, and I am very cognisant of some of the concerns that Children’s Hospices Across Scotland—CHAS—has raised with the committee. However, it is important to emphasise that the numbers involved are likely to be exceptionally low indeed.

Joe FitzPatrick: Thank you.

The Convener: The bill would require someone to be “ordinarily resident” in Scotland for 12 months before they would be eligible for assisted dying. Last week, in giving evidence, Police Scotland raised questions about what is meant by the term “ordinarily resident”. I am keen to explore why that term was used and what “ordinarily resident” means in the bill.

Liam McArthur: I sat in on that evidence session and was interested to hear those comments. The phrase “ordinarily resident” is used to accommodate situations where individuals may be working outwith Scotland for a period. They might be on holiday—possibly a prolonged holiday—but to all intents and purposes are living in Scotland and registered with a medical practice here, which is also a requirement under the bill.

The terminology is fairly commonly used in law in Scotland, although perhaps less so in the criminal law, which is perhaps where Police Scotland comes into contact with the issue more often. I do not see the issue as problematic. The phrase tries to acknowledge that somebody may be resident in Scotland but, over a 12-month period, they may be outside it for weeks or months at a time, whether for work or personal reasons.

The Convener: Do you think that the bill needs tightening up to define what the phrase means, to address the concerns that were raised at that evidence session about people travelling to Scotland and setting up a temporary address here in order to access assisted dying?

Liam McArthur: As I say, “ordinarily resident” is a legal concept that is understood. I noted the concerns that Police Scotland raised. I would be interested to know whether Police Scotland feels that there is an alternative definition that would address its concerns. The concept is fairly well established, and I do not know whether there is a way of defining it in the bill any differently from what is set out in the explanatory notes and policy memorandum, which I think make the policy intent clear.

That is another area where I would be happy to reflect on any proposed changes. However, the fact that the “ordinarily resident” requirement sits alongside a requirement for people to be registered with a GP probably gets around the concerns.

I understand where Police Scotland is coming from because it engages more often with the criminal law, and perhaps that is where some confusion arises, but I am fairly comfortable that that concern has not been raised by others and that the concept is pretty well established and understood.

Sandesh Gulhane (Glasgow) (Con): Good morning. I refer members to my entry in the register of members’ interests. I am a practising NHS GP and chaired the medical advisory group on the bill.

Today is world cancer day. We had 35,379 new cancers registered in Scotland in 2021, which is an increase of 5.5 per cent from 2019 figures. Although I appreciate that not all cancers are terminal, some are. As we live longer and there are an increasing number of cancers, there will be more people who have terminal cancer.

We have heard about the palliative care sector being relatively underfunded. Those who provide end-of-life care are struggling at the moment. Given that we are struggling to cope with demand, there is a criticism that, without more money going into the sector, some people would turn to assisted dying because they cannot access palliative care. How do you respond to that?

Liam McArthur: It is as you say, Dr Gulhane; that concern is very often raised. It is important that we avoid seeing the issue as a zero-sum game or an either/or choice. We need more investment in palliative care, particularly around access. There will always be improvements to palliative care that we will want to make, but the issue that arises more often than not is about access rather than quality.

There is also an issue around understanding that palliative care is not just at the specialist hospice end; it is more often delivered by doctors and nurses in other settings. It has been clear from the debate around my bill, and the overall debate around the health and care service, that the needs of palliative care are given less attention than needs in other parts of the health and care set-up. You can perhaps see why that is the case, given the pressures in other parts of the health service. One of the real positives about this debate is that it has shone a light on those issues, but it is not an either/or—we need both.

In the jurisdictions around the world that have a terminal illness model, and in the states in the US and Australia where a similar model has been introduced recently—this holds true for the more expansive models—the vast majority of people who are accessing an assisted death are in some form of palliative care or have had access to such care.

That demonstrates that those are people who have, to their mind, exhausted what palliative care can provide for them, and that accessing an assisted death is the choice that they opt for at that point. The most recent figures in relation to Oregon are that around 90 per cent are in receipt of palliative care or have had palliative care. In Victoria and Queensland in Australia, the figures are north of 80 per cent. Again, the picture is fairly consistent.

We need to improve access to palliative care. The debate around the bill has provided a platform for people in the palliative care sector to make that argument, but I caution against seeing it as an either/or choice, because, overwhelmingly, people who are accessing assisted dying in other jurisdictions with either similar models or other types of models are often in receipt of the best palliative care.

As palliative care practitioners would acknowledge, palliative care can do wonderful things, but it cannot always meet the needs of people with a terminal illness, and that is reflected in the figures.

Sandesh Gulhane: We have heard from previous witnesses that by passing the bill, we will open the door to a slippery slope, mission creep or scope creep. They cite, as you have, Canada, Oregon and the Netherlands as examples. Do you think that that will happen here through legal challenges, and how do we safeguard against it?

Liam McArthur: The slippery slope argument is made consistently. I point the committee to the report published by the House of Commons Health and Social Care Committee in February last year, at the end of an 18-month inquiry into assisted dying and end-of-life choices, which concluded that there was no international evidence of a jurisdiction that has introduced a terminal illness mental capacity model that is similar to the one that I am proposing and that is being considered by Westminster, where the eligibility criteria have changed. That was confirmed in the evidence that the committee heard from the witnesses who are involved in the process in Australia.

The argument that one of the witnesses made to try to substantiate the claim of a slippery slope in Oregon is that different conditions among those accessing assisted dying were featuring to a greater or lesser extent, but that does not necessarily say anything other than that patient confidence and medic confidence in the procedures perhaps evolve over time, and that those with certain conditions find that the palliative care that is available meets their needs up to a point, but they find themselves beyond that point at a certain stage.

Although minor changes have been made to the residency requirement in Oregon—over the years it was found that the requirement did not provide any meaningful safeguard, so it was removed—the eligibility criteria on terminal illness and mental capacity have not changed.

I have always acknowledged that the models in Canada and the Netherlands are more expansive; they have always been more expansive models. In the Netherlands, that has been the case for many years.

The Canadian model, which is often cited, has evolved through court process, which is sometimes brought into the debate here as something of a risk, but the constitutional arrangements in Canada are very different from those in Scotland and in the UK. The legislation was introduced as a result of a case that was brought before the supreme court in Canada on the basis that the ban on assisted dying was unconstitutional. The Parliament then introduced legislation, which was not felt to go far enough, so it was then legally challenged on appeal, which was upheld, and the scope of the legislation was expanded.

The arrangements in Canada and the Netherlands, both of which enjoy overwhelming public support, are very different from what is being proposed here. As I say, there is no example of a terminal illness mental capacity model having been introduced, whether in the US, Australia or New Zealand, where the eligibility criteria have changed.

Sandesh Gulhane: We are short of time, given the number of questions that we have, but I have a final question. We heard from disabled people's groups, who were very clear that nobody who is disabled supports assisted dying. That is the evidence that we heard from those groups. How can the bill ensure that, as we heard from disabled people, we do not allow vulnerable groups to be pressured into using it rather than accessing other forms of treatment?

Liam McArthur: The perception that those in the disability community are overwhelmingly opposed to a change in the law is not borne out by the evidence that the committee will have heard from Professor Colburn at the University of Glasgow. His fairly comprehensive research points to attitudes in the disability community and the international evidence on how assisted dying is accessed. Polling consistently shows that support for a change in the law to allow for assisted dying is every bit as strong among those in the disability community as it is in the population at large, at the mid-to-high 70 per cents in the main.

I understand the concern that people in the disability community often feel that their lives can be devalued, that access to the rights that they have is not realised consistently or that there are rights that they still do not have. I stand in solidarity with them with regard to improving that situation, but we do not improve it by denying terminally ill adults the right to an assisted death when they choose it. It would be wholly intolerable for somebody with a disability who had an advanced progressive terminal illness and mental capacity to be denied the same access as an able-bodied person to the choice that is set out in my bill—people in the disability community would rightly be up in arms in such an instance.

All I can do is offer the reassurance that having a disability alone does not make you eligible to access an assisted death—you need to have an advanced progressive terminal illness and mental capacity in order to be able to do so. If you have a disability as well, I see no reason why you should not be able to access an assisted death in the same way and, if further support is needed in order for you to be able to access it, so be it. As I have said, I think that the disability community broadly recognises that, which is why polling consistently shows very strong support for a change in the law.

10:30

Brian Whittle (South Scotland) (Con): Good morning, Mr McArthur. I have a quick supplementary around the vulnerable disability group. We had a round-table session in the Parliament with a variety of really excellent contributors, one of whom was the father and guardian of an adult son who had a learning disability. He pressed us really hard around the human right of his son should he request assisted dying—however, he has guardianship of his son. Where does the bill fit with that scenario?

Liam McArthur: I will bring Amanda Ward in on the specifics. The capacity assessment that would be required in order to be eligible relates to the choice of an assisted death, not to a broader capacity issue. It would be expected that support be provided to allow an individual to make that assessment, which, I would hope, would allow access to a wider range of individuals to meet the eligibility criteria to have that choice. Amanda, can you add anything to that?

Dr Ward: As with guardianship, advance directives have been raised in the committee. The bill is very clear that the request must come from an adult with full mental capacity. As Liam McArthur said, we have made provisions in the bill for proxies and other things when people need support to do that. However, the bill does not allow for someone with guardianship to try to take a person through that process, in the same way that it does not allow for advance requests, because the person must have mental capacity at the time of the request, right through the patient pathway until the moment when they would self-administer the medication.

Section 3(2)(a) of the bill is quite specific around mental disorders, too. You would be excluded under the eligibility criteria if you were suffering from a mental disorder that would affect the making of an assisted dying decision—rather than a broad mental disorder. To answer your question, someone with guardianship could not take their son through that process unless their son qualified under all the eligibility criteria in the bill.

Paul Sweeney (Glasgow) (Lab): Thank you, Mr McArthur, for attending today. Witnesses raised further questions on the practical administration of a substance if someone were physically impaired and unable to administer it. Obviously, you mentioned proxy with regard to the certification, for example. Could you talk us through the practical application of administering a substance if someone were physically unable to do so due to paralysis and so on?

Liam McArthur: Again, MND Scotland was particularly strong on that point. Self-administration is integral to the proposals that I have made. On that same panel, I think that there was an acceptance that there are other means whereby that self-administration can take place, whether by signalling through eye movement or other mechanisms.

It is important to ensure that there is the capacity and intent, but the development of medical technologies is now allowing self-administration to happen in a way that would have been very difficult to conceive of a number of years ago. It is important that the self-administration criteria remain and I am confident that that can be achieved while not excluding those who meet the eligibility criteria in terms of advanced progressive terminal illness and mental capacity.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): I remind members of my entry in the register of members’ interests, in that I am a member of the Humanist Society of Scotland.

Mr McArthur, some of the questions that I was going to pose to you have already been explored a little bit, but I will go into them further. The ability of doctors to undertake potentially complex capacity assessments has been raised with us, as well as some concerns about the resource implications of doing those assessments. How comfortable are you that our doctors have the ability to assess capacity effectively?

Liam McArthur: Thank you very much for that question. The issue has probably come up with most of the panels that the committee has heard from.

I am reassured that medics make capacity assessments routinely in relation to a swathe of different treatments and care options. Almost certainly, additional training will be required to make a capacity assessment in the context of an assisted dying process, but I would see that as augmenting or adapting the training that registered medical professionals routinely undertake.

As expertise builds up, we will need to look at support for medical professionals who are involved in the process—both peer support through the sharing of information, understanding and so on, and pastoral support. In speaking to those who are involved in the process in places such as Australia and the US, I note that they often point to the process as being one of the most fulfilling aspects of medicine that they have been involved in. However, it may well be challenging for others, so the need for that wider support element is almost inevitable.

Medics make capacity assessments routinely, and although further training will be required in terms of the specifics of the bill, I do not see that as adding greatly to the workload of, or the pressure on, the medics who would be involved.

Elena Whitham: Another issue that I want to explore is whether your bill has taken into account the outputs of the Scott review with regard to taking a human rights-based approach to capacity issues—not just looking at whether someone has capacity or not, but having a supportive environment that allows someone to be able to express their will clearly. What account does the bill take of that approach?

Liam McArthur: Again, that is an interesting point. An awful lot of work is going on in that area, not least in relation to the Scott review. The bill is framed very much in the context of where things stand at the moment. The assessment is a capacity assessment in the context of the decision around an assisted death. Where additional support might be needed—and taking into account Dr Ward's earlier comments—that can be provided, but capacity would still need to be established around the decision to opt for an assisted death.

Elena Whitham: I want to explore that further in relation to the definition of "mental disorder" that is included in the bill, which Dr Ward referred to. A mental disorder as defined in the "Diagnostic and Statistical Manual of Mental Disorders" could include learning disabilities and things such as neurodivergence, autism and so on. Is there potential for individuals who have such a mental disorder to have their capacity assessed through a human rights-based approach, so that it is not a case of saying that someone either has or does not have a mental disorder but so that the person has support to have that assessed?

Liam McArthur: I will bring Dr Ward in on that. Having a mental disorder does not preclude someone from accessing the option that would be available under my proposals. A capacity assessment would still need to be undertaken in the context of the decision around an assisted death. Appropriate supports could be put in place to ensure that the individual's capacity was realised, but with some conditions, it might be felt that a mental disorder impacts on the capacity to make a choice about assisted death. In those instances, the person would not meet the eligibility criteria.

Dr Ward: I point to the existing context in relation to end-of-life treatment and how we currently support patients with neurodivergence issues or mental disorders. We use many approaches and tools to ensure that the decision is the person's own and that they have full capacity, so there are existing provisions in that regard.

Taking a human rights-based approach has been central to what we have done throughout. What Mr McArthur has done in section 3(2)(b), which has not been replicated in other jurisdictions, is lay out what the capacity test should look like. I imagine that the committee has been following closely the evidence that has been taken on the Terminally Ill Adults (End of Life) Bill at Westminster this week. That bill just points to the Mental Capacity Act 2005. We were cognisant of the fact that changes were being made in relation to mental capacity in the background while the bill was being drafted, so we tried not only to take account of existing law in relation to capacity but to itemise exactly what the capacity test might look like.

Convener, may I quickly pick up on the training point, given that it is relevant to the capacity issue?

The Convener: We will come to questions on that later. If we do not cover that, I will be happy to come back to you.

Elena Whitham: The bill asks healthcare professionals to assess whether coercion is taking place as well as capacity. The committee has heard from some that coercion is very difficult to assess. What is your response to that?

Liam McArthur: As with capacity, the assessment in relation to coercion is made routinely by medical professionals, albeit in other contexts but still relating to treatment and care options. There is probably an argument for adapting the training that medics receive to reflect the context in which those assessments would be undertaken. However, the General Medical Council has set out very clear guidance on how to assess whether coercion is taking place. It has also set out very clear guidance on assessing domestic abuse and controlling or coercive behaviour.

Therefore, guidance is already in place, but I accept that it might need to be reviewed and an assessment made of whether changes are required, given the change in the law that the bill would introduce. However, I am fairly confident that an assessment of whether there is coercion can be made.

I would also observe that, at the moment, the point at which we assess whether coercion was involved happens post-mortem. We know that those who are facing what they feel is a bad and undignified death often take matters into their own hands. There might well be other instances in which coercion is at play, but, because the individual patient cannot have that conversation with their medic or other family members when there is coercion, that information does not emerge and the conversations do not happen. Information might emerge only after somebody has taken their own life.

I understand the concern about coercion, but my bill will put in place protections that currently do not exist for many people who are in a very vulnerable state near the end of their life.

10:45

Elena Whitham: We have heard that coercion can be defined as making people act in a way that is contrary to their best interests. Will you tell us about the people with a terminal illness who have contacted you while you have been working on the bill and who feel strongly that the status quo does not work in their best interests?

Liam McArthur: As I said in my opening remarks, the personal testimony of people with a terminal illness or who have lost somebody to what could broadly be described as a bad death has stood out to me. I went through the process with the earlier bills in 2010 and 2015, and that testimony has come through far more prominently as part of the process for my bill than was the case previously. More and more people have that personal experience.

I remember sitting in this committee room listening to somebody from the Australian state of Victoria talk about his experience after being diagnosed with myeloma. He talked very warmly about the quality of the treatment and palliative care that he was in receipt of, but he said:

> "During my time in hospital, I got a taste of what would be in store for me as my blood cancer progressed to terminal. It was horrifying—something that no human being should have to endure."

I was also contacted by somebody from the Western Isles with MND, which was touched on earlier. They said:

> "I'm not afraid to die. I want to live. I want my life to continue. But right now, I am living with extreme anxiety and suffering. For me, assisted dying is, funnily enough, a lifeline. I could let go of sleepless nights, stressful days and constant anxiety-ridden thoughts."

I have sat on the other side of the table, and this is one of those occasions when you need to make a judgment about whether the change that would be introduced would make things better. At the very least, you want to avoid making things worse. With this bill, the status quo has consequences—if we do not introduce this choice, we will be accepting that those individuals and others will continue to face hellish options at the end of their life, despite the best endeavours of palliative care and despite any investment that we might wish to make in improving access to palliative care. That seems intolerable to me. Those voices need to be at the centre of the debate that we are having on the issue and must inform the decisions that we take.

Elena Whitham: Thank you.

Carol Mochan (South Scotland) (Lab): I want to ask about the service model. As you will know, in our evidence-taking sessions, a lot of questions have been raised about the doctors who would be involved. Would the bill result in doctor shopping? How would we deal with large numbers of doctors conscientiously objecting? Are GPs in a position to be the doctors involved, or might a specialist service work better? Should there be an opt-in service rather than an opt-out service? What are your views on those questions?

Liam McArthur: That issue has been a really interesting element of the debate. As you will be aware, I have opted to place this very much within the framework of health and care services, because I think that that would be the most effective way of ensuring safeguards and a more effective and efficient way of delivering the service. The pathway for the patient needs to be as seamless as possible, with an assisted death being one of a series of end-of-life options.

One of the safeguards that is built into the process is the discussion that needs to take place between the co-ordinating physician and the patient to ensure that the patient is aware of all the options that are available—palliative care, social care or other types of health and care treatments—so that the decision is informed.

Things may change over time—as the committee has heard, prognoses are highly problematic, and more so in relation to some conditions than others. That is one of the reasons why I have not set a six-month timeframe, which is a feature in other jurisdictions. Things may change over time, and there may be an on-going conversation, but I think that it is safest for all concerned if this is embedded in the health and care service.

I find the idea of a stand-alone service problematic. Expecting somebody to be lifted and shifted out of a current pathway into another service at what is probably one of the most vulnerable points of their life—their final days—does not seem acceptable. I am perhaps more sympathetic to the notion of opt-in and opt-out, but

I would need to understand how that would work in practice and how to avoid creating unnecessary obstacles to people accessing the option.

As for the numbers involved, the appropriate training would need to be given to people to carry out the work. As we see from other jurisdictions—I refer to evidence that I gave to the Finance and Public Administration Committee—the number of registered medics is around 400 in Victoria and Queensland. The number of people in Victoria who were actively involved in 2023-24 was around 300; in Queensland, the figure was around half that—about 120. The numbers are not terribly high.

There would be a wider expectation that training would be required of those who might not be as directly involved, but who would need to be aware of what the law is and of how they might signpost somebody who asked them for advice. Indeed, some people might want to do the training for their own peace of mind, so that they understand the legal provisions. There is a training requirement, but the number of patients involved is likely to be very small, certainly in the first couple of years; it will gradually increase as public awareness increases, as medic confidence increases and as medics get the training that they need in order to deliver the option.

I do not see any reason why, in Scotland, we would find difficulties with our capacity to deliver this option that have not been experienced in any of the other jurisdictions concerned, including those in Australia, New Zealand and the US, which operate a similar model.

Carol Mochan: Regarding the experience of the doctors involved, would the bill need to specify that? Should the medical profession have guidance on that?

Liam McArthur: I think that that would come through guidance. I can understand the committee’s frustration in wanting to understand with real clarity how the model would work in practice. Some elements can, and absolutely must, be expressed in the bill itself, but the committee will understand from this and other bills that some elements are more appropriately covered in secondary legislation, recognising that they will almost certainly need to be frequently reviewed, revised and updated.

A great many more aspects will probably need to be reflected in guidance from professional bodies, regulators and others. That is the appropriate way to take the proposal forward, I think. However, I entirely understand why there is a desire to see as much detail as possible in the bill, and I sympathise with that. I hope that I have provided that detail as far as I can in the bill and in the supporting documentation—the explanatory notes and the policy memorandum—where I have sought to flesh things out. Ultimately, you are right: some elements will have to await guidance. I think that that is a reassurance for patients and medical professionals; that is absolutely where things ought to be.

Carol Mochan: Given your experience of looking into the issue and visiting other jurisdictions, do you think that it has been a good approach to provide for institutional objections, or would you wish to avoid that. That has happened in some other areas, although, as you know, it has been questioned both ways.

Liam McArthur: I have probably not said enough about conscientious objection. This is fundamentally about choice; it is about giving dying Scots the choice, should they wish it. However, that works both ways, and there absolutely needs to be a robust conscientious objection mechanism in place to allow medical professionals who would otherwise be involved to opt out of that involvement, subject to the expectation that they would then refer the patient to someone who could provide that support. That conscientious objection choice for the medic is fundamental.

My problem with an institutional objection is that the organisation in question might well involve and include individuals who are supportive of a change in the law. It then ceases to be about individual choice, because the risk is that barriers can be put in place to individuals who, despite meeting all the eligibility criteria and being protected by the safeguards that are in place, find that, as a result of an institutional opt-out, they are not able to access the choice. We have seen that happen in other jurisdictions, and it has proved problematic.

I think, though, that there are ways of managing that. I know from speaking to those involved in the hospice sector in New Zealand, for example, that there is a mixed picture with regard to the engagement of individual hospices. Although some might not directly be involved in the provision of assisted dying, they will allow practitioners into the hospice to help deliver the service. There might well be a way of having a more flexible approach that recognises the strong emotions and feelings that some people have around this issue, but which ensures that those emotions and feelings do not stand in the way of individuals who meet the eligibility criteria accessing the choice that I feel they need to have.

Carol Mochan: That was very helpful. Thank you.

The Convener: I call Brian Whittle.

Brian Whittle: I want to explore a little bit further the issue of palliative care that Dr Gulhane raised earlier. I hope that I am not putting words in your mouth, Mr McArthur, but I think that you would agree that the ideal scenario is for people to have access to palliative care as well as assisted dying. However, we know that that is not the case; indeed, one in four Scots is not getting access to palliative care. As you have highlighted, the bill is shining a light on the provision of such care, and I think that that is very welcome.

The other thing that we have heard about is the inequality of access to palliative care between Scottish index of multiple deprivation level 1 and SIMD level 5 areas. My question, then, is this: do you want the bill itself to guarantee access to palliative care alongside access to assisted dying?

Liam McArthur: I would probably question whether it would be competent to do that in the bill. That aside, I think that what might be problematic in the assumption that palliative care is for everybody is that it might almost be seen as a requirement for one to go through and exhaust all palliative care options before one has the right to choose an assisted death.

As I have said, from what we have seen internationally, it is overwhelmingly the case that those who access this choice are or have been in receipt of palliative care. Moreover, the committee heard from the witnesses in Australia that, as a result of the assisted dying legislation, there had, in a number of cases, been a significant uplift in investment in palliative care, too, which, one would hope, would address some of the access issues. Perhaps even more interesting, though, was the improved engagement with palliative care—I think that that was a very clear message from one of the witnesses.

What that reflects is that the discussions that need to take place about the reasons why an individual is making the request—and then the discussion that needs to take place around the options that are available—are leading to people having raised awareness of what palliative care options are available in a way that is perhaps not happening here at the moment. I would expect that to be the case in this instance.

11:00

As I say, I think that your suggestion would be problematic. I have been very supportive of your colleague Miles Briggs's attempts to introduce a bill on the right to palliative care—that is an important campaign, which I have strongly supported. We need to put something in place that is competent and that improves access to palliative care through the debate that is opened up and the pressure that it builds to invest more in palliative care, but I think that amending the bill in the way that you suggest, Mr Whittle, would be problematic in the same way that saying, "You are not able to access palliative options until you have exhausted all curative treatment options," would be.

Brian Whittle: You are absolutely right that palliative care is not for everybody and that, if the bill passes, the fact that someone does not access palliative care should not prevent them from accessing assisted dying. I fully understand where you are coming from with that. The concern is that if someone seeks palliative care and it is not accessible, the pressure towards assisted dying grows. That is the concern. If somebody speaks to their GP and requests more information on or to start the process of assisted dying, at that point, should the GP discuss palliative care options and what happens if they are not available?

Liam McArthur: As I say, all treatment and care options need to be discussed for there to be an informed decision. The rationale—that is, the reasons behind the individual coming to their decision—needs to be understood, but it needs to be an informed decision, and it can only be an informed decision where there is an understanding of the various options that are available. Those options would not stop at palliative care but would include social care, and there would be other factors that play on the lived experience of the individual.

Through the process that I propose to put in place, the discussions that would happen would provide safeguards that are not in place at present, for situations in which it is felt that an individual's care needs are not being met. If an individual made a request of that nature, I am fairly sure that the co-ordinating medical professional would go to some lengths to ensure that those issues were addressed. In a sense, the safeguards that my bill would put in place do not exist at the moment.

As I said, if we do not pass the legislation, there is a risk that the status quo would continue to have outcomes that we, as a society, should not accept. Although the amendment that you are suggesting would probably be competent in the context of the bill, the issue would be better addressed by the requirement under section 7 of the bill that I have introduced, which requires the care options to be discussed and steps to be taken where medics feel that other support is necessary and can be put in place. That assessment will change over time; an original assessment of those options might well be accurate, but over the period of a terminal illness, other options, which were not necessarily considered at the outset, might be deemed to be more appropriate.

Brian Whittle: I will move to the topic of unassisted suicide. Some people have told us in evidence that the bill might have a positive impact in reducing the number of unassisted suicides, although others have said that it will have no impact.

I have a practical question. Have you discussed that with insurance companies and do you know their take on whether assisted dying would be deemed to be suicide and might therefore make insurance policies unworkable or those deaths ineligible for insurance payouts? Have you had that conversation?

Liam McArthur: That was probably one of the first conversations that I had. The Association of British Insurers has confirmed that assisted dying would not be considered to be suicide.

The issue of language has been at the very centre of this debate. There are those who seek to draw parallels between assisted dying and suicide. In a recent statement, a number of Australian organisations involved in suicide prevention said:

> “We are concerned that suicide is being confused with voluntary assisted dying. The two are very distinct, and using the terms interchangeably can be damaging.
>
> Suicide is when a person tragically and intentionally ends their own life ...
>
> Voluntary assisted dying is not a choice between life and death. It is an end-of-life choice available to eligible terminally ill people who are already dying. It offers an element of control and comfort over how they die when death becomes inevitable and imminent ...
>
> Both suicide prevention and voluntary assisted dying are as important as they are distinct. Confusing these terms can delay access to suicide prevention services for people in distress, and complicate care for those who are at end of life.”

I know that you have pursued with previous witnesses the fact that the suicide rate among terminally ill people across the UK is around two and a half times the rate in the population at large. We cannot know the details in every instance, but that does tend to suggest that, in the absence of the option that is reflected in my bill, many people are taking matters into their own hands. Meanwhile, others who have the financial wherewithal and physical capacity to access the services provided by Dignitas in Switzerland are doing so, but probably weeks or even months ahead of time in order to ensure that they have the physical capacity to do so. Even then, those individuals are not able to seek the support of medical professionals or even family members, for fear of exposing them to the risk of prosecution.

I understand why there is a concern about normalising this approach to death, but we are talking about people who are dying anyway, and this is about their choice, dignity and control regarding the timing and means of their death. It is not about suicide, which is a very different issue that must be tackled differently.

Brian Whittle: You highlight the issue of those who have a terminal diagnosis. That will inevitably have some impact on their mental health, and, as you say, the suicide rate among that cohort is about two and half times the norm. I will push again on the issue of access—or lack of access—to other services. Are you concerned that the lack of access to other services would inevitably lead people down a certain path?

Liam McArthur: I do not think so. My proposals would put in place a heavily safeguarded and transparent process whereby the individual who makes the request would be supported to understand the available options and in which medics would identify where there are needs and where those needs are not being met. All of that would happen in a way that is simply not the case at the moment, when those individuals are being left entirely to their own devices, often alone, and are making horrendous choices and decisions for themselves that not only further traumatise them but, as we know, traumatise those whom they ultimately leave behind. There are certainly gaps in palliative care, mental health and broader health and care services.

As I said, the proposals will put in place a robustly safeguarded process that means that anybody who comes forward to make the request has the reassurance of knowing that the wider context for the choice that they are seeking to exercise has been tested to the nth degree. That can therefore bring a degree of further reassurance and safeguarding to things that are happening at the moment. Decisions on matters such as double effect, palliative sedation and all the rest of it are being taken by medics, sometimes placing them in an invidious position, often without the input of the patient and sometimes without even the input of family members. There is an opportunity here to provide not just a robust safeguard but a degree of transparency that will be to the benefit of patients, but also to the benefit of medical practitioners.

I invite Dr Ward to add to that.

Dr Ward: On the point about mental health issues, the committee has heard that depression is also present in people who are terminally ill. In an earlier evidence session, the committee heard from Professor Colin McKay, who is a professor of mental health and incapacity law, and he mentioned a study of terminally ill people in Oregon and the Netherlands. It showed that depression was prevalent at a rate of between 8 per cent and 47 per cent, but the percentage of people who went on to have an assisted death was only between 2 per cent and 17 per cent. That study shows, as the professor said, that the screening works in the assisted dying process.

It might also be a useful reference point for the committee to look at the evidence from the mental health charity SANE, which wrote to the Westminster committee.

Emma Harper: I have a quick question regarding palliative care versus the choice of assisted dying. We have heard evidence from other countries that, even though someone may have opted to go through a process of assisted dying, they might still say, “No, I won’t proceed,” and then continue, knowing that they can still choose that, with a palliative care process. Is that your experience from your research?

Liam McArthur: You make an entirely valid point, Ms Harper. In jurisdictions with a terminal illness mental capacity model, it is pretty consistent across the board for around a third of those who apply for an assisted death to not end up taking it. It is fairly safe to assume that, in the main, that is because they find that the palliative or other care that they receive meets their needs all the way through to death.

I suppose that it was implicit in my quote from the woman with MND that it is about having the insurance policy of knowing that, if things get too much, the option of an assisted death is available. That, in itself, has a palliative benefit, because it provides a degree of reassurance. It allows the individual to get on with living their life and making the most of whatever time is still available to them, whether that is measured in years, months or days. The fear of what is to come cannot be overestimated. Whatever the physical aspects are, the existential suffering that those at the end of life go through is one of the worst aspects.

As you will know better than I, Ms Harper, pain management is pretty sophisticated. A lot of the pain can be managed. I have heard physicians in Australia say that they very rarely deal with issues of pain. It is the existential suffering that leads individuals to opt for an assisted death. The fact that such a high number of people make the choice but then do not go through with it indicates why it has been chosen and the benefits that come with simply having that insurance policy in the background.

11:15

David Torrance (Kirkcaldy) (SNP): Good morning. My questions are about the act of assisted dying, the means of death and the substance used.

Some respondents to the committee have raised concerns about complications during assisted dying. Evidence from Oregon has been cited that indicates that 7 to 11 per cent of people have complications during assisted dying, which range from vomiting and waking up to prolonged deaths. On the other hand, in evidence from witnesses from Australia and Canada, the committee has been told that there have been minor complications, such as not being able to get intravenous drips in, but nothing major. How would you address that?

Liam McArthur: The evidence that the committee heard from Australia was very telling. There have not been examples of problems.

It is worth pointing out—the medics on the committee will understand this far better than I do—that the act of dying can involve quite distressing implications for the patient and for those family members who might be supporting them. We need to be cognisant of that in understanding how an assisted death would work.

The evidence from the witnesses in Australia was telling, as I said. There are historical reasons in the US for why issues might have arisen there—certainly in the early stages—around the regulation of medications and what could be used. As far as I can see, issues with access to those medications now appear to have been addressed. The more relevant evidence from more recent years comes from Australia, where there do not appear to be problems. Dr Ward might want to add to that.

Dr Ward: I want to assure the committee that we have had extensive engagement with pharmaceutical colleagues and stakeholders. Just this morning, I helped the Royal Pharmaceutical Society, which the committee has heard from, Community Pharmacy Scotland and others to arrange a meeting with Professor Michael Dooley, who is the person whom many of the state Governments in Australia tasked with finding a protocol that worked 100 per cent. The society will now meet him to have a discussion about the medication and, in particular, the self-administration aspect and how that works, other than just through swallowing.

I want to assure the committee that, although there are sensitivities around discussing the medication and the pharmaceutical aspects, we have explored those matters in detail. As Liam McArthur said, there were issues 20 years ago in Oregon, when assisted dying was new or emerging, but there is now a very refined protocol that we know works at 100 per cent effectiveness.

David Torrance: Section 15 of the bill describes assistance as providing a terminally ill adult with a substance to end their life, staying with them until they have decided that they wish to use the substance or removing the substance if they decide that they do not wish to use it. The UK bill contains more detail. It says that someone providing assistance may "prepare that substance for self-administration by that person ... prepare a medical device which will enable that person to self-administer the substance, and ... assist that person to ingest or otherwise self-administer the substance."

We have heard MND Scotland's concerns on the issue. Why does your bill not define what actions would be considered to constitute self-administration?

Liam McArthur: I was interested in those exchanges. To go back to Ms Mochan's questions, I note that that element might well fall more appropriately into guidance. However, the self-administration element is an integral part of the process.

It is worth reflecting not so much on the differences between the bill that I have introduced and the bill that is being considered by Westminster but on the fact that, in other jurisdictions that have similar legislation, very often, the medication is dispatched to the patient and the medical professional is not present when the medication is delivered.

I am happy to look at whether further refinement of that is necessary. It is an important safeguard that the medic is there, not least to ensure that a final assessment of capacity and intent is made.

There is a feeling that an individual may wish, in their final moments, to have a degree of privacy. How you manage that while ensuring that there are safeguards is probably a question to reflect on further. As I have said, the safeguard that is in the bill seems to be robust; it is absent from other jurisdictions, which does not seem to be a problem, but that is for those jurisdictions, rather than me, to justify.

David Torrance: The bill states that a doctor or nurse must stay with a person until they have died, but not in the same room. In its evidence, Police Scotland questioned how a health professional could be sure that no third-party involvement was taking place.

Liam McArthur: Given the process that would be gone through before that point, there would be a fairly high degree of reassurance about intent and whether there was any coercion. If there was coercion, that would obviously bring the process to a halt. Those safeguards need to be seen as relevant to the point at which the medication is delivered and the assessment of intent and capacity is made.

I was interested to hear those concerns. I am not necessarily sure that the patient's wish for a degree of privacy and discretion at the end of their life is something that we would want to see denied, but I am happy to look at any further clarifications that might be helpful in that regard.

Dr Ward: I now live in Queensland, Australia, and there are many jurisdictions throughout the world where, as Liam said, the medication is sent in the post. That makes it the person's decision as to the time and place and who is there.

I was involved with Margo MacDonald and Patrick Harvie on the previous bills on the subject, which did not require there to be a healthcare practitioner at the death. That is an additional safeguard that we have added in.

To quickly respond to David Torrance's previous question about why the bill does not include detail on how much assistance can be given, my understanding is that that is because the law in England and Wales is different. They have the Suicide Act 1961, which specifically prohibits assistance in dying. We do not have that prohibition in Scotland, so there is a distinction in the existing law.

David Torrance: I have no further questions.

The Convener: As we are only halfway through our questioning, I will briefly suspend the meeting for a comfort break.

11:23

Meeting suspended.

11:31

On resuming—

The Convener: Welcome back. We will continue to take evidence from Liam McArthur and his accompanying witnesses. I refer members to my entry in the register of members' interests, which states that I am employed as a bank nurse by NHS Greater Glasgow and Clyde.

I would like to explore a couple of issues with you, Mr McArthur, starting with conscientious objection. We have heard various arguments and questions at committee in relation to the conscientious objection clause in the bill, who it includes and what the clause extends to. Section 18(1) of the bill sets out that no one is

"under any duty ... to participate in anything authorised"

under the bill, if they have

"a conscientious objection"

to doing so. The bill does not prescribe to whom the conscientious objection would apply, but the policy memorandum indicates that it is intended to apply to doctors and other health care professionals who are involved in the process. There is some argument that the clause replicates a provision in the Abortion Act 1967 and is therefore likely to be interpreted in the same way by the courts. That would mean that the objection clause might extend only to those people who are directly involved in the process of assessing, prescribing and providing assistance. Could you perhaps clarify your thinking around that and who you envisage that the conscious objection clause would apply to?

Liam McArthur: As you have described, it would be my expectation that the clause would apply to the people who are directly involved in the process, which I think is a proportionate approach to conscientious objection. A degree of caution needs to be exercised when drawing parallels between the process that is described here and abortion legislation. I think that the way in which the conscientious objection clause works is appropriate in the context of assisted dying.

Other people might be, at some stage, removed from the process. One of the examples that was given to me was of people in a hospital or a hospice setting who are aware that colleagues are, through the proposals in my bill, engaged in assisting somebody at the end of life, and might have an objection to that.

Extending that conscientious objection too extensively is problematic. It is about choice for those who are actively participating in the process. Extending it more widely runs the risk of putting up unnecessary and unjustified barriers to individual patients who meet all the eligibility criteria by denying them access to that choice.

The Convener: It sounds like what you propose in terms of that conscientious objection would be quite discrete. How do you counter what surveys of palliative care staff and staff who work in hospices say? According to those surveys, quite large numbers of staff have talked about leaving those services should your bill be passed.

Liam McArthur: I have been interested in those surveys. Going back to the response that I gave about how many people are likely to be involved in the process, as we see from jurisdictions with similar models, it is a relatively low number. It is likely to be a very low number in the first and second years, but over time, it is likely to increase.

At the end of last year, I spoke at the Hospice UK conference in Glasgow. It was clear to me from the exchanges there that there is a considerable amount of discussion and debate about the issue in the palliative care sector. There are certainly people who strongly oppose a change in the law, and people who are similarly strongly in favour of it. A great many people have questions and simply want to know how it would impact on the care that they deliver to their patients. As I said to them, I think that introducing the choice of an assisted death as one of a range of end-of-life choices allows them to do what they do well, which is meet the needs and limit the suffering of the people they support.

Attitudes to legislation before it is in place often change, and can change dramatically, after the legislation is introduced, when people have a clearer understanding of what the implications may be. I do not see any reason why the situation here in Scotland would be any different from that in states in Australia and the US where practitioners have engaged in the process and, as I said, have often found that one of the most rewarding things that they are able to do is give those whom they are supporting a good death. That seems to be at the heart of what palliative care is about.

I have heard the concerns, and I have tried to do my best to engage with the sector to provide a degree of reassurance. Obviously, the bill, which includes a conscientious objection clause, does not compel anybody to engage with the process, but I am confident that there will be sufficient doctors to support it. As I said, those numbers are likely to increase over time as understanding and confidence increase and as the training is rolled out to practitioners.

The Convener: Last week, a group of GPs in my constituency asked me a question that I was not able to answer. They asked whether there would be a duty for someone expressing that conscientious objection to refer a person requesting assisted dying to another assessor. Can you give me a definitive answer?

Liam McArthur: There would be an expectation, as there is with the way that conscientious objection works for abortion, for the medical professional to refer the patient on to somebody who can provide support. That is an important principle in the delivery of health and care services. It protects that choice on the part of the practitioner but does not put up unreasonable barriers to patients accessing the choice that they should have to get the support and treatment that they feel that they need.

The Convener: The status of assisted dying as a reasonable treatment option in Scotland is unclear and there have been calls for that to be addressed directly in the bill. If assisted dying is considered to be a reasonable treatment option, doctors would have a duty to discuss it with patients in appropriate situations, regardless of any conscientious objection to the practice that they might have. How do you respond to that?

Liam McArthur: The bill and the supporting documents are clear that the process is initiated by a request on the part of the patient for an assisted death, at which point the requirement is for the co-ordinated medical professionals to ensure that they understand the rationale for arriving at that decision, and equally to ensure that the individual is aware of all the treatment and care options that are available.

Listening to the evidence that the committee has heard in recent weeks, I recognise that, as much as one would like definitive clarity, proscribing or prescribing what a medical professional can and cannot discuss with their patient is territory into which we, as parliamentarians, probably need to tread very carefully. The expectation is that the process is initiated by the patient making the request, and thereafter the process and the safeguards that we have taken the time to discuss this morning would kick in.

The Convener: One of the other areas that the committee has touched on is qualifications. I believe that the bill speaks about medical practitioners, although I might be misquoting slightly there. However, witnesses were clear that the level of qualification that would be required for doctors to be able to participate in assisted dying could encompass those at foundation year 2 level. When representatives of the Royal College of Psychiatrists were at committee, we asked about their level of confidence in such a junior doctor participating in those assessments of capacity and so on. They were quite resolute that they did not feel that such a junior doctor would have sufficient experience at that level of their training. Why have you chosen that particular term, which encompasses such junior doctors, and, should the bill be agreed to at stage 1, would you look to amend that provision?

Liam McArthur: That evidence was very interesting. It is also fair to say that the BMA and the Royal College of GPs seemed to be fairly relaxed about the way in which that part of the bill was expressed.

I recognise that this is an element of the bill on which the detail is probably more appropriately set out in secondary legislation and in guidance. Training would be required for doctors to undertake the work that is involved in providing support to patients around assisted dying—we touched on some of that earlier.

As it stands, the bill probably goes as far as it can in expressing who is likely to be involved in this process, but there is an opportunity there. My expectation is that the Government would work with the professional bodies to identify how best to express that through secondary legislation and guidance.

Emma Harper: I will pick up on the duty to refer. Let us say that I am a carer looking after somebody who is at the end of their life in their home, and I am a conscientious objector, and the person I am looking after at the end of their life says, "Okay, that is it—I am done. I want to go down the assisted dying pathway." How do we support the conscientious objector who is a carer to refer on? Do they just keep their mouth shut, or do we require them to refer? Would it be part of secondary guidance, education and legislation to require them to refer, because this is about the human right of choice at the end of life?

Liam McArthur: Again, it is probably more appropriate to pick that up in guidance. On whether there would be an expectation that somebody in that position would refer the individual to their GP to seek support, that would seem to be the most logical option in those circumstances. That would be difficult to express in the bill, so it would be better for it to come through less in secondary legislation and more in guidance.

As I mentioned earlier, there will be training requirements for those who are directly involved, but there will be a wider training requirement with regard to raising awareness of what the change in the law means among those who are involved in health and care more generally. With regard to whether someone has a conscientious objection, it would be in their interests to understand the implications. However, as I said, that would probably be better expressed in guidance than in the bill.

11:45

Gillian Mackay (Central Scotland) (Green): Section 22 of the bill precludes provisions that relate to reserved matters, which has raised concerns about Scottish ministers' ability to designate an approved substance for assisted dying, because that designation is critical for the bill's practical implementation. I appreciate that Mr McArthur said that not everything needs to be in the bill, but the practical implications are obviously of interest to the committee. What steps or negotiations are being considered with the UK Government to resolve that issue, and, if the issue could result in a delay, how could that be managed in the interim?

Liam McArthur: Although it maybe did not feel that way at the time, it was helpful to hear from the Cabinet Secretary for Health and Social Care. Although the Presiding Officer has deemed the bill to be competent in the context of the Scottish Parliament's powers, I have always acknowledged that putting in place a fully functioning process of assisted dying in Scotland will require matters that are the preserve of Westminster to be addressed, in particular in relation to medicines, the Misuse of Drugs Act 1971 and so on. However, as the committee heard on numerous occasions last week from Mr Gray, those matters can be resolved only at the point at which the Scottish Parliament decides that a change in the law is required.

I do not think that I am breaching any confidences by saying that I have had early and occasional discussions with the UK Government as well as the Scottish Government. Those discussions have really just been to keep the Governments updated on the bill's progress. I think that it was June 2021 when I first announced that I was planning to introduce the bill, and it has been important to keep people up to date with what has been going on in the background and to reassure them that it would emerge at some point.

However, those discussions have taken place in the context of a recognition on both sides that the UK Government and the Scottish Government have, quite understandably and justifiably, taken a position of neutrality and are awaiting the outcome of the stage 1 vote, at which point the mechanisms that can address the issues of legislative competence can be addressed. I am confident that that can happen in a timely fashion.

Gillian Mackay: I turn to another issue in the same vein. The bill grants ministers the power to set qualifications for participating doctors and requires them to take account of a second opinion. However, it is the case that some of those aspects might also be affected by reserved matters such as the regulation of health professionals. What deliberations have you had on that matter in particular? Dr Ward might wish to contribute on that point. What collaborative processes do you envisage, and what prospects are there for securing the necessary consents from the UK Government? What overlap is there, in relation to that provision in particular, between the bill here and the bill that is in the UK Parliament?

Liam McArthur: In relation to interaction with UK responsibilities, the other matter, which gains less attention than the medication, is that of the regulation of professional bodies. However, similarly, that would need to be addressed in order for the fully functioning process of assisted dying to be put in place. That is not to say that the bill as it stands is not competent or that it cannot go through the full scrutiny process and be passed by the Parliament.

I can understand why the committee, MSPs, the wider public, and those with an interest in the matter are keen to have a clear understanding of how the powers are to be exercised. That would give us confidence as to how the bill would work in practice. I do not know whether Dr Ward wants to add anything on the specifics of the regulation of professional bodies.

Dr Ward: In the accompanying documents, we set out the processes that we have explored and would explore to make it fully competent post a positive vote at stage 1. I will hand over to my colleague Claudia Bennett.

Claudia Bennett (Scottish Parliament): I am not sure what I can add to what Mr McArthur has already said. When we drafted the bill and were instructed on it, very careful consideration was given to the way in which the framework for assisted dying could be devised within the limits of the Scotland Act 1998. The member has given evidence explaining the policy on which his legislative competence statement is based. He has been clear from the start that there may be some issues about implementation and has given some suggestions in the policy memorandum on the possible ways in which those could be resolved. It is now for the member and the UK and Scottish Governments to discuss that further.

Liam McArthur: It is worth bearing in mind that this is a sensitive issue that needs careful and sensitive handling. From the outset, I was very conscious that I did not want to use the bill as a mechanism to push the boundaries of constitutional arrangements, so, as Ms Bennett has articulated, I have operated in that framework. I am very confident that the mechanisms to resolve those issues exist. Given that a very similar bill is going through the Westminster Parliament, coincidentally at the same time as the bill that we are considering, I think that that enhances the opportunities to ensure that relatively speedy progress can be made in this area once the Scottish Parliament decides whether it is supportive of the general principles, in support of a change in the law.

Sandesh Gulhane: I turn to death certification and how a health professional would go about filling in the relevant forms. We do not want to skew the death statistics. If someone has terminal lung cancer, for example, it is very important that that is captured in the data. What is the thought process on the way that you would like a health professional to fill in the forms?

Liam McArthur: As you will be aware, the schedules to the bill are, in effect, the forms for this and other aspects of the reporting requirements. It is important that death certificates reflect the underlying progressive advanced terminal illness that gave rise to the application, as well as the fact that medication had been administered to allow for an assisted death. For clarity and transparency, both those things need to be captured, which is what the schedules to the bill set out.

From my initial discussions with the chief medical officer, I recognise the legitimate concern that there may be some sensitivity about the way in which the information is expressed and the distinction between suicide and assisted dying, which goes back to an earlier point. The chief medical officer and his colleagues helpfully suggested that codes are used for registrations that may allow for that information to be captured in a way that respects and acknowledges the sensitivity of what we are discussing.

I am keen to explore that further, but it is important that we understand who is accessing the option of assisted death, what conditions are involved, when people are accessing it and their sociodemographic characteristics. We need as much information as possible—anonymised, of course. As we might touch on later, it will be crucial to report on and understand the picture of how the legislation is working in practice. There are the annual reports, which will feed into the five-year review that is also set out in the bill.

If we look at other jurisdictions, we see that there are a lot of similarities in who is accessing assisted dying, the reasons why they are doing so and the demographic profile, but to my mind it is absolutely essential that we gather information in Scotland. In fact, the only element of my proposals that changed between the initial consultation and when I brought the bill to Parliament was in respect of tightening up the data-reporting requirements that were envisaged. For public confidence, and for the confidence of patients and medics, the more robust those requirements are, the better.

Sandesh Gulhane: We will come on to the reporting aspect. To go back to death certificates, it is vital that both aspects of the death are captured, but it seems to me that at section 1a of the certificate, which notes the way that someone has actually died, the big terminal illness that the person has had should be listed, with assisted dying being listed in section 2 of the certificate, so that both elements are captured but we do not lose sight of the terminal illness itself.

Liam McArthur: That would certainly be my view; I am conscious that others take a different view on that. I think that there is a way of ensuring that the information that is needed is captured appropriately.

As I said, I was reassured to some extent in my discussions with the CMO and his colleagues that there is a way of navigating the matter so that it is undertaken sensitively but makes absolutely sure that the relevant information is available so that we have the understanding that we need about how the legislation is working in practice.

Sandesh Gulhane: To move on to reporting, are you happy that there is enough in the bill to enable us to look robustly at what has happened over each year, which will feed into the five-year review? If you think that that is the case, what learnings have you taken from other jurisdictions that already undertake reporting? Let us not reinvent the wheel.

Liam McArthur: As I said, the number of those who are likely to take up the option of assisted death in the initial years is likely to be fairly low—we have certainly seen that pattern in other jurisdictions. The information that we have on who accesses it, when and how and so on, will, therefore, be more limited than one would expect in later years. However, it is important that we capture information from the get-go, so the annual reporting requirements will kick in for year 1 to ensure that the Government and relevant bodies, and the Parliament, understand what is happening.

I know that some concerns have been expressed as to whether a five-year review is too far down the line; some argue that a three-year review may be more appropriate. There is a balance to be struck in that regard. I understand why there may be a desire to ensure that any changes that might be needed can be taken account of as quickly as possible. However, if we do not have a detailed data set on which to draw, we, as parliamentarians, will find it more difficult to make a decision, informed by those in the field, about how the legislation is working and whether and where amendments might be required.

A five-year review seems to me to strike the right balance in order to give us the data set while ensuring that there is an annual reporting system in place that can pick up things in real time.

Sandesh Gulhane: Do you think that we might need any additional information from the reporting that may be able to provide additional safeguards and reassurance?

12:00

Liam McArthur: It would certainly be an option for the Scottish Government to add additional requirements on data gathering. I have sought to set out the data that, on the face of it, looks to be the most relevant, and what I have set out certainly reflects what the data-gathering processes look like in other jurisdictions. However, if the Government or stakeholders that are informing the Government feel that other elements need to be added, there is a mechanism for doing that.

As with any data gathering, there needs to be an understanding of why something is being added to the list. Such processes are not without time and cost implications, so we need to understand the purpose for which we are gathering data.

However, as I said, the data would need to be as comprehensive as it could be in order to give the clearest possible picture of how the legislation was working in practice and to inform any future decisions about how the legislation might need to be adapted.

Paul Sweeney: In last week's evidence session, Police Scotland and the Crown Office and

Procurator Fiscal Service seemed to be content that the current law and the bill would interact in a way that would not hinder prosecution in appropriate situations. Sections 19 and 20 of the bill deal with criminal liability and mirror the provision for civil liability. Section 19(1) states:

> "It is not a crime to lawfully provide a terminally ill adult with assistance to end their own life",

but section 19(2) states:

> "Subsection (1) does not limit the circumstances in which a court can otherwise find that a person who has assisted another to end their own life has not committed an offence."

The explanatory notes highlight that that would be in the context of complying with the bill's provisions.

Could there be the risk of litigation or police complaints being made? Could the provisions be tested by people disputing their relative's competence or in other scenarios in which things end up being augmented by case law?

Liam McArthur: We have both been involved in politics for long enough to know that predicting what individuals will seek to legally challenge is very difficult. However, like you, I was reassured by the responses from the Crown Office and Procurator Fiscal Service and Police Scotland on those provisions in the bill.

We touched on coercion earlier. Having spoken to practitioners and those who are involved in the oversight of such legislation in Australia and the US, I know that they consistently argue that the greater concern is not family members coercing somebody into assisted dying but family members having difficulties with the decision that a relative has taken to opt for that choice. That points to the concern that you have raised, and it is why the safeguards and procedures that will be in place are as robust as they are. First and foremost, they will provide protection for the patient, but there will also be robust safeguards for medical practitioners who operate in this area.

We wrestled over the bill's phraseology. It is difficult to capture the discussions that take place between a patient and family members, because families operate very differently. A requirement that a discussion takes place with the family could be highly problematic, because family members might be estranged from one another, for example.

However, in order to manage the process, including the process of grieving after the death, clearly, the more discussion there is—either with the family or with the support network around the individual—the better. That would certainly be the expectation. I would expect medical practitioners to give that advice to their patients. The more such conversations take place, the more we will minimise the risk of family members feeling that the process is not robust or even feeling blind-sided by the decision that a relative has taken.

Paul Sweeney: Do you think that it might be worth considering the provision of further detail on dispute resolution mechanisms—for example, in circumstances in which interested parties, family members or people with power of attorney might have a concern about coercion?

Liam McArthur: In looking at other jurisdictions, it is interesting to see the landscape that grows up around such legislation. Many charities and third sector organisations that have been campaigning for a change in the law have made it clear that they expect to continue to provide help, support and advice to people who might seek to access assisted dying. Those organisations might also be able to provide the sort of support that you are talking about. The need for that might be rare, but it would be good to think that, where such a need existed, it would be met.

The consistent feedback from jurisdictions in which assisted dying laws have been introduced is that the process of coming to terms with a loved one's death and going through the grieving process thereafter is eased by knowing that that loved one had the choice, the control, the dignity and so on at the end of life that, at the moment, are absent here in Scotland, for a small but not insignificant number of people.

I need to keep reinforcing the point that we are talking about assisted dying because that is the focus of the bill. However, the vast majority of Scots will continue not to need an assisted death. They will be supported by palliative care, social care and other health and care services up to the point of death.

Paul Sweeney: When it comes to conditions for which the prognosis is hard to determine, there might well be a long period after someone has made it clear that they want to have an assisted death. They might have made the relevant provisions in accordance with the bill, but there could then be a long period in which scope existed for further pressure to be applied or for other influences to be exerted on the person's thinking. Many people who have a terminal illness and expect to receive palliative care might want to make provision for an assisted death because they think that having the option to end their life on their terms might provide some comfort. In the end, that option might not be used, but making such provision could create an open-ended period in which many circumstances could change.

Could more detail be provided on situations in which there were such longer periods? Could there be intervals at which the desire for an assisted death was reassessed by relevant professionals, such as the co-ordinating doctor?

Liam McArthur: I think that the only relevant point at which a reassessment would be required is the point at which medication might be provided to an individual who sought to act on their initial request. Such an individual would have been through the full process and would have made a second declaration. There is no time restriction on such a declaration—it would remain valid—but at the point at which medication might be provided, as I said earlier, there would still be a requirement to establish capacity and intent. Any change in that would prevent the process from proceeding.

It is important, for the reasons that were discussed with Ms Harper, that people can choose to pursue an assisted death at different stages. Some people might have the relative luxury of going through the process relatively early, in order to provide themselves with a degree of comfort and reassurance, but there are others whose diagnosis might come far closer to the point of death and who need to act with greater speed, so to speak. They will need to get things in order in a shorter timeframe. However, as I said, the point at which the medication is provided is the point at which capacity and intent would be established.

Individuals with a terminal illness will receive on-going support, whether that is from their GP or a consultant. They will almost certainly be in receipt of on-going treatment or palliative care, so those discussions will be on-going. Therefore, although I find it difficult to imagine a situation in which the issue will not arise in the background, I suspect that the focus will still be on the treatment and palliative options that are available, which might change over time. As the committee has heard on numerous occasions, it is not only the prognosis period that is difficult; the way in which the terminal illness develops over a period can be difficult to predict. The discussions will need to continue on an on-going basis.

Paul Sweeney: It is hard to balance risks. There are risks in every aspect of human behaviour and situations are complex and varied.

It is clear that it will be an offence if someone is coerced into making a first or second declaration. Might one influence on a person’s thinking about whether to undertake an assisted death be the lack of provision of alternative medical treatments, such as palliative care? Could the denial of timely treatment act as a coercive influence on a person’s thinking, and might that lead to legal disputes about access to other treatments? Might family members consider the denial of those alternative treatments to be the stimulus that caused a person to undertake an assisted death and might that lead to a criminal case?

Liam McArthur: That takes us back to the issues that Mr Whittle raised earlier. Any discussion of the options exposes them and allows an opportunity to address them. The committee heard from witnesses in Australia that the quality and level of engagement with palliative care has gone up since the introduction of assisted dying, not only because additional investment has gone into that care but because conversations have raised awareness of palliative care and have led to discussion of and active engagement with what those options are and how they might be applied.

As I said in response to your initial question, there is probably no way to prevent an individual from bringing a legal challenge, but the mechanisms in the bill provide a high level of protection against such cases arising. Challenges tend to come from family members who have a difficulty with the decision that their relative has made. Conscientious objection exists in the medical profession and we can put that into the bill, but we cannot put into the bill protections for family members who are implacably opposed to the option and who therefore might have difficulty with a relative opting to go down that route.

Paul Sweeney: People from other jurisdictions, particularly Canada, have mentioned the phenomenon of so-called doctor shopping, when the fact that some clinicians are unwilling to participate nudges someone who is persistent in their desire towards clinicians who would be minded to accept that. If someone were accessing a cohort of clinicians who were minded to support their position, even when other clinicians had concerns, would that create an inevitable risk of coercion?

Liam McArthur: I am minded to reflect on the advice of the chief medical officers from across the UK about those who engage in this debate praying in aid patient experience from other jurisdictions but doing so without the consent of those patients and without necessarily knowing the full facts about what happened.

The bill has pretty robust protections regarding how the request and any assessments will be made. When those eligibility criteria are not met, the process will cease. It would still be possible for any patient who was deemed ineligible to access assisted dying to go to another medic and seek another opinion, but it is not immediately obvious why another medic would automatically come to a different opinion.

We have seen examples in other jurisdictions of what happens to those who are found not to be eligible. That does not stop them making an application, but the safeguards do what they are supposed to do, which is to prevent the patient from accessing the available services. That may be because they do not have capacity or because their terminal illness does not meet the requirements of the legislation. The safeguards in those countries do not stop someone making an application but should prevent them from being able to proceed with it.

We trust our medical professionals to make many life-altering or even life-ending decisions, and we ensure that they have the training to make the decisions that they must make. In this instance, we will require a second medical practitioner to make assessments, too. Ultimately, if the bill were put in place, it would be the most heavily safeguarded end-of-life choice available.

12:15

Paul Sweeney: There are a lot of provisions in section 23 on guidance, and the Scottish ministers would be able to make secondary legislation to set out the detail on a lot of that. Might there be instances around this area when it would be preferable to set out provisions in the bill, rather than relying on ministers to augment the bill through secondary legislation?

Liam McArthur: I definitely have that poacher-turned-gamekeeper feeling at the moment. I have sat where you are on many occasions, Mr Sweeney, and made precisely that argument—usually to Government ministers—about the importance of putting certain things in the bill.

I think that a balance needs to be struck. As I said in answer to earlier questions, I absolutely understand the desire to have as much clarity as possible about how the process would work. I do not think that it is in anybody’s interest to put things in the bill that would require to be changed by primary legislation if emerging evidence suggested that change was needed. That is why, through the explanatory notes and the policy memorandum, I have tried to flesh out the details as best I can. A lot of the detail sits more appropriately in either secondary legislation or, as I said earlier, in guidance, because that would allow the understanding of medicine, which is developing at pace, to be factored into how the bill would operate in practice.

Sandesh Gulhane: I want to turn again to coercion, but to take a slightly different angle. I was concerned by the evidence that was given by Police Scotland about coercion. I will give you an example. Two doctors sign to say that a person can go ahead with the assisted death that they have chosen, and the person goes ahead with it. Later on, a family member, for whatever reason, decides to challenge that and says that there was coercion and other things going on.

The police said that there does not seem to be enough robustness in the process that medics would follow to be able to say that there was no coercion. Despite their best efforts, medics would be liable to be in trouble with the law if it was subsequently found that there was coercion. Is there a way of tightening up the provisions on coercion to deal with that?

Liam McArthur: I was intrigued by that evidence. To some extent, it begs the question whether Police Scotland has the same concerns around double effect, palliative sedation, withdrawal of treatment and other treatments that are legal at the moment. The proposal that is set out in my bill would put in place, as I have said, the most rigorous and robustly regulated end-of-life choice that there is. The assessments around coercion and capacity are as robust as they can be, requiring not just one but two medical practitioners.

In response to the question, I would be interested to know whether Police Scotland has the same concerns in relation to what is legal at present, where there is just as much scope for complaints or legal challenges to be made. In comparison, my proposed system would be far more transparent, with the views of the patient absolutely at the centre and, if there were any concern among the doctors or if there were an onward referral to a specialist, the process would come to a halt. That would provide greater protection not just for the patient but for medics, who, as I said, seem to be put in a fairly invidious position in the choices that they are having to make.

Sandesh Gulhane: Is there scope to have a discussion with Police Scotland in order to create, through secondary legislation, a process that medics could follow? It is important to say that there is a big difference between neglect or someone outright not doing their job properly, and someone doing their best where it is subsequently found that there are issues. Is there scope to discuss with Police Scotland and the Crown Office and Procurator Fiscal Service the creation of a process that is robust enough to defend medics who use the process for assisted dying properly?

Liam McArthur: There is always value in having further conversations, but I think that the bill as it stands provides those protections.

The committee also heard from the Crown Office last week about the expectation that deaths that occur through the assisted dying process would be subject to oversight by the Lord Advocate. I know that the Crown Office was slightly uncomfortable in anticipating the Lord Advocate’s view in that regard, but I think that that would be a reasonable expectation and, again, it would provide a degree of reassurance.

I do not know whether any other colleagues want to come in on that.

Nick Hawthorne (Scottish Parliament): In response to what Sandesh Gulhane said, I point out, in schedules 2 and 3 to the bill, the declarations that medical professionals make and sign, which state:

> "To the best of my knowledge"

the person is

> "making the request to be lawfully provided with assistance to end their own life voluntarily and, in particular, have not been coerced or pressured by any other person into making it."

It is to the best of their knowledge at that point.

My only other point is to refer back to the specific nature of the offence in section 21 of the bill, which talks about a person coercing the

> "terminally ill adult into making a first or second declaration".

I draw the committee's attention to those two points.

The Convener: I have a couple of questions in relation to court involvement. The bill before the UK Parliament makes provision for all assisted dying applications to be considered by the High Court for England and Wales. Court involvement was seen as an additional protection by some of the respondents to this committee's call for views. Was that something that you considered?

Liam McArthur: I did, because I was aware that it had been an aspect of earlier bills that had come before the Westminster Parliament. However, I was not necessarily convinced that I could see what additional safeguard it would put in place.

The balance is always to ensure that the safeguards do what they are intended to do, and do not simply act as an unnecessary obstacle while not providing any protection. In that context, I understand that the committee that is looking at the bill at Westminster is likely to consider an amendment to remove that provision, although it remains to be seen whether that happens.

Again, I note that I drew a bit of reassurance—as I said to Dr Gulhane—from what the Crown Office said to the committee about the Lord Advocate's oversight of deaths and assisted dying. That may offer the sort of reassurance that the public might have expected court oversight to provide.

As I said, it remains to be seen whether that aspect remains a part of the UK bill, but I am not convinced of the arguments for introducing it in Scotland, or that it would add anything other than a delay to the process for those who meet all the eligibility criteria.

The Convener: Several respondents to the consultation on the bill noted that there is no provision for challenging or reviewing decisions that are made by doctors on whether someone's illness meets the definition in the bill of terminal illness, whether they have capacity to make the decision or whether they have been coerced. The Edinburgh Napier University centre for mental health practice, policy and law research submitted that it was

> "concerned at the lack of any accessible mechanism by which the decision of a doctor can be appealed or independently reviewed by the courts."

Again, is that something that you considered? Now that the bill has been under some scrutiny, would you consider amending it in that regard?

Liam McArthur: The fact is that there are two practitioners, acting independently of each other, making the assessment of both terminal illness and capacity, and they will have the option, where it is felt to be necessary, to refer to a specialist in relation to either the terminal illness and/or the person's capacity. Those safeguards go well beyond the safeguards that are in place for many, if not all, other treatments that are available to patients.

Ultimately, whether or not we agree with the choice that an individual makes, if they meet the eligibility criteria, it would be unreasonable to deny them the opportunity to make that choice and activate the provisions that are set out in the bill.

The Convener: Conversely, is it unreasonable for there not to be an appeal process for someone who has perhaps been denied access to assisted dying?

Liam McArthur: I see what you mean—almost the other way round. I suppose that the safeguard is that two medics need to be satisfied that the patient meets the eligibility criteria—that they have an advanced progressive terminal illness and that they have the capacity to make the decision. We have covered the other safeguards. If the patient does not meet those criteria to the satisfaction of both medics, the option to go to another medical practitioner remains open to them, as we discussed earlier. However, it is difficult to see how the patient would satisfy them and a second medical practitioner that they meet the criteria. There is the option for an individual to seek a diagnosis, but medical professionals will make these assessments. If the patient does not meet the criteria, it is important for the patient, the medics and public confidence that the law, as it stands, remains extant. We cannot have situations in which people are being assisted to die in ways other than those that are set out in the bill. The criminal law continues to apply, as we heard from the Crown Office and Police Scotland last week.

Joe FitzPatrick: I will ask about some issues around the financial memorandum. You had an extensive evidence session with the Finance and

Public Administration Committee, so I do not propose to redo that, but I will give you an opportunity to respond to some of the points that that committee has flagged up to us.

The first area that I will speak about has been touched on already, so maybe we do not need to spend too much time on it. You briefly mentioned training time costs, which you suggested would be £200,000 in the first year. The Cabinet Secretary for Health and Social Care says that the Scottish Government believes that training costs for doctors would be something more like £6 million. That is a huge difference.

Liam McArthur: It was an extensive session, but, as the Health, Social Care and Sport Committee is finding, I appear to be party to extensive evidence sessions on this topic.

To some extent, the issue emerged from the modelling that was used to predict the numbers. As I acknowledged to the Finance and Public Administration Committee, we could make an argument that, if rising numbers of people take up the option of assisted death, the associated costs will be higher, but, equally, drawing on the international evidence, we could make an argument that the costs will be lower.

With regard to the training costs, the numbers of people that are likely to be involved in training as a result of take-up are expected to be relatively small because a lot of that training is already taking place. As I said in response to Ms Whitham earlier, assessments of coercion and capacity are already being made. I absolutely acknowledge that there will perhaps be a requirement to update the training that is provided, but we are not talking about something that is wholly new to the medical profession.

To some extent, I am at a slight disadvantage with regard to the Scottish Government's assessment of the costs. I have set out a financial memorandum that shows my working, but I am not clear about how the Scottish Government has developed its figures.

12:30

To go back to the point that was made by Ms Mochan about whether it should be an opt-in or an opt-out service, if it is assumed that everybody—every GP, nurse and consultant—needs to have training to deliver a service, it may well be that the costs will be greater than if an incremental approach is taken.

Again, that probably touches on the question about the implementation period for the bill. What is the expectation for that? What is the trajectory leading up to implementation and then in the initial years?

I think that there was collective agreement at the Finance and Public Administration Committee in relation to the financial memorandum that this was a very wicked problem to try and get your head around. There is not an example of a similar financial memorandum having been put in place in other jurisdictions. It was an exercise in trying to make some reasonable assumptions around take-up and extrapolating them over the first few years and then up to 20 years out.

Joe FitzPatrick: The finance committee has pointed out the happy coincidence, or coincidence, that the process of this bill is taking place while there is a bill going through Westminster, which means that awareness of the issue is perhaps higher than it has been previously. That suggests that the costs might be higher than you have envisaged. I guess that, when you did your calculations, you did not know that the Westminster bill was going to be at the stage that it is.

Liam McArthur: I was ploughing a lonely furrow at that point. The Isle of Man and Jersey have picked up the pace, and we obviously have seen developments at Westminster.

The argument is not an unreasonable one. Some of the issue is about public awareness, but some of it is about the preparedness of the medical profession to deliver assisted dying. Even though the legislation may be implemented, until the medical professionals involved have the training required in order to deliver assisted dying, it may be more difficult to access over those initial stages.

The issue is about awareness, but it is also about a degree of comfort with the process and not only an understanding of it in theory but an understanding of how it works in practice.

In states in Australia that adopted legislation later on, we have seen that numbers were higher in the first two or three years than they were in states such as Victoria, which were the earliest adopters. However, at that early adoption stage, legislation was in place in other jurisdictions, and I am sure that there were fairly extensive public awareness-raising campaigns.

As such, and as we agreed almost unanimously at the finance committee, predicting the numbers is highly problematic. I have set out my best estimates by drawing on the parallels with Oregon and Victoria, which give us the longest data set to try and base comparisons on.

Joe FitzPatrick: You mentioned Oregon and Victoria and how your cost estimates are based on those two systems. Most of us, and anybody who has been watching the evidence, will understand why you did that. However, the finance committee raised the point that it heard evidence that you should have used Canada. I will therefore give you the option of quickly explaining why Oregon and Victoria, and not Canada, are the basis for your estimates.

Liam McArthur: I am highly delighted that you have asked me that question. With regard to the finance committee's letter to you, the thing that confused me a bit was the weight that was attached to the suggestion that Canada would be a more appropriate model. The point was certainly raised by one or two of those who gave evidence, but even cursory scrutiny of the different models in place in Canada, as compared to those in Oregon and Victoria, would give you a pretty definitive answer as to why Oregon and Victoria were used.

I used both of those places because they used the terminal illness and mental capacity model, which was adopted in Oregon in 1996-97 and then more recently in Victoria, as the first of the Australian states. That means that we have probably the largest data sets on who is accessing the choice—and when, how, and so on—and we do not have to rely on an understanding of other demographic factors, or on whatever may be at play in the US, but not in Australia. Therefore, I think that it was a good comparator. No two assisted dying laws anywhere in the world are the same, but those two laws reflected the models that are most closely aligned to the bill that I have introduced and they give us the largest data set.

The eligibility criteria in Canada are far more extensive than the eligibility criteria in my bill, so it is difficult to see why you would use that as a model to understand who would access assisted dying and how, were it to be introduced in this country. I was slightly confused—not by the fact that that has been raised by witnesses but by the fact that the finance committee appeared to attach more weight to it than I think was justified.

Joe FitzPatrick: Thank you. Those were the main questions that I had in relation to the letter.

The Convener: I have a point for clarification. I asked the cabinet secretary to clarify this last week, when he spoke about figures of just over £6 million on the basis of training 50 per cent of doctors, taking into account those who might wish to opt out of the scheme. Your figures are based purely on medical staff. They do not take into account pharmacy or nursing staff or any other allied health professional.

Liam McArthur: I am pretty sure that the figures are based on just medical staff, but I will ask Nick Hawthorne to answer that.

Nick Hawthorne: I will refer directly to the financial memorandum. In paragraph 65, we say that the

"training required will be for NHS Scotland to determine",

but that it is anticipated that this could involve online training. The financial memorandum also makes reference to registered medical practitioners "such as pharmacists", so some account was taken of other staff. That was not done to the full extent that you outlined, but it certainly included pharmacists.

The Convener: Okay, but the financial memorandum did not include any other profession that might be involved in the care of someone who was accessing assisted dying.

Nick Hawthorne: No.

Liam McArthur: No. As I said, the model was built on the assessment of take-up and the associated costs. I understand that the Scottish Government has taken a different approach to the modelling, which probably inevitably results in a far higher cost. However, as I said to the finance committee, the approach that we took to the financial memorandum was a reasonable attempt to assess those costs. I think that the finance committee also applied a degree of pressure on me to estimate the savings that would be made. As I said to that committee, that would be an even more precarious assessment to make, given that that would depend very much on who was accessing assisted dying and the point in their terminal illness at which they accessed it.

I think that it is a reasonable estimate of the financial costs, and I point to the fact that, broadly, the measure would be cost neutral, recognising that those who would access assisted dying are in receipt of treatment and care at the moment.

The Convener: In view of the letter from the finance committee and its determinations, what the Scottish Government has put on record and the omissions that you have alluded to today in relation to your financial memorandum, will you be looking to review your financial memorandum?

Liam McArthur: I do not think so. It is difficult to know on what basis I would try to develop a different approach to the financial memorandum. Earlier, we discussed whether it would be an opt-in or an opt-out model, which I can see having a sizeable bearing on the costs. However, on the basis of assessing the likely take-up and the associated costs, recognising that we are talking about patients who are going to be in the health system already, we are talking about a lot of the training being training that is already routinely delivered. It might need to be adapted, but it is certainly not a case of a standing start. It is also fair to say that there will be training models and modules that are available in other jurisdictions that would help to inform the training.

You cannot have a lift-and-shift approach, because the health and care system here is very different from those in Australia and the US, but at least they provides pointers to how you would deliver this. As I have said, I think that the financial memorandum remains a reasonable assessment of the likely costs.

Emma Harper: I have a final question. Are the two independent doctors allowed to confer with each other? I do not know whether the bill makes that explicit. Could they be a doctor at the hospital and a doctor in the GP practice, or could they be two GPs in the same practice? What makes them independent? Are they not allowed to confer with each other during the process?

Liam McArthur: In response to your question about the doctors being two GPs in the same practice, that would not be permitted. The doctors need to act independently of each other, and one of them must have had no prior relationship with the patient themselves. The second doctor will have the medical notes, but they will carry out their assessment of terminal illness and mental capacity.

Dr Ward, did you want to add anything?

Dr Ward: Just that section 6 sets out in detail the relationship in that respect. Scottish ministers will be responsible for some regulations, but I think that the bill sets out pretty straightforwardly what the doctors can and cannot do in relation to the assessment under sections 6 and 7.

Emma Harper: That is fine—thank you.

Liam McArthur: Was that okay?

Emma Harper: I just wanted to clarify that.

The Convener: I thank Mr McArthur for his extensive evidence. I know that it has taken quite a substantial amount of time—more than we had anticipated—but the committee has certainly been able to ask the questions that were presented as a result of previous evidence.

I thank you and your witnesses, Mr McArthur. That concludes the public part of today's meeting.

12:41

Meeting continued in private until 13:05.

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