OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 11 November 2025

The Scottish Parliament
Pàrlamaid na h-Alba

Session 6

Tuesday 11 November 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

30th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeremy Balfour (Lothian) (Ind)
Miles Briggs (Lothian) (Con)
Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Jackie Dunbar (Aberdeen Donside) (SNP) (Committee Substitute)
Pam Duncan-Glancy (Glasgow) (Lab)
Ross Greer (West Scotland) (Green)
Daniel Johnson (Edinburgh Southern) (Lab)
Fulton MacGregor (Coatbridge and Chryston) (SNP)
Liam McArthur (Orkney Islands) (LD)
Stuart McMillan (Greenock and Inverclyde) (SNP)
Sue Webber (Lothian) (Con)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 11 November 2025

[The Convener opened the meeting at 08:30]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 30th meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance and Carol Mochan. Jackie Dunbar, who is joining us as a substitute, wishes to make a comment.

Jackie Dunbar (Aberdeen Donside) (SNP): Thank you for letting me say a few words, convener. I would just like to tell the committee that, although I was not at last week's meeting, I have listened to the whole proceedings. I am therefore not coming in cold, so to speak, and I feel able to take part in today's session.

The Convener: Thank you, Ms Dunbar.

Agenda item 1 is for the committee to decide whether to take item 2 in private. Do members agree to take that item in private?

Members *indicated agreement.*

The Convener: We will move into private session to consider item 2.

08:31

Meeting continued in private.

08:45

Meeting continued in public.

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

The Convener: Our third agenda item is day 2 of stage 2 proceedings on the Assisted Dying for Terminally Ill Adults (Scotland) Bill. I welcome to the meeting Liam McArthur, who is the member in charge of the bill, and a number of other members who have lodged amendments.

Today, we will not go beyond the debate on amendment 242, which is in the group on advocacy services. That means that no amendments beyond amendment 243 in the marshalled list will be called.

I intend to suspend the meeting shortly before 11 am to enable members and staff to participate in the act of remembrance in the Parliament's garden lobby.

Amendment 65, in the name of Liam McArthur, is grouped with amendments 224, 66, 49, 225, 67, 230, 68, 155, 34, 34A, 34B, 70, 35, 35A, 35B, 71, 71A, 196, 254, 255, 270, 46, 46A, 47, 47A, 48 and 72. I point out that amendment 47 is pre-empted by amendment 59, which is to be debated in the group entitled "Assessments of the terminally ill adult".

Liam McArthur (Orkney Islands) (LD): Good morning. I start with a declaration of interests and remind the committee that I receive support from three separate campaign organisations—Dignity in Dying, Friends at the End and the Humanist Society Scotland—that have helped in supporting the costs of a website during the consultation on my bill and of a staff member who works on the bill.

As I did last week, I will start with my amendments before moving on to the considerable number of other amendments in the group.

My amendment 65 seeks to allow the Scottish ministers to regulate any training that the co-ordinating registered medical practitioner, the independent registered medical practitioner and the authorised health professional must have completed in order to carry out their roles under the bill. I made clear throughout stage 1 that training will be required for those health professionals who are directly involved in the assisted dying process. A specific requirement for training was not included in the bill because I believe that the profession is best placed to devise, develop and roll out the training that it considers most appropriate and that training does not require to be mandated in the bill. Further, the bill already sets out qualifications and experience requirements for medical professionals, which I am seeking to extend to authorised health professionals. It is also worth acknowledging that the Health and Care (Staffing) (Scotland) Act 2019 already places a duty on health boards and the Scottish health service to ensure that staff are suitably trained.

However, after further reflection ahead of stage 2, I have lodged amendments 65, 67, 34A, 35A, 35B, 46A and 47A to add the provision of training to the existing regulating powers that the bill confers on the Scottish ministers with regard to the qualifications and experience that the co-ordinating registered medical practitioner, the independent registered medical practitioner and, if my amendments 34 and 35 are agreed to, authorised health professionals should have. That would allow the Scottish ministers, after consultation with relevant partners, to regulate the training, qualifications and experience that those health professionals must have in order to participate in any assisted dying scheme.

Amendment 65 therefore seeks to add training to the matters that the Scottish ministers may make regulations on, in addition to the qualifications and experience that are required to take on the role of co-ordinating registered medical practitioner. Amendment 67 seeks to do likewise for the role of independent registered medical practitioner, and amendment 34A seeks to do the same for the role of authorised health professional by adding the word “training” to my amendment 34, which seeks to allow the Scottish ministers to make regulations setting out the qualifications and experience that a registered medical practitioner or a registered nurse should have in order to take on the role of authorised health professional.

Amendments 35A and 35B are consequential. They seek to add the word “training” to amendment 35, which requires regulations that are made under amendment 34 regarding the authorised health professional to be consulted on before they are laid or made.

Amendments 46A and 47A are consequential. They seek to add the word “training” to amendments 46 and 47, which require first sets of regulations to be subject to the affirmative procedure and subsequent regulations to be subject to the negative procedure.

Amendment 48, which is also consequential, clarifies which regulations under section 15(8) are which, as there are two regulation-making powers in that subsection.

I note that amendment 47 would be pre-empted by amendment 59, which we will come to in a later group.

Paul Sweeney’s amendment 34B seeks to amend my amendment 34 to change the word “may” to “must” and require the Scottish ministers to make regulations. That links to certain other amendments in the group, which I now turn to. Although I have always considered those who work in healthcare to be best placed to determine training factors and I therefore want to allow some flexibility as to whether that is determined by Government regulation, I am open to amendments 34B, 224 and 230, which would make it a requirement for such regulations to be introduced.

I note that the Government suggests that amendment 34 might be defective, so Mr Sweeney might wish not to move it at this point, pending further discussions with the Government ahead of stage 3.

Ms Duncan-Glancy’s amendment 225, in relation to the co-ordinating registered medical practitioner, sets out that Scottish ministers

> “must, in particular, specify training or qualifications related to”

a range of matters, namely:

> “knowledge of palliative care and alternative care options to providing terminally ill adults assistance to end their own lives ... understanding of independent living, in accordance with article 19 of the UN Convention on the Rights of Persons with Disabilities ... awareness and identification of coercion, pressure or undue influence”

and

> “equality and non-discrimination principles, with specific reference to the rights and experiences of persons with ... disabilities ... terminal illness, or ... socio-economic disadvantage.”

I note that that provision would extend only to the co-ordinating registered medical practitioner and not to the independent registered practitioner.

Again, I am of the view that those who work in healthcare are best placed to determine what training would be required and most useful. I agree with Ms Duncan-Glancy on the importance of doctors being appropriately trained on all relevant issues, including in areas such as palliative care and the rights of disabled people, but I do not consider that that sort of detail would be appropriate in the bill.

Pam Duncan-Glancy (Glasgow) (Lab): If a similar amendment was brought back at stage 3 and it included the co-ordinating practitioner and the independent practitioner, would the member support it?

Liam McArthur: There is an issue with the amendment not referring to both roles. However, my principal concern is about how appropriate it would be to put that level of detail in the bill, as opposed to requiring through guidance that those aspects be incorporated into training to ensure that those who participate in the process are aware of the issues that Pam Duncan-Glancy has quite rightly raised.

Pam Duncan-Glancy: I understand the concerns around that. However, most of those things are very important. The member will know that, if something is not in legislation, it becomes very much at the discretion of the co-ordinating bodies. When resources are tight, some of those things might not be supported or funded. Does the member agree that it is crucial to set out in the bill any aspect of what the amendment seeks to do, in order to protect against it being ruled out because a body does not have enough money to provide the training?

Liam McArthur: The issues that are highlighted in the amendment are extremely important and they will be crucial in relation to the assessments that are made of particular individuals, not across the board. Again, one needs to take into account whether that would be more appropriately set out in the bill or best left to secondary legislation or guidance. I believe that those issues are better reflected in guidance. I do not think that it is a resource issue; it is about ensuring that the profession is able to have input to the way in which training is designed and taken forward.

I turn to Jackie Baillie's amendments 66, 68, 70, 71A and 72. I ask for those amendments not to be moved. I have spoken to my amendments on training, and I ask members to support those instead. My amendments seek to allow Scottish ministers to regulate for training, in addition to qualifications and experience, that is relevant to the co-ordinating registered medical practitioner, the independent registered medical practitioner and the authorised health professional, and they would require all regulations to be consulted on.

Jackie Baillie's amendment 49 would require any regulations made in relation to the qualifications and experience that the co-ordinating practitioner should have to include minimum training standards and qualifications and experience that are required specifically to deal with a person aged between 18 and 24 or a person with a fluctuating illness and/or an unpredictable prognosis. The amendment would also require Scottish ministers to review the regulations in relation to qualifications and experience, but not training, from time to time.

I am sympathetic to the amendment, not least due to my engagement with Children's Hospices Across Scotland over the past few years, but I draw members' attention to my amendments on training. They will allow ministers to set out what training, as well as what qualifications and experience, a person must have to be the co-ordinating practitioner, independent registered medical practitioner or authorised health professional.

I note that, as Jackie Baillie's amendment stands, the co-ordinating registered medical practitioner would be subject to the requirement, but not the independent registered medical practitioner. I also note that the part of the amendment in relation to minimum training standards that are required may overlap with Jackie Baillie's amendments 66 and 71, which also provide for the co-ordinating practitioner to have completed training to be specified by ministers in regulations.

In relation to the part of the amendment that relates to specific qualifications and experience that would be required in relation to those aged under 25, I note that the regulation-making powers in the bill will allow ministers to specify that if it is felt necessary. The bill requires ministers to consult relevant persons ahead of laying any such regulations in order to ensure that what medical professionals consider necessary is properly reflected. That is the case in the amendment, which is concerned with specific training and experience in relation to diseases, illnesses or conditions of a fluctuating nature and with unpredictable prognoses.

On that basis, I ask for amendment 49 not to be moved and I ask Jackie Baillie to consider how the bill as amended stands after stage 2. As ever, I am happy to work with her ahead of stage 3 on any further aspects that may need to be addressed.

I turn to Mr Whittle's amendment 155. Section 6(6) of the bill sets out the circumstances in which an independent registered medical practitioner may carry out an assessment under section 6(3). Amendment 155 seeks to add the requirements that the independent registered medical practitioner must not have consulted the co-ordinating registered medical practitioner on the case, have been provided with access to any notes prepared by the co-ordinating practitioner on their assessment, or have been provided with any other notes prepared by the co-ordinating registered medical practitioner since the date of the first declaration.

With regard to maintaining the independence of the two doctors, I believe that steps would be taken to ensure that as a matter of existing practice. Again, I believe that consistency in the principles and approach with other areas of medicine is important. However, I am open to further discussion with Mr Whittle on that.

I consider Mr Whittle's amendment 196 and Paul Sweeney's amendments 254, 255 and 270 to be unnecessary, due to the amendments that I have lodged on training.

I look forward to hearing members' comments and I will respond to them if appropriate.

I move amendment 65.

Paul Sweeney (Glasgow) (Lab): In this group, I will address two sets of amendments—three of the amendments deal with capacity, and two deal with practicalities. I will therefore address them in their two sections.

In relation to the capacity amendments, which are amendments 224, 230 and 34B, I note that assessing capacity is an extremely complex task that requires specific expertise and careful judgment. That is one of the reasons why the Medical and Dental Defence Union Scotland has recommended the creation of a multidisciplinary panel. It also means that we need to be clear about who is qualified to make those assessments in the first place.

Amendments 224, 230 and 34B would legally require, rather than simply allow, the Scottish ministers to set out by regulation the qualifications and experience that are needed for doctors taking part in the assisted dying processes. That would ensure that only appropriately trained and experienced practitioners were involved, strengthening the safeguards for both patients who seek to access the service and participating clinicians.

The amendments are about giving clinicians the tools and confidence that they need to carry out their duties responsibly, and ensuring that patients receive careful assessment. Amendments 224 and 230 therefore propose to leave out “may” and insert “must”, which would strengthen the language.

I note Mr McArthur’s comments on his amendment 34 and I am happy to rest on those at this stage, depending on further discussions.

Turning to practicalities, my amendments 254 and 255 seek to strengthen the practical framework for administering assisted dying safely and responsibly. The amendments would require the Scottish ministers to provide proper training for doctors. That would guarantee a high standard of care, creating a better working environment for medical staff and reassurance for patients. Together, those measures would ensure safety and consistency during the most sensitive stage of any assisted dying process.

09:00

The Convener: I call Daniel Johnson to speak on behalf of Jackie Baillie to amendment 66 and other amendments in the group.

Daniel Johnson (Edinburgh Southern) (Lab): I will be speaking to a number of Jackie Baillie’s amendments today, and I ask members to bear with me as they hear more than they might have expected to hear from me.

At last week’s meeting, we heard the concern that, although we can examine what is in the bill, what will be enacted and put into effect will be a matter of practice and of professional conduct. That is why training is so important both to how the bill operates at the start, should it be passed by Parliament, and to how it continues to operate as it evolves over time. It is important to ensure that the bill makes adequate provision both for the training that will be required by the professionals we will ask to make the most sensitive of judgments, and, critically, for the oversight of that training.

Sandesh Gulhane (Glasgow) (Con): I declare my interest as a practising general practitioner in the national health service.

It will be for the medical profession to deal with implementing the bill and actually doing the work, which is the same as with many other aspects of medical training. As a GP, I have a professional responsibility to keep myself up to date; medicine changes every 10 years, and everything that doctors learn at medical school becomes almost useless after they qualify. Given that, would it be better to allow the professionals to decide what training they need as part of a process that must evolve, because things change, rather than having MSPs making absolute decisions that they are not qualified to make?

Daniel Johnson: Those points are well made, but we must be clear about what amendment 66 would do and, critically, where it comes from. Jackie Baillie’s amendments were drafted in conjunction with the British Medical Association and other professional bodies, so it is not MSPs who are asking for this but the profession itself, because doctors are concerned about the very points that I am setting out. Furthermore, amendment 71 states plainly that the regulations “must” be made in consultation

“with trade unions and professional bodies”.

Such matters are always about balance, but the medical profession and medical practice are highly regulated. It is not true that the law has nothing to say about medical practice or that it does not set out standards, review periods and expectations about training, because it does. Amendment 71 would require ministers to put in place regulations that set out training requirements and professional standards, which would be kept under review.

Amendments 66, 68, 70 and 72 are largely consequential. In addition to the medical and clinical considerations, amendment 71A sets out the need to consider domestic abuse. There has been a great deal of concern about the possibility of individuals facing undue pressure or coercion by third parties. Amendment 71A was drafted in consultation with Dr Anni Donaldson, an academic who is an expert on domestic abuse. It is important that any such training takes account of the dynamics of how domestic abuse can take place, how to respond effectively when that may be in play, and how treatment can be offered in such circumstances.

Amendment 49 was drafted in consultation with CHAS, which Liam McArthur referred to. Although CHAS operates in Jackie Baillie's constituency, its office is in my constituency. I do not know whether that is a declaration of interest, but there is certainly an overlap.

It is true to say that the way in which terminal illnesses manifest in young people can be substantially different in how patients are treated and the nature of those illnesses. Understanding the prognoses requires a great deal of attention.

It is right that we think about how the provisions in the bill might extend to younger people—they will find themselves in a very different set of circumstances from the bulk of the people who we think of as being in this cohort, who will be substantially older. Amendment 49 therefore seeks to add specific training requirements for those who will consult young adults and younger people and assess the degree to which the illness is terminal, advanced and progressive. The amendment would require additional qualifications and understandings on that.

Pam Duncan-Glancy: Amendment 225 would make provision about training for medical practitioners who are providing assistance. It specifies that medical practitioners must undertake training or have qualifications that are

> "related to ... knowledge of palliative care and alternative care options to providing terminally ill adults assistance to end their own lives ... understanding of independent living, in accordance with article 19 of the UN Convention on the Rights of Persons with Disabilities ... awareness and identification of coercion, pressure or undue influence"

and

> "equality and non-discrimination principles, with specific reference to the rights and experiences of"

disabled people, terminal illness and socioeconomic disadvantage.

My amendments in the group are crucial to the bill because they would safeguard against the concerns that have been raised by many people, including some disabled people, that not having adequate information and support on the right to practical assistance to lead an ordinary life through things that support independent living can have a huge impact on their lives. It can mean that disabled people feel that they are a burden and that they do not have their care needs met. It can mean that they are frightened of what life could be like should they lose a particular function. In fact, when you meet other disabled people or understand what your rights are and what you should be able to expect, life can sometimes appear to be a lot more tolerable. It is crucial that people who are supporting people to carry out assisted suicide give that support and create that awareness in order to help people understand what their other options are.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): Ms Duncan-Glancy is making a powerful case. Better training for the practitioner who takes someone who is seeking assisted dying through the process is, of course, to be welcomed, but that would not be in place of, say, a social work referral or a palliative care referral, when that is deemed to be required. I ask for clarity on that. Would both be required, or just the provisions that you are setting out?

Pam Duncan-Glancy: Both would be required. There are amendments in later groups—including amendments in my name and, I think, in the member's name—that would cover that. Amendments that we have previously discussed would also have encouraged such assessments, which are absolutely essential to safeguarding people throughout the process.

As committee members and others have noted, the point about identifying coercion is that coercion is a difficult concept to appreciate fully. From previous work that the Parliament has done on coercion, particularly in relation to gender-based violence and domestic abuse, it is clear that a specific, nuanced approach is required, so that people can understand the experience of each individual. In this matter, it is also important to understand the effect of societal pressures that can be considered to be coercive. Through time, the internalised ableism that I have mentioned in the past and which I spoke about in the stage 1 debate can begin to infiltrate into disabled people's minds and lives, including people who are seeking assistance under the bill. Those areas are really important.

We know that training on the UNCRPD, on disability equality and on what is available to support disabled people to enjoy their lives in the same way as others, with freedom, choice, dignity and control, is hugely undervalued and not often provided, especially in financially constrained situations. That is important, which is why I have asked that it be included in the bill.

We are discussing not just aspects of independent living such as self-directed support, which is a right under the Social Care (Self-directed Support) (Scotland) Act 2013, but whether somebody will be assisted to die. Everybody around individuals needs to fully understand what resources are available to support disabled people in those contexts.

Sandesh Gulhane: I want everyone to live their best life. I want people with disabilities to live their best life. Your amendments seek to get people with disabilities in front of social workers, but would this be the right point to do that? Should we not be getting people with disabilities to social workers a lot earlier than in the final moments of their life? That would help everyone and not just those who are right at the end.

Pam Duncan-Glancy: The member is right, which is why we should be legislating to make it easier to choose to live than to choose to die. We have a bill in front of us that is not necessarily doing that.

Our constituents face significant barriers in accessing social work assessments, and some are waiting a considerable time for assessment. It is really important that social work assessments to support disabled people to live independently are provided in a timely fashion and backed up with the resources to meet their needs, as assessed. Amendment 225 would not specifically require a referral to social work, but such referrals should be happening. That is a separate issue from what my amendment requires, which is that people should be trained in and understand the law around social work access. The member is right to say that that is important but, as the Royal College of General Practitioners Scotland has pointed out, many professionals are doing a whole host of activities in their current role, and adding to that will require them to understand what responsibilities that includes, which should include the ones that are set out in my amendment 225.

Amendment 270 would establish an assisted dying training authority to develop and oversee mandatory training and accreditation for medical practitioners who were involved. The proposed ADTA would ensure that practitioners were trained in palliative care alternatives, in recognising coercion or undue influence, and in equality and non-discrimination principles. Only accredited practitioners could participate in the assisted dying procedure, which would ensure consistent standards, ethical awareness and public confidence.

Assisted suicide is irreversible—once it is carried out, it cannot be undone. That means that every decision to end a life must be made with complete information and with the confidence that those who are overseeing the process are fully competent in doing so and have all options available to them to explain to the person who is seeking access.

However, the bill does not currently require mandatory training for medical practitioners who are involved. There are amendments on regulation, including amendments in the name of Liam McArthur, but not on the detail. The detail is what matters in legislation such as this. There is no guarantee that individuals will be adequately equipped to detect coercion, undue influence or vulnerability, and there is no assurance that equality, non-discrimination and patients' rights will be consistently respected. That is not a minor oversight—it is a profound gap in safeguards at the heart of a system that literally involves life and death.

Amendment 270 attempts to close that gap, uphold ethical standards and maintain public confidence in the process by ensuring consistency, professional competence and moral awareness at every step in the system. If the state decides to legalise assisted suicide, it has a duty to protect the most vulnerable from error, pressure and inadequate care. Amendment 270 would enshrine that duty in law and ensure that decisions about life and death were made responsibly, ethically and transparently.

09:15

Brian Whittle (South Scotland) (Con): I welcome Liam McArthur's offer to engage in developing amendments. I restate that I am undecided about my position at stage 3. In considering all amendments, I will be seeking to make the bill the best piece of legislation that it can be.

I will speak to amendments 155 and 196. In relation to amendment 196, the concern is that the care of patients who seek assisted dying will extend beyond the authorised health professional roles that the bill specifies. All healthcare professionals who provide care to a patient who seeks assisted dying should have adequate training. Amendment 196 recognises that the relationship with healthcare professionals who look after patients may alter when a patient decides that they will take the route of assisted dying. We have not considered that, which is why I lodged the amendment. It provides for the Scottish Government to bring forward training on the legislation for healthcare professionals. As I said, it is key that those who care for people towards the end of their life are able to understand the decision that is made by a patient and maintain that relationship.

The concern behind amendment 155 is that medical professionals' opinions must be truly independent of each other. Amendment 155 would limit access to notes by the independent practitioner. Except for seeing the referral, the independent practitioner would not be able to consult the co-ordinating medical practitioner on the case, and, from the point at which the first declaration was made, they would not have access to the notes by the co-ordinating medical practitioner, including that practitioner's assessment.

I listened to what Liam McArthur had to say, but my concern is that the position needs to be absolutely clear and has to be in the bill. Once a patient has declared their intention to seek assisted dying, there must be no co-ordination between the two assessing practitioners. That is why I lodged amendment 155. It is important that both medical professionals are truly independent of each other.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): I am wondering about the potential for there to be a lot of missing context should the second medical practitioner not have access to the original notes. Would that be a concern when it comes to fullness of information?

Brian Whittle: For absolute clarity, up to the point of a declaration that the patient wished to seek assisted dying, all the notes would be readily available. Once the assessment was to be made after the declaration, however, I think that it would be absolutely crucial that both medical practitioners were independent, because they both have to come to the same conclusion for assisted dying to be granted. To make that absolutely independent is crucial.

The Convener: I have concerns about what Brian Whittle is proposing, given that, after the first declaration, there might be a change in a patient's clinical circumstances—for better or worse. If the second medical practitioner was not able to access those notes, they would be basing a clinical judgment on historical information as opposed to current medical information. Does he see that that could, potentially, cause an issue?

Brian Whittle: My overriding concern is that, if we are asking two independent medical practitioners to make a consideration, they must be able to come to the same conclusion independently of each other. One cannot influence the other. That is absolutely crucial to the bill.

Sandesh Gulhane: I, too, want to focus on the notes aspect. I have a couple of questions. First, are you saying that only the notes of the first person who has made their assessment should not be made available to the second person, as opposed to all the notes?

Secondly, people have a right to a second opinion in healthcare in general, following things such as complaints. When I am speaking to the patient, having the other person's notes in front of me gives me a bit of context.

Moreover, if the patient says something completely different from what has been written by somebody else previously, that is an alarm bell for me. It makes me think, "Hang on a second—something is not quite right." Given my position when working as a doctor, I would hope that I am able to act independently when I am asked to act independently and that I would not be unduly put into a position by somebody else. Having those notes really helps.

Brian Whittle: I thank Sandesh Gulhane for his intervention. As it comes from the perspective of a medical professional, it is really helpful. To clarify, my response to his first point is that it would be the notes on the assessment of the person's right to seek assisted suicide; the amendment is not about access to all the notes.

Sandesh Gulhane made the point that a person might say something completely different to one medical practitioner from what they said to another; in that circumstance, you would surely come to a different conclusion. That is the protection that we must have; if we are going to have two independent medical practitioners making the assessment, they have to be truly independent and they both have to come to the same conclusion independently of each other. That is why I lodged amendment 155.

Liam McArthur: I thank all colleagues for their contributions. To touch on the points that Brian Whittle has just made, I certainly understand his intent. However, for reasons that other colleagues have flagged up, I think that, as currently drafted, amendments 155 and 196 are perhaps problematic. I reiterate the offer to work with Brian Whittle ahead of stage 3, but I also point to the General Medical Council guidance, which already sets out strict provisions in relation to undue influence of one practitioner over another. It is an area on which I am happy to work with Mr Whittle ahead of stage 3.

The exchanges so far this morning have underscored the crucial importance of training. I note, with perhaps a little regret, that I did not foresee that and put it in the bill in the first instance. The debate has highlighted the importance of such training to specific groups, whether that be people in the disability community, as Pam Duncan-Glancy referred to, or people under 25, as Daniel Johnson referred to on behalf of Jackie Baillie, as well as specific training and understanding in areas such as palliative care and coercive controlling behaviour.

In a sense, the Parliament has had an opportunity to set out its expectations on what the training would involve. For the reasons that Sandesh Gulhane underlined, there are risks in putting such provisions in the bill instead of allowing them to rest in secondary legislation or, more likely, in guidance, which is where such provisions sit at the moment.

Daniel Johnson: I am grateful for your reflections on those points. Do you acknowledge that the amendments that have come from the professional bodies themselves reflect a need or desire from the professions that we strike a slightly different balance as to where not just training but qualifications sit and how they are reviewed?

Liam McArthur: I take that point entirely. Those representations have facilitated the debate around the issues that need to be picked up in training. However, I question whether we should take a different approach to where the detail sits in relation to this bill compared to where it sits in relation to other pieces of legislation that we pass. I get that this bill is perhaps seen as more significant than some other pieces of legislation, but I would caution against taking a different approach in relation to this from the approach that we take to other clinical practice. That would only open up scope for confusion and misunderstanding—indeed, it would undermine the safeguards. I think that, irrespective of where we stand on the bill, we are all determined to ensure that the safeguards are as robust as possible.

Sandesh Gulhane: I just want to clarify that the law does not give ministers, either at Westminster or here, powers over postgraduate training. That is deferred to the GMC and its regulations on training. As Daniel Johnson has said, it is very important that training and other guidance be discussed with registered bodies, including the GMC. We should ensure that there is uniformity to postgraduate training and education, and we should give experts the ability to develop the training.

Liam McArthur: I thank Sandesh Gulhane for making that point and I agree with him.

I welcome Bob Doris's intervention, because he shone a light on the interplay between the requirements for training and the necessary option that is available to those who are involved, whether they are the co-ordinating registered medical professional or the independent registered medical professional, to make referrals to specialists that are in palliative care or social work and social care. It is perhaps unreasonable to expect everybody to be an expert in everything, so referrals to those who have the relevant expertise will be important. The training needs to pick up much of what we have discussed but, alongside that, there is the absolute expectation that specialist referrals will be made when required and that the advice that is provided thereafter will be taken on board by the co-ordinating medical professional.

Elena Whitham: I have a lot of sympathy with Jackie Baillie's amendments, not least those related to domestic abuse, given that I used to work for Scottish Women's Aid. However, do you think that stating in the bill that the training needs to be done in person will prove problematic for individuals accessing such training across the country, given our geography?

Liam McArthur: That is a helpful issue to raise, and that is why we need the training requirement to be developed by those who are operating in the area. There will be areas where face-to-face engagement is crucial and areas where it will not be felt to be essential. Ultimately, we need to ensure that the professionals who have the relevant expertise inform the way in which guidance will be taken forward.

The amendments in this group, which have a great deal of overlap for wholly understandable reasons, have facilitated a useful debate, if not about what will be in the bill then, certainly, about what the Parliament should expect in subsequent elements of the process. I press amendment 65.

Amendment 65 agreed to.

Amendment 224 moved—[Paul Sweeney]—and agreed to.

Amendment 66 moved—[Daniel Johnson].

The Convener: The question is, that amendment 66 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Sweeney, Paul (Glasgow) (Lab)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Whittle, Brian (South Scotland) (Con)

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

Amendment 66 disagreed to.

The Convener: Amendment 151, in the name of Miles Briggs, is grouped with amendments 27, 154, 74, 186, 39, 190, 40, 11, 248, 41, 191, 192, 16, 20, 52, 193, 194, 249, 80, 81, 198, 60, 211, 82 and 213. I draw members' attention to the information on pre-emptions as set out in the groupings.

Miles Briggs (Lothian) (Con): Good morning, colleagues. Amendments 151, 154, 186, 198 and 213 would establish an opt-in model of participation for healthcare staff. The proposal for those amendments comes from a number of organisations that represent healthcare professionals who are associated with carrying out the functions in the bill. All those organisations are neutral, in principle, on introducing legislation on assisted dying, but they want to ensure that any legislation that is introduced protects the needs of healthcare professionals who choose or choose not to provide assisted dying to their patients. If assisted dying were to be introduced by the bill, that would be a significant change for healthcare professionals. Therefore, it is vital that they are given a genuine choice as to whether to participate and to what extent.

The amendments would allow only those individuals who have registered that they are willing to carry out functions under the legislation to take on the roles of co-ordinating doctor, independent doctor, authorised health professional or pharmacist responsible for supplying an approved substance for use under section 15 of the bill. Amendment 198 would establish a register of willing individuals for that purpose.

09:30

In its stage 1 report, the committee called for further exploration of an opt-in system at stage 2 and recognised that a number of stakeholders were in favour of such a system. The BMA firmly believes that only those individuals who positively choose to provide the service should be able to do so, and has long called for an opt-in system for healthcare professionals, should the law change. That has been accepted in other parts of the United Kingdom and Crown dependencies in all current legislation making its way through those jurisdictions. In Jersey and the Isle of Man, doctors and nurses register their intent to provide the service. Under the Westminster bill, doctors and nurses opt into the required training.

The preferred model would be a register, as it would have the added advantage of making it easier for health professionals to direct a patient to a doctor who would fulfil the role of co-ordinating registered medical practitioner. It would also make it easier for the co-ordinating medical practitioner to identify someone to fulfil the role of independent registered medical practitioner and, if required, an authorised health professional. A register would also allow health boards to accurately map the staff who are available locally and nationally to provide assisted dying.

I welcome the fact that Liam McArthur recently agreed that the bill should be based on an opt-in system. However, I believe that that must be made explicit in the bill in order to give health professionals across our country the reassurance that they need.

It is important that we recognise the psychological difference between assisted dying being something that all health professionals could be expected to participate in versus it being expected only of those who have positively chosen to opt in. Some of the benefits of establishing an opt-in model are that it would give a greater degree of choice about participation, protect against any expectation or pressure to do training and participate, and ensure that staff who participate receive the appropriate training and are deemed competent to carry out all roles.

Brian Whittle: Whether the decision is to opt out or opt in, our medical professionals will have patients who move from not being in a position to seek assisted dying to one in which they are. Would it not be responsible to have assisted dying training across the whole of the medical profession, given that, even though they might not want to participate in helping somebody with assisted dying, medical professionals will have care responsibilities for such patients?

Miles Briggs: If the bill passes, it will be acknowledged by all healthcare professionals. The important choice for people whether to take part is what I am trying to introduce with this opt-in. I am sure that, as Sandesh Gulhane outlined, this will become part of a training conversation. However, on whether staff want to be part of delivering assisted dying in our NHS, the point at which someone starts their career is where the opt-in model would be best placed. That would answer a lot of questions that medical professionals are raising with all of us in relation to whether, in the course of their careers, they will have a patient who requests assisted dying of them and how they will be able to deliver on that patient’s wishes. I therefore urge the committee to vote for the establishment of an opt-in system in the bill to provide that assurance.

Sandesh Gulhane: On a technical point, the GMC holds separate lists for registered general practitioners, consultants and so on. Are you proposing that the GMC would create lists for people who are opting in to be the registered medical practitioners specifically, rather than making proposals in relation to care responsibilities or anything else? Are you talking about something that specific?

Miles Briggs: I will come to amendment 194 in a second, but, with regard to how we would ensure the provision and updating of training, a single opt-in register makes sense. I am open with regard to where the register would sit. Given the professionals with different responsibilities in this area, it would be sensible, at stage 3, to look at how the register could best be taken forward by the professional bodies.

Jackie Dunbar: For clarity, you said that the option to opt in would be offered at the beginning of someone's medical training. Do you foresee having an opt-out option, if someone changed their mind as their training went on and they had experience of dealing with day-to-day situations? Whether someone has opted out or opted in, could they change that later?

Miles Briggs: There are two aspects to that. People will register their wishes to opt in at the point that they are coming out of training and starting their careers, but I take on board your general point. There must be flexibility for people who opt into the system and then decide that they want to change that. The opt-out model does not create the capacity that we need with regard to professionals—to know where they are, to provide on-going training and updating of training, and to ensure that we have actively asked healthcare professionals, "Are you intent on doing this work and have you opted in to do it?" That is what will create the specialist team to deliver across the country for everyone. Otherwise—this is one of my concerns—some people might only ever have one patient request assisted dying of them over the course of their career. To put an individual in that situation is not fair and does not necessarily provide all the safeguards that the bill has been pointing towards. That is why I see the opt-in model as providing exactly what we want to achieve.

Amendment 194, which also touches on some of the issues that Jackie Dunbar was perhaps pointing to, is from the BMA, which represents all branches of practice by doctors who will be associated with carrying out the functions in the bill. The BMA is neutral on the principle of introducing legislation on assisted dying but wants to ensure that any legislation that is introduced protects the needs of doctors, whether they choose to or choose not to provide assisted dying to their patients. BMA Scotland members are concerned that choosing to or choosing not to provide assisted dying might impact on them professionally and that they might be subject to discrimination or detrimental treatment in their current job or with regard to any future job that they might apply for. Concerns include jeopardising career prospects and being ostracised.

All other jurisdictions where assisted dying is being introduced and debated have included statutory protection for doctors from detriment on the basis of their views and/or intentions with regard to assisted dying. Amendment 194 includes protection for the employee-employer relationship and for potential employees and GP partners who are independent contractors to the NHS. It would protect those who might wish to participate and those who choose not to participate in assisted dying for any reason.

During the stage 1 evidence, other professional bodies representing healthcare staff took a similar position to BMA Scotland on the need for the inclusion of additional protections in the bill. The committee also recognised the issue and requested further consideration at stage 2. I urge committee members to vote for this and other amendments that provide protection for health professionals against discrimination or detriment based on their views and intentions in relation to assisted dying.

I move amendment 151.

The Convener: I call Liam McArthur to speak to amendment 27 and the other amendments in the group.

Liam McArthur: Thank you, convener. I start with an apology that my remarks are, again, going to be on the lengthy side. Again, it is a reflection of the fact that I want to do justice to the amendments in the group. I thank Miles Briggs for helpfully setting out the rationale for his amendments and the case for an opt-in model; that has always been my intention and I think that my amendments in the group reinforce that.

Amendments 39 to 41 amend the current conscientious objection provision in the bill to broaden it out and ensure that no person is under any duty to directly participate in anything that is authorised by the bill. That provision is broader than the conscientious objection provision, as a person no longer needs to claim a conscientious objection to participating but can decide not to directly participate for any reason.

My original policy intention was to include a conscientious objection provision similar to that provided in abortion law, so that health professionals would not be under a duty to participate in the provision of assisted dying if they had a conscientious objection to doing so. It has always been my intention that no health professional would be expected to participate if they did not wish to, and this approach should cover anyone who is directly and actively involved in the process—by which I mean anyone carrying out functions in the process as set out in the bill's provisions.

Following stage 1, I have reflected carefully on how best to ensure that the bill fully reflects my intended policy, and I have concluded that, to simplify the matter further, the bill, instead of relying on a CO provision, should allow anyone carrying out such functions to not participate directly for any reason, thus ensuring that only those who are content to participate directly do so. That will have implications for overall training need, thereby reducing some of the cost issues that have been raised by the Scottish Government.

Amendment 39, which adds the word “directly” after “participate”, is in line with my view that there should be no blanket provision that would allow any person, however peripherally involved in some aspect of the wider process, to be able to not perform their role. Instead, it is intended to ensure that the provision is focused on those people who are directly involved—for example, the independent registered medical practitioner or the authorised health professional, who might be approached by the co-ordinating registered medical practitioner to undertake the duties under sections 6 and 15. Amendments 39, 40 and 41 enable a debate to be had on the pros, cons and potential consequences of a change from CO to only those directly participating who are willing to do so.

On amendment 27, it has always been my policy that a person first seeking assistance should be directed to another medical professional if the medical professional whom they first approach does not wish or is unable to perform the role of co-ordinating registered medical practitioner. My understanding is that such signposting already takes place in healthcare settings and, therefore, it was not specifically provided for in the bill as introduced. On reflection, however, I have decided to lodge amendment 27 to ensure that someone seeking an assisted death is either directed towards a registered medical practitioner who is willing and able to participate, or given further information on how to proceed.

That will not require formal referral of the person to a specific registered medical practitioner, but it will require a registered medical practitioner who is approached by a terminally ill adult looking to make a first declaration and who is unwilling or unable to participate to signpost the person to where they can receive information on how to proceed and/or where they can make a first declaration. That might involve, for example, a GP at a medical practice directing a person to another GP at the practice who is willing to participate in assisted dying provision. In later groupings, we will have a chance to consider amendments on the provision of information.

As for other amendments in this group, amendments 151, 154, 186, 198 and 213, in the name of Miles Briggs, form part of the debate on how best to provide for health professionals in deciding whether they wish to participate directly in the provision of assistance. Indeed, we have heard as much from Mr Briggs himself. At the heart of the amendments is a requirement for

> “Scottish ministers, by regulations,”

to

> “establish and to maintain a register of persons willing to carry out functions under this Act of ... a co-ordinating registered medical practitioner ... an independent registered medical practitioner ... an authorised health professional”

and

> “a registered pharmacist ... supplying”

the

> “substance.”

I considered such an approach when I was originally looking at how best to proceed on the issue and came to the view that the establishment of such a register was not necessary. In practice, it is, as has been seen in other jurisdictions, likely that such registers will form part of the information that is held in each health board, and nothing in the bill at the present time will prevent that from happening. However, I am not persuaded that mandating the establishment and maintenance of a central register and requiring individuals to notify Scottish ministers of their willingness to participate is appropriate or proportionate.

That said, I again pay tribute to Miles Briggs for the way in which he has engaged with me on these and, indeed, other issues, particularly around palliative care. I am keen to continue working with him to see how the bill might be further strengthened, and I thank him for the constructive approach that he has taken throughout, not just with me but with other colleagues.

On related amendments that were lodged by the equally constructive Jackie Baillie, and which are being spoken to by the ever-constructive Daniel Johnson, amendments 74 and 80 to 82 relate to the establishment of a register of psychiatrists who can undertake assessments, as set out in the bill. The amendments provide that psychiatrists may apply to be on the register and, to do so, must be approved medical practitioners or must

> “meet criteria specified by the Scottish Ministers in regulations”.

I recognise Ms Baillie’s work with the Royal College of Psychiatrists on those provisions.

09:45

It is important that the assessing registered medical practitioners are able to seek input from specialists when assessing capacity, which is why the bill provides for that in section 7(2)(b). That provision allows for such referrals to be made by either assessing doctor to

> “a registered medical practitioner who is registered in the specialism of psychiatry”

or who

> “holds qualifications or has experience in the assessment of capacity”.

Section 7(2)(c) provides that the views of such specialists must be taken into account by the assessing doctors. I firmly believe that such specialists will be capable of assessing the capacity of an individual for the purposes of the bill without any need for the creation of a new register, just as currently takes place in other matters of determining capacity.

Section 3(2) sets out the capacity requirements for a person to be judged as eligible to request assistance. I note that the Scottish Government has highlighted legal and technical concerns, and deliverability challenges, with the amendments, which, on balance, I do not believe to be necessary.

Amendment 74 would be pre-empted by amendment 159 in the group dealing with the assessment of terminally ill adults. Several amendments in that group are concerned with the issue of providing for variations of a no-detriment provision to ensure that no person suffers any detriment as a result of a decision on whether to participate, as Miles Briggs explained. Those amendments include Daniel Johnson's amendment 11, Jeremy Balfour's amendment 192, Paul Sweeney's amendment 248 and Miles Briggs's amendment 194, which establishes

> "Employment and partnership protection (for involvement or non-participation)".

Employers

> "must ensure that there is no employment detriment to their employee"

for actually, or potentially, participating, or not participating, in the act. As I have stated, it is important that those who do not wish to participate directly in the process are protected and I support the principle of individuals suffering no detriment.

I note that the Scottish Government has indicated that such amendments may relate to the reserved matter of employment rights and duties and industrial relations. As I have previously said, I am aware that the Scottish Government is working with the UK Government to ensure the full operation of the bill, should it be passed. The Scottish Government will consider the effect that this amendment and others might have on current engagement with its UK Government counterparts and I hope that the cabinet secretary will continue keeping the committee informed about those discussions. In the meantime, Parliament might wish to return to and address the issue when further amendments are addressed at stage 3.

Patrick Harvie (Glasgow) (Green): For clarity, is Liam McArthur asking the committee not to support any of these amendments but saying that he thinks it might be possible to address the issue in another way, within devolved competence, at stage 3? Is that where he is at?

Liam McArthur: To be clear, as Miles Briggs helpfully indicated, this is a feature of the legislation that is being taken forward at Westminster and in Jersey and the Isle of Man and it is my intention and expectation that it will also apply to this bill.

I have some concerns about passing amendments at this stage while there are on-going discussions between the UK and Scottish Governments in relation to areas of legislative competence. This will have to be a feature of any legislation that is finally passed by Parliament but, at this stage, I urge the members who lodged the amendments not to press them but to be reassured that we can return to the issue at stage 3.

This group also contains amendments that seek to allow organisations to opt out of the process. Daniel Johnson's amendment 16 would extend the conscientious objection provision to care homes and hospices, therefore introducing an organisational conscientious objection, rather than having the conscientious objection provision limited to individuals, as it is in the bill at present. Amendment 20 would add a no-detriment clause to the effect that a care home or hospice that opts out as per amendment 16—and in line with the general no-detriment provision for individuals and organisations in amendment 11—

> "must not be subject to any detriment by a public authority as a result"

and would provide that no funding of a care home or hospice can be dependent on it providing or permitting assisted dying.

With regard to amendment 16, I refer to my amendments to remove the conscientious objection element and replace it with a broader no-duty-to-participate provision. My amendments to section 18 would mean that no individual was under any duty to participate directly in anything that was authorised by the act. There would be no obligation to claim or demonstrate a conscientious objection; not wishing to participate for any reason would be sufficient.

As I have stated, I have significant concerns about establishing an organisational opt-out. As I told the committee at stage 1, with such an opt-out, although an organisation might well include individuals who are willing to participate in the process, it ceases to be about individual choice. The risk, too, is that barriers are put in place to individuals who, despite meeting all the eligibility criteria and being protected by the safeguards that are in place, find that they are not able to access that choice as a result of an institutional opt-out. We have seen that happen in other jurisdictions, and it has proved extremely problematic. I must say that it also cuts across the patient-centred principles and ethos at the heart of palliative and hospice care.

Likewise, for Jackie Baillie's amendments 52 and 60, I support the principle of a no-duty-to-participate provision for individuals, but I am not supportive of extending that to permit organisations to decide whether to participate. Establishing such an organisational choice could act as a significant barrier to a person being able to access assistance under the act. The potential effect of the amendments would be that a person in a particular care home or hospice would need to be moved to other premises in order to access the assistance that they wish, at the most inappropriate of times. Some of the testimonies that are set out in the Dignity in Dying briefing for today's proceedings are certainly worth reading in that context.

It is not to say, however, that hospices should not be given flexibility in the way that they engage with the provisions of the legislation, as we see in other jurisdictions. However, my position remains that an individual can decide not to take part for any reason, but if a registered medical practitioner and other relevant health and social care staff are willing and able to participate, the fact that the terminally ill adult resides in a particular setting should not prevent them from accessing assistance, if eligible.

I note that amendment 190 pre-empts amendment 40 and amendment 41 pre-empts amendment 191. I turn to Jeremy Balfour's amendments 190 to 193 and 211. Regarding amendment 190, my amendments to section 18 reframe the section by replacing the reliance on a CO with a wider no-duty provision, so that no person is under any duty to participate directly in anything authorised by the act. Amendment 190 would amend the existing CO provision too broadly, in my view, by referring to a person facilitating

"in any way, anything authorised"

by the act. I note that the British Medical Association, when addressing similar amendments in the Westminster bill, reinforced the need to

"ensure that the doctor's views are respected, whilst also ... ensuring that patients can easily access the information and support they need."

Amendment 190 could exclude patients from accessing their crucial right to information, which I note that Mr Balfour would not wish to see.

Amendment 191 would move the burden of proof away from existing legal precedent. It is also not necessary, as, if a decision is made to move to a wider no-duty provision, such a provision will not be required in any event. I have lodged an amendment to remove that subsection from the bill, subject to further discussion and considerations, including with the cabinet secretary, ahead of stage 3.

Amendment 192 is another no-detriment amendment. As I have said, I am sympathetic but, given the amendments that I have lodged to section 18 and the further considerations that might be required ahead of stage 3, I ask the member not to press it.

Amendment 193 and consequential amendment 211 also seek to establish a form of institutional objection, as does Stuart McMillan's amendment 249. I have made it clear why I do not support such an approach. I urge members not to press those amendments and the committee not to support them.

The Convener: I call Daniel Johnson to speak to Jackie Baillie's amendment 74 and amendment 11, in his name, and all other amendments in the group.

Daniel Johnson: The amendments that I will speak to in this grouping fall into three substantive sub-categories: the first is on individual opt-outs, the second is on organisations and particular views in relation to hospices and care homes, and the third is on a register for psychiatrists.

First, it is important that we ensure that individual opt-outs are as straightforward as possible. That speaks to amendments 11 and 16, in my name in particular. I will not reiterate the arguments that Miles Briggs set out very clearly.

Amendments 52 and 60, with regard to hospices, were also drafted in conjunction with CHAS. I listened carefully to what Liam McArthur said and I understand the broader point about an institutional and organisational opt-out. However, hospices require a particular degree of care and attention with regard to the bill. We are not talking about large, faceless institutions. Any of us who has visited a hospice will recognise that they are often small and very personal contexts, and they are not clinical environments. This is not necessarily about an ideological opt-out; it is about allowing hospices to look at the implications of the bill and get their care right for the people who are in their care, and I—

Liam McArthur: Will the member take an intervention?

Jeremy Balfour (Lothian) (Ind): Will the member take an intervention?

Daniel Johnson: If I may, I will finish my sentence, at the very least.

The concern is that, because of the intimate nature of hospices, practice with regard to one person may well interact with practice for others in the same context. We are talking about small settings where the small numbers mean that there are not sufficient staff to undertake the proposed duties, particularly if there are staff who wish to opt out, which there may well be. There is a great deal of concern among those who work in hospices. I have spoken to such people—just outside my constituency, actually, rather than inside it—and there is concern that there may not be sufficient capacity or the necessary physical layout to provide what is proposed in the bill in a delicate and understanding way, because there will be implications for other people.

With that, I have finished my sentence, so I will first take Mr McArthur's intervention and then listen to Mr Balfour.

Liam McArthur: I thank Daniel Johnson for taking the intervention and for setting out a reflection on the hospice sector that I fully recognise. I understand the concerns that have been expressed, but would he accept that the hospice sector is made up of hospice communities that do not simply include those who are directly employed in those hospices but stretch rather wider? Within those communities, there will invariably be those who are very concerned about what is proposed in the bill and would not want to participate at all; there will be others who are very comfortable with it and see it as an extension of the sorts of patient-centred support that they already provide; and there will be others who are uncertain, as I know many colleagues are, and who will want to see the detail of the bill and how it might impact on them before they make a decision one way or the other.

The risk in introducing an institutional or organisational conscientious objection is that we would remove from individuals in the hospice community the choice to participate, if they wish to, with the strict safeguards that are in place, and we would allow, essentially, a veto on that choice by those who are opposed to it, for reasons that I fully respect, who would be under no duty to provide anything that is set out in the bill. Does the member accept that that cutting across individual choice is something that we should steer clear of if at all possible?

Daniel Johnson: I understand the point and I recognise that this is complicated and delicate, but the flipside of that coin is that there is a very real concern among those in the hospice sector that, if what is proposed in the bill is undertaken, especially in small, intimate settings, the practice with regard to palliative care for those who do not wish it will be affected. That would essentially be impossible to avoid, given the nature of many of those settings. It would not be the case in every setting, and it may well be that the regulations would make specific considerations. However, I ask the member to understand that, if his argument is correct, there is a very real flipside to the same coin, which is that one practice would be unavoidably affected by the other.

Liam McArthur: I do not want to cut across Mr Balfour, but I understand the point that has been made. The concern in relation to an organisational opt-out is that, in a sense, any nuance in the debate about how an individual hospice might participate—the extent to which it might participate in the delivery of what is proposed in the bill on behalf of the patients who meet the eligibility criteria and wish to pursue that choice—would be lost. The organisational veto of any choice exercised by individuals within that hospice community is not a place that the Parliament wishes to go. There will be nuances around how each hospice engages with the legislation—we have seen that in other jurisdictions—and it is safeguarded in the provisions in the bill.

10:00

Daniel Johnson: Again, I would just say that the reverse could also be true. By not permitting that, you are, in effect, creating a mandate and therefore there is a concern that practice in palliative care will be inextricably altered by that practice. We need to listen to that concern.

Jeremy Balfour: Does the member have concerns about future proofing the bill, if it is passed? As funding for hospices is already under pressure, future Governments and Parliaments might look at the act and fund only hospices that also provide such assistance, unless they have an absolute opt-out.

Daniel Johnson: That is very much at the heart of why I lodged amendment 20. It is one thing to propose a notional opt-out, either for individuals or for organisations but, especially for hospices, it may be that the practice becomes such that opting out would not be a financial practicality, especially given the precarious financial circumstances in which hospices find themselves—they get only partial funding through the NHS. Again, we need to tread carefully. I recognise that it is a matter of balance but, given the very personal nature of the situation, it is important that we allow that flexibility, especially for hospices and care homes.

Elena Whitham: I wonder whether you recognise that, if the amendment were agreed to, it would create difficulties for an individual who might be in a hospice setting at the end of life and be forced to move out. There has been testimony to that from across the world. When an institutional opt-out is in place, it creates a system in which the person who is at the centre of care is unable to realise their wishes. That can create a lot of stress and anxiety in their final hours.

Daniel Johnson: Yes, but, again, there is the question whether introducing such assistance in care homes puts pressure in the other direction, on people who do not wish to consider an assisted death. At the very heart of this is the personal nature of hospices, many of which are very small, which means that assisted dying almost becomes the assumption that they are introduced to. I recognise the point, and the stress that might be caused.

Joe FitzPatrick (Dundee City West) (SNP): That is nonsense.

Daniel Johnson: I am sorry; is that an intervention?

Joe FitzPatrick: Yes. Thank you for taking an intervention. We have seen examples from other parts of the world where individual choice is effectively removed. My concern is that we are joining dots and assuming that a set of circumstances will come about if we do not have an institutional opt-out. I just feel as though there are dots being joined ahead—

Daniel Johnson: Yes. It is certainly not nonsense to raise concerns about patient pathways. In any clinical circumstances, a patient journey and the degree to which it is patient-centred is of critical salience. We live in a world in which healthcare settings are very complex, terminology is used that people do not necessarily understand or are not familiar with, and there are considerations and circumstances that people are not used to. Healthcare is often disempowering to the patient. Therefore, making sure that those settings are such that people are comfortable is important.

Another thing that very often happens in a healthcare setting is that people's decisions are, naturally, influenced by the broader assumptions within such settings. I do not dismiss that for a moment. If the member is asking me whether there is speculation, my answer is, yes, there is. That is absolutely what stage 2 is about. It is about exploring such speculations.

I recognise the complexity of allowing opt-outs and that patients might need to move. I see that Sandesh Gulhane is forming words, but I would like to make a little progress. I did not intend to speak for so long on this group. I am just asking us to contemplate. It is not that I dismiss those things, but I ask those people who are asking about movement causing disruption or distress whether the reverse is also possibly true. Given the very intimate setting of a hospice, introducing someone into that environment with a set of assumptions in favour of assisted dying may well cause disruption or distress for the other cohort of people. I do not think that the issue is binary, but I ask the committee to consider that.

Amendments 74, 80, 81 and 82 were also drafted in conjunction with the Royal College of Psychiatrists. I promise that I will not speak to those at such great length as I have spoken to the previous amendments.

Amendment 80 would create a register of psychiatrists to undertake capacity assessments. The key point of amendment 74, if it is not pre-empted by amendment 159, is that such assessments should be drawn by practitioners from a central register. Amendment 81 would ensure that the register of psychiatrists was not just a list but would be used to improve learning and general clinical practice. It would enable data collection on assessments that were carried out under the bill to be used for oversight. Amendment 82 is a consequential amendment.

Throughout our deliberations, there has been a concern about making assessments of capacity. The psychiatric profession in particular is taking a keen interest in that. When it comes to people with associated mental health conditions—particularly, in later life, dementia—getting input and a detailed understanding from the psychiatric profession is very important.

Stuart McMillan (Greenock and Inverclyde) (SNP): I listened to Liam McArthur's comments, but it is still worth while to speak to my amendment 249, which was drafted with the Salvation Army. The stage 1 report noted in paragraph 356 a "widespread view" that there needs to be more clarity about how institutions could reasonably be expected to respond to the legalisation of assisted dying if the bill were to pass.

The Salvation Army is a key provider of social services across the country, including in my Greenock and Inverclyde constituency. It provides 16 residential and non-residential services for people who are experiencing homelessness. It has informed me that, in countries in which assisted dying is legal, such as Switzerland, Government funding and commissioning for its residential services in particular was put under threat because it had not wished to provide facilities for assisted dying on its premises.

Section 18 of the bill recognises that individuals who are working with a terminally ill person may have a personal conscientious objection to assisted dying. It respects their right to hold that objection by saying that nobody should suffer any detriment because they cannot, in conscience, take part in the assisted dying process. However, the Salvation Army—which I support in this aspect—believes that organisations, too, can have a conscience that is based on their ethos. Many organisations that provide care and support to vulnerable people, including people who are terminally ill, do so because the people who founded the organisation had a set of moral beliefs that impelled them to provide care for people who need it. Those beliefs have entered into the conscience of that organisation. They provide the moral and ethical basis for its continued work. They are the reasons why the organisation continues to do what it does.

Sometimes, those beliefs will support or be neutral towards the idea that terminally ill adults should be able to choose to have help to end their lives. In such cases, the organisation will be able to accommodate the legalisation of assisted dying with little difficulty. However, that will sometimes not be the case; sometimes an organisation will have a view of human life, or of its role at the end of life, that will not be able to accommodate legalised assisted dying. If such an organisation is told that it must accommodate legalised assisted dying or it will lose public funding for its services, it will face a very difficult dilemma of a kind that the bill says that an individual should not be exposed to.

The Salvation Army is calling for a clear statement in the bill that organisations should have the right to exercise conscientious objection to participation in assisted dying. No organisation or individual should be penalised for their conscientious objection to assisted dying. [*Interruption*.] Sure, I was just coming to an end.

Joe FitzPatrick: I am trying to understand the point. You made the point that the Salvation Army is an organisation, and part of that involves, in effect, providing people's homes. Are you saying that, when someone is dying in their own home, they should not be allowed to access the provisions of this legislation if they qualify and wish to do so? Should the Salvation Army be allowed to block people from carrying out, in their own homes, a decision that they have made? Or any other organisation? You mentioned the Salvation Army but it is obviously much wider than that.

Stuart McMillan: No, that is certainly not the purpose of amendment 249. I am not sure whether the Salvation Army operates in your constituency, Mr FitzPatrick. I know from the engagement that I have had with it over many years, because of the range of services that it operates, that that is certainly not where it is coming from. I go back to the point about Switzerland that I referred to. In the end, the Salvation Army had to operate within the new law that was introduced in Switzerland, but it found it difficult to undertake that.

Regarding the situation in Scotland with this legislation, the Salvation Army would not want to be in a position in which people would have to leave its premises. At the same time, it is an organisation that clearly does not believe in the premise of assisted dying.

Elena Whitham: I will further explore that point. The effect of the amendments proposing an institutional and organisational opt-out would be that somebody would not be able to avail themselves of an assisted death in what would essentially be their own home. Having been in and out of many organisational settings where people who are experiencing homelessness reside, I know that that is their home at that point. Is the Salvation Army talking more about its funding being at risk? You cannot uncouple those points, which is maybe where you are trying to go with the amendment. Should organisations have an organisational opt-out, those points would be inextricably linked.

Stuart McMillan: The issue is clearly a concern for the organisation because of the experience that it faced in Switzerland. Fundamentally, it will abide by the law in any country in which it operates, which I am sure that we would all appreciate and expect. However, as an organisation, it does not support the legislation that is being proposed. If the bill were to pass, it would be difficult for the organisation to operate the bill's provisions, particularly in its residential settings. However, it would not break the law.

The Convener: Jeremy Balfour will speak to amendment 190 and other amendments in the group.

Jeremy Balfour: Thank you, convener. Before I start, I will make a point of order about the Scottish Government's non-presence at this meeting. I understand that the Scottish Government is neutral on the bill, but we have heard a number of comments from Liam McArthur this morning about what the Scottish Government is and is not doing with the UK Government. Has the Scottish Government chosen not to be here, or has it not been asked to come? It would have been helpful to have an update from the Scottish Government on the amendments that we are considering. Was it the Government's choice not to come, or was it deemed not to be appropriate?

10:15

The Convener: As Mr Balfour will be aware, the Scottish Government has taken a neutral position on the bill and, as it has not lodged any amendments, its presence is not required.

Jeremy Balfour: That is helpful, thank you. I wonder whether it would be helpful to get an update from the Scottish Government on its position, particularly in relation to some of the amendments that we are considering.

The Convener: The committee received an update letter from the Cabinet Secretary for Health and Social Care last week or the week before, I think. That is on the committee's website, so you might wish to familiarise yourself with that.

Jeremy Balfour: I think that I was just asking for the Government to address some of the very specific points that have been raised this morning.

Obviously, I am coming late to the party in speaking on the amendments, and it has been interesting to hear from Mr McArthur and other members.

I come first to my amendment 190. I appreciate others' remarks about the changes that have been suggested, particularly by Mr McArthur, but I still have concerns that, even if the amendments were agreed to, the provisions would be inadequate and there would still be encroachment on individual conscience. I am concerned that to refer someone is not a neutral act; it is participation in the process. It makes the objector an essential link in the chain that leads to another person's death. That is not conscientious objection; it is compelled complicity. If we are serious about respecting moral diversity in our health service, we cannot reduce conscience to a paperwork exercise. A doctor or nurse who believes that assisted suicide is wrong must not be forced to facilitate it indirectly. To do so would be to empty the right of conscience of any real meaning.

My amendment goes further than other amendments that we have debated in that it includes not only doctors, nurses and pharmacists, but administrators, who will have to do a lot of work behind the scenes. Even with the amendments lodged by others, if I were a secretary or a personal assistant working for someone in this area, I would be legally required to participate in parts of the process, including referral, recommendation and administration. That means that those who do not agree with assisted suicide would be forced to do something that goes against their moral conscience.

Liam McArthur: I am grateful to Mr Balfour for taking an intervention. I draw a parallel with established practice in the way that conscientious objection works in the area of abortion, where there is no requirement for a practitioner to participate but there is an expectation of a referral or a signpost on, so that a patient is not left with no option whatsoever. There is a duty on medical practitioners, whatever their views, to ensure that their patients get the support that they need. The no-duty provision makes it far clearer that there is no expectation on a practitioner to participate. The BMA has raised issues in relation to the specific understanding of "referral", which is why amendments refer to signposting. However, whether it is referral or signposting, is that not a reasonable way of respecting the rights and choices of medical practitioners, while ensuring that patients do not come up against a brick wall when they are looking for choice, often at a very vulnerable point in their lives?

Jeremy Balfour: I would have more sympathy with that view if we were going down the road of Miles Briggs's amendment 198. If there was a list that was available to somebody who wanted this, they could see who was and who was not willing to facilitate it. That would be very clear. I would be able to look on a website and see who was willing and who was not willing to do this and I could then go through that process. That is one of the issues.

I also think that the amendments do not deal with those at an administrative level who would be asked to do things that go against their views. I am worried that, again, we are going to exclude people from a workplace environment where they would be happy to do everything else that might be required, but not this particular thing. We may end up losing people from those workplaces.

I appreciate what Mr McArthur said. However, my amendment 190 is not about trying to obstruct patient choice, but about ensuring that individuals who are against assisted suicide are not drawn into it. To compel participation in assisted suicide, even as a referrer, is to turn conscience into mere compliance. My amendment, if it is accepted, would give protection in that regard.

My amendments 191 and 192 are follow-on amendments. Again, I accept what Mr McArthur says, but this area of law is new and depends on individual choices. That is why I think that the burden of proof should be reversed from what is in place for other areas of law.

Amendment 191 specifies that if

"a claim of conscientious objection"

is alleged to have

"been improperly or falsely made",

the responsibility to prove or justify that claim

"lies with the person or institution"

making the allegation, rather than with the individual who is exercising the objection. The rationale is simple: it is to protect individuals and organisations that conscientiously refuse to participate, ensuring that they are not unfairly required to defend their ethical or moral stance.

Amendment 192—[*Interruption*.]. I am happy to take an intervention.

Patrick Harvie: Section 18 of the bill, which the member seeks to amend with amendment 191, refers to "any legal proceedings". Amendment 191 states that the burden of proof would lie

"with the person or institution alleging"

an improper or false claim. It is not clear to me that there would always be a person making an allegation of an improper or false claim of conscientious objection, even if the current framing of the opt-out remains. Surely it would be possible for there to be legal proceedings in which no such claim was made. How can the member require that all legal proceedings have to rest on a claim that may or may not exist?

Jeremy Balfour: The issue is about protecting the individual. Wherever the claim comes from and whatever proceedings follow, it is about ensuring that the individual who is being accused does not have to prove the case, and that it is for the other party, whoever that is, to prove the case.

I move on to amendment 193, which is, in some ways, similar to the amendments from Stuart McMillan and Daniel Johnson. I would be deeply concerned if we were to say to hospices and other charitable organisations whose ethical framework defines their care as "life affirming" that they had to go through this procedure. To compel them to participate or risk losing public funding—as we have heard with regard to Switzerland—would violate their moral integrity and betray the trust of those they serve. The amendment seeks to put that right by effectively expanding section 18.

If healthcare providers are going to be exempt, surely hospices, hospitals, care homes and hostels that formally have ethical, religious or philosophical policies that refuse to permit assisted suicide must be allowed to opt out. If not, we are going to see hospices or organisations not taking on certain individuals so that they are not in breach of the law.

We could also see the reverse, with people who want care or help—

Jackie Dunbar: Will the member take an intervention?

Jeremy Balfour: Let me just finish this sentence.

People who want help would not be taken in because providers do not want to have to move them or do something else.

Jackie Dunbar: I thank the member for taking my intervention.

I am following this part of the discussion very closely. You said that, if care homes and hospices were not allowed to opt out, that would prevent them from taking people in. Would this not also apply to people that they want to employ as members of their team? It would have the opposite effect. If a care home opted out and said that it was not willing to participate, that could mean that anybody it wanted to employ would have to have the same opinion. My father was in a care home, and it would have caused me great concern that his care home would not be fully staffed in the future. Are you saying that if there was no opt-in or opt-out, that would not be the case? I feel a bit conflicted.

Jeremy Balfour: I do not think that that is the key issue. A person can believe lots of things, but it is about what they do in practice. Amendment 193 and those that were lodged by Daniel Johnson and Stuart McMillan give people clarity. We are not saying that somebody cannot believe that assisted suicide is right; all that we are saying is that they cannot practise it in particular institutions. We are not in any way telling people what they can or cannot believe; we are saying that, if they work for a certain care home, they will not be able to carry out the procedure in that home.

The advantage of that is that an older person going to a care home or someone going to a hospice would know exactly what services the institution is going to provide, and they could make the appropriate choice. If I think that, at some point, I might have a terminal illness, I might look for a particular care home that allows me to make that choice. The same is true for other institutions.

Elena Whitham: Will the member give way?

Jeremy Balfour: Just let me develop this point.

We already have that in other areas of law. We say that people have to have certain beliefs or follow certain practices to take certain jobs. It is not a new concept, and it is important to note that we are not telling people that they must think in a certain way. All that we are saying is that particular homes, hospices, refuges or whatever will not carry out the procedure. That gives clarity to staff and to those who might want to use the service.

Elena Whitham: I thank the member for taking the intervention.

I want to explore the issue a little further. I am thinking about an individual who might avail themselves of a particular hospice or organisation in their area because that is the closest to them, and who might go there with no intention of ever seeking an assisted death, but who then might change their mind as they approach the end of life, depending on what circumstances are presented to them.

I have had that happen recently with a dear friend's mum, who is very strongly of a Catholic faith and who, in her last days, decided to use medical assistance in dying in Canada. That would not have been foreseen.

Does the opt-out that the member and others describe in their amendments include any other practitioner from outside that organisation who has opted in going into what is effectively somebody's home to provide them with a service that they would be eligible for should the bill pass? It is not just about the institution; it encompasses anybody else and prevents them from going in to provide that service.

Jeremy Balfour: With regard to your first point, the overwhelming majority of people in Scotland now go to hospices at a very late stage. They do not go there for weeks or months; they go there for the very last few days of their lives. Very few people will go to a hospice for a long period of time. That is not how the hospice movement works in Scotland.

Elena Whitham: Will the member take an intervention?

Jeremy Balfour: Just a second.

On the other issue that you raise, you are saying that someone who wants to work for a certain hospice or organisation that does not carry out assisted suicide—assisted dying—must accept that. My point is that that is already the position in law in other areas. An organisation will have certain beliefs, philosophies and ideas. Someone does not necessarily have to sign up to those intellectually, but they do have to sign up in practical terms.

10:30

Elena Whitham: Will the member give way?

Jeremy Balfour: The convener will kill me for saying this, but I am happy to do so. That was perhaps an inappropriate word to use.

Elena Whitham: I want to explore that further. I understood your point about the opt-out applying to anyone coming to work for an organisation with an institutional opt-out. However, I was talking about any other practitioner whose services that person might avail themselves of coming in from an external position. Are you saying that that institution would have a complete opt-out, so that it would not allow another medical professional from a different setting to come into its setting to help that person to achieve an assisted death?

Jeremy Balfour: I would draw a distinction. Perhaps we will need to come back to this at stage 3. If it was a hospice or a physical building that had the opt-out, I would say that they would be excluded from doing that.

More and more people are choosing to die at home, and their care package might be run by a hospice. If an individual decided later on that they wanted to die at home through assisted suicide—assisted dying—that would be different, because the medical professional would be coming into their home. However, an organisation must be able to keep its ethos.

One of my biggest concerns is that, as with all legislation, we are not just deciding for tomorrow, next year or the year after; we are deciding for future generations. We all know the financial pressures that hospices are facing, and 50 per cent of their money comes from the Scottish Government. My worry would be that future Governments—not this Government or the next one—would say that hospices would get the funding only if the procedure was offered as part of their service. There would be nothing, as the bill is drafted, or even with the amendments that Mr McArthur has lodged, to prevent a Government from doing that. That is my big concern

We should put in place a safeguard so that organisations that offer brilliant services—we all agree about that—would not be forced to do something that they are philosophically opposed to or miss out on funding. That is where I am coming from.

Sandesh Gulhane: Will the member take an intervention?

The Convener: Mr Balfour needs to conclude.

Jeremy Balfour: He does; I agree.

Sandesh Gulhane: I just want to say to the member that I do not feel that his statement about hospices is quite correct. Hospices are not places where people go simply to die and to spend the last few days of their life. Hospices are not full of death; they are full of joy and hope, and they give people the comfort that they need. People go to a hospice for a while before they die. I think that Mr Balfour's contention was not quite correct.

Jeremy Balfour: I absolutely accept your first point. When I go to Marie Curie or St Columba's Hospice Care in Edinburgh I am always surprised by how joyful those places are—I often come away feeling much more hopeful than I felt before I went in. I also accept that people go for day treatment, and for many weeks.

I was really pointing to in-patients. The experiences that have been shared with me at Marie Curie and St Columba's Hospice Care—the two hospices that are in my region—are that people do not go there for long periods as in-patients. I accept that people go there as out-patients, and those services could be offered by other institutions that did not want to opt in.

I will stop there, convener.

Paul Sweeney: Amendment 248 reflects the themes that have been broadly discussed by colleagues. As it stands, the bill does not offer enough protection for doctors and other clinicians who, for personal or professional reasons, might not wish to take part in the assisted dying process. Amendment 248 would therefore add a clear statutory protection that would ensure that no individual would face any detriment in relation to employment, regulatory or disciplinary matters for choosing to participate or not to participate in the assisted dying process. Fundamentally, that is about respecting professional judgment and ensuring that doctors and other clinicians can act according to their conscience, without any fear of adverse consequences.

I am, however, mindful of what Mr McArthur said about on-going discussions in relation to the intersection of devolved and reserved competences and the technical detail that needs to be matured, so I am not minded to move amendment 248 at this stage.

Sandesh Gulhane: In Edinburgh, as in Glasgow, which I represent, we are lucky to have more than one hospice. We do not have enough beds, but we are very lucky to have choice. When someone is in a rural setting and has no choice about where they go, opting out will exclude them from being able to access hospice care. We should not put up any barriers to anyone who wants to access hospice care. Everyone who is dying should receive palliative care.

Patrick Harvie: I will be brief, and I will not address everything, but I want to put something on the record about the question of an organisational opt-out. I looked at the various amendments on that as I was going through the amendments for the first time, and I was genuinely open to the argument. I would, however, like to raise one concern that was in my mind when I started reading the variations on the theme but which have not been touched on in the discussion. I would be concerned that, if we were to place a requirement on organisations to adopt a policy either in favour of or against participation in assisted dying, that could place organisations under inappropriate pressure. That happened to a certain extent in the early days of the similar policy coming into place in Australia. Campaigners for either view of the policy could place inappropriate pressure on organisations.

In particular, we have not talked about public sector organisations. In what way would an organisational policy, whether it is to participate or is framed as a conscientious objection, be determined for a publicly owned body? Would that ultimately risk becoming politicised, with a political decision having to be made by a local authority, for example? That would be inappropriate.

I was genuinely interested in hearing the argument to see whether a coherent case could be made for some kind of provision on an organisational policy. I have listened, and some of the arguments in favour of the amendments have been framed clearly in terms of protecting personal choice and the individual decisions that people have a right to make, as well as the desire to protect people from being in an environment that places one expectation or the other upon them about the way in which they might exercise their choices. That suggests that it might not be impossible, but nothing that is on the table at the moment suggests that we have a way of giving an organisational policy—

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

Patrick Harvie: Yes—in just a moment.

I do not see anything on the table that would not lead to an organisational policy that does not, almost by definition, place everybody who is receiving services from that organisation under the expectation that they will make one choice rather than the other.

Jeremy Balfour: I do not know whether the member is worried by this, but, for example, in British Columbia, Delta Hospice Society has now had its funding completely removed because it is not willing to offer assisted suicide. Does he recognise that experience in other jurisdictions shows that there is a real threat to charities and people who provide good services that they could lose their funding? Does he recognise that they need to be protected in some way?

Patrick Harvie: On the contrary, I think that Jeremy Balfour, in giving that example, makes a good argument for retaining the opt-out at the individual level—that is, at the level of the individual medical practitioner or professional—and not placing that decision at the organisational level. After all, it would be organisations that would receive funding rather than individuals, and if the opt-out were to remain at the individual level, the issue would not arise.

Therefore, I am not convinced that we should be supporting amendments on organisational opt-outs, as they are framed at the moment. If anyone wants to attempt a different formulation at stage 3, I will look at the matter again.

Miles Briggs: Listening to the debate, I think that the delivery of an opt-in system will address a lot of the concerns, and I am therefore keen to see it in the bill. Real-world experience is what we will all be looking towards if the bill is passed. This is very much about hospices, care homes and hospitals, but the wish of the vast majority of people is to be able to die at home, and the question is how that will be fulfilled by professionals with the experience and the training. As the best way of doing that will be through an opt-in system, I will press amendment 151.

The Convener: The question is, that amendment 151 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Sweeney, Paul (Glasgow) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

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

Abstentions

Dunbar, Jackie (Aberdeen Donside) (SNP)
Gulhane, Sandesh (Glasgow) (Con)

The Convener: The result of the division is: For 2, Against 5, Abstentions 2.

Amendment 151 disagreed to.

Amendment 49 moved—[Daniel Johnson].

The Convener: The question is, that amendment 49 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Sweeney, Paul (Glasgow) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 2, Against 7, Abstentions 0.

Amendment 49 disagreed to.

Amendment 225 moved—[Pam Duncan-Glancy].

The Convener: The question is, that amendment 225 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Sweeney, Paul (Glasgow) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 2, Against 7, Abstentions 0.

Amendment 225 disagreed to.

Section 4, as amended, agreed to.

The Convener: I suspend the meeting.

10:45

Meeting suspended.

11:12

On resuming—

Schedule 1—Form of first declaration

Amendment 85 moved—[Bob Doris].

The Convener: The question is, that amendment 85 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Haughey, Clare (Rutherglen) (SNP)
Sweeney, Paul (Glasgow) (Lab)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Gulhane, Sandesh (Glasgow) (Con)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 2, Against 5, Abstentions 2.

Amendment 85 disagreed to.

The Convener: I remind members that amendments 2 and 152 are direct alternatives. The text of whichever is last to be agreed to is what will appear in the bill.

Amendment 2 moved—[Sandesh Gulhane].

The Convener: The question is, that amendment 2 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Dunbar, Jackie (Aberdeen Donside) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

Abstentions

FitzPatrick, Joe (Dundee City West) (SNP)

The Convener: The result of the division is: For 8, Against 0, Abstentions 1.

Amendment 2 agreed to.

11:15

Amendment 152 moved—[Pam Duncan-Glancy].

The Convener: The question is, that amendment 152 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

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

Amendment 152 disagreed to.

Schedule 1, as amended, agreed to.

After section 4

Amendment 27 moved—[Liam McArthur].

The Convener: The question is, that amendment 27 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Against

Sweeney, Paul (Glasgow) (Lab)

Abstentions

Whittle, Brian (South Scotland) (Con)

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

Amendment 27 agreed to.

Section 5 agreed to.

After section 5

The Convener: Amendment 153, in the name of Brian Whittle, is grouped with amendments 156, 163 and 209.

Brian Whittle: With regard to amendment 153, the concern is the protection of patients and their wishes and the protection of healthcare professionals, as well as the provision of clarity on the patient's decision for family members and friends. Amendments 153 and 209 make provision for the Scottish Government to bring forward a template advance care directive for patients who are accessing assisted dying. Amendment 163 would ensure that completion of the advance care directive was part of the assisted dying process by making it a requirement under schedule 2 to the bill. Amendment 156 would make the discussion of an advance care directive mandatory.

Overall, this set of amendments would help to avoid doubt with regard to patients' intentions and would provide clarity for patients, healthcare professionals and loved ones. I have researched UK and international examples of what should be included, and this provision is standard elsewhere. Introducing this practice through the bill would give us a clear way to evaluate how these directives can work in practice.

The advance directive makes the patient's wishes clear with regard to specific items of care that might prolong their life if they become incapacitated and cannot continue with the assisted dying process, if they become incapacitated due to the effects of the approved substance with which they may end their life, if they choose to cancel their declaration, or if they decide not to use the substance. The advance care directive cannot be used to choose assisted dying in the event of incapacity.

The template requirement is to allow a standard format for the advance care directive that fits the needs of healthcare professionals and makes information easy to locate when it is needed. The power is given to ministers to expand the care beyond what is listed, if required, in consultation with health professionals.

Sandesh Gulhane: Would there be a cost to the individual for creating an advance care directive?

Brian Whittle: No—it would come as part of the process.

The Convener: Have you concluded, Mr Whittle?

Brian Whittle: Yes, I have concluded.

I move amendment 153.

Liam McArthur: I thank Brian Whittle for setting out the rationale for his amendments, which I think allow us a bit of a reprise of our earlier debate in relation to the amendments on future care plans. I think that the points about how desirable it would be, for a whole host of reasons, for more people to undertake to make future care plans and advance care directives have been firmly put on the record.

With regard to Brian Whittle's amendment 153, I note that there is nothing in the bill as it is introduced that would prevent someone from having an advance care directive should they wish to have one. Although I can see the value of advance care directives, I am cautious about anything that would cause undue delay and prolong the suffering of someone who was seeking an assisted death. I would also raise the question whether people may not wish to have such a directive.

Brian Whittle: That is entirely within amendment 153—the patient has the ability to say, "I don't need to fill anything in," and that, in itself, is an advance care directive. There is no need to write screeds of text. If the patient does not want to participate in an advance care directive, that, in itself, is completing an advance care directive.

Liam McArthur: I thank Brian Whittle for that clarification, which is helpful in addressing an issue that came up in relation to future care plans: the fact that, however desirable they are and whatever benefits may derive from them in terms of understanding the individual's wishes at the end of life, the process still needs to be voluntary.

The Scottish Government has confirmed that

> "advanced directives are not legally binding"

in Scotland and that

> "Mandating their use in this context could create uncertainty for practitioners and patients."

Should amendment 153 be agreed to, I would not oppose amendment 156, which would require the assessing registered medical practitioner to explain and discuss advance care directives with the person who was seeking an assisted death—something that Mr Whittle has further clarified.

After extensive discussions with stakeholders, including medical organisations and practitioners, I have been cautious about imposing measures that might unduly interfere with patient autonomy, the doctor-patient relationship or existing clinical practice. Although assisted dying must be carefully regulated, the bill should establish a clear regulatory framework, with the detailed guidance and best practice procedures developed in consultation with those who work directly with patients and in healthcare.

Amendments 163 and 209 are consequential to the aforementioned amendments.

Brian Whittle: I thank Liam McArthur for his engagement. To clarify, it is important not just that an advance care directive is available to patients, but that the healthcare professional ensures that there is an understanding—

Jeremy Balfour: Will the member take an intervention?

Brian Whittle: Of course.

Jeremy Balfour: On the rare occasions that the drugs did not work when they were administered to a person, if there was no advance care directive in place, what would the doctor or the nurse, or the hospice, do if they did not know what the patient's wishes were? Surely these amendments would give the patient greater protection in that respect.

Brian Whittle: It is exactly that point that started me down this route. On the very rare occasions—and it is rare—that the system does not work and it leaves the patient either incapacitated in a vegetative state or incapacitated in pain, an advance care directive clarifies the patient's wishes.

Joe FitzPatrick: I am very sympathetic to what the member is trying to achieve in these amendments, but, given the way in which they are worded, it seems like the directive is less a voluntary thing and more something that has to be done. The amendments seem to be saying, "You must have an advance care directive," whereas I believe very much that it should be a matter of patient choice. My concern is that, if patients do not want an advance care directive, they should not have to have one. I think that you said that that was your intention, so I wonder whether it would be better if the wording could be finessed and the amendment brought back at stage 3, in order to make it clear that the provision is not saying, "You must have this in order to proceed."

Brian Whittle: That is absolutely the intention. Not filling in an advance care directive will, in and of itself, be the completion of an advance care directive, but it must be offered.

To clarify my view, I would rather that these amendments be passed and amended at stage 3, if it is felt that they need to be amended. I want to make sure that advance care directives are available and an option for everybody. If someone decides not to fill in an advance care directive, that, in itself, will be the completion of an advance care directive.

I press amendment 153.

The Convener: The question is, that amendment 153 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Sweeney, Paul (Glasgow) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)

Abstentions

Gulhane, Sandesh (Glasgow) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

The Convener: The result of the division is: For 2, Against 4, Abstentions 3.

Amendment 153 disagreed to.

The Convener: Amendment 226, in the name of Fulton MacGregor, is grouped with amendments 233, 100 to 103, 133 and 134.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Hello, can you hear me?

The Convener: We can hear and see you, Mr MacGregor.

Now we cannot hear you—you must be muted.

Fulton MacGregor: I think that I am unmuted now. Good morning. I apologise—

The Convener: You are muted again, Mr MacGregor.

Fulton MacGregor: I am not sure what is happening. Can everybody hear me now?

The Convener: We can hear you now, but it would perhaps be best if you do not touch the keyboard while you are speaking.

Fulton MacGregor: Yes, thanks, convener. I apologise to you and the rest of the committee that I am not there in person for this meeting. Due to commitments with another committee, the best way to almost be in two places at once was to attend remotely, so thank you for allowing me to do that.

I will speak to amendments 226 and 233. I put on the record that, similar to the amendments that we discussed last week, these amendments have been worked up in collaboration with the Scottish Association of Social Work. The amendments are intended to strengthen the safeguards in the bill in relation to adults who might be vulnerable, lack capacity or be at risk of coercion or abuse. They do not seek to alter the principle or intention of the bill, but, rather, to ensure that any decision that is taken under the bill is fully informed and free from external pressure.

Amendment 226 would insert a new section after section 5 entitled “Indications of vulnerability”. The purpose of that new section is to ensure that,

“where a terminally ill adult makes a first declaration”,

the co-ordinating registered medical practitioner must check with the relevant local authority whether there are any indications from social work or adult protection records that the person might be vulnerable, lack capacity or be at risk of experiencing coercion or abuse.

Medical professionals are best placed to assess clinical capacity and consent, but they might not always have access to the wider social information that is held by local authorities. Local social work teams often have insight into whether an individual has previously been known to services or might have on-going vulnerabilities that are not immediately apparent in a clinical setting.

Under amendment 226, the local authority would have 48 hours to check its records and respond to the practitioner, either confirming that there were no known concerns or highlighting any matter requiring further assessment. If any concerns were raised, either by the local authority or indeed by a family member, friend or legal representative, a further assessment would have to be carried out within 14 days. Such an assessment, conducted by the relevant local authority, would make a recommendation on whether the individual could safely proceed under the bill or whether the process should be paused.

11:30

The approach draws on existing safeguarding practice established under legislation such as the Adult Support and Protection (Scotland) Act 2007, the Adults with Incapacity (Scotland) Act 2000 and the Domestic Abuse (Scotland) Act 2018. In essence, it would ensure that the robust frameworks that are already in place for protecting adults at risk are properly integrated into this new and sensitive process. It is not about creating unnecessary bureaucracy, but about ensuring that all appropriate checks are made before any irreversible step is taken.

Amendment 233 would complement that by requiring that, when a co-ordinating medical practitioner considered whether to approve an assisted dying request, they would have to take into account any recommendation arising from that vulnerability assessment. It would tie the safeguarding process directly into the bill’s decision-making mechanism, ensuring that the professional assessing the declaration could not simply proceed without regard to the findings of a local authority review.

Taken together, the amendments aim to give greater confidence both to the public and to practitioners that every reasonable step has been taken to identify and address vulnerability. They reflect existing good practice in health and social care and have been developed following discussion with the professional Scottish Association of Social Work, as I said at the outset. Ultimately, this is about ensuring that any decision made under the legislation is truly autonomous, informed and unpressured. I believe that these amendments provide a proportionate and constructive way of achieving that, and I hope that colleagues will consider supporting them.

Finally, I know that it is difficult for people to intervene on someone who is online, so I will be listening to the points that people make in the debate. I apologise again for being online.

I move amendment 226.

The Convener: Thank you, Mr MacGregor. I have a couple of questions about your amendment 226, and other members have indicated that they have questions, too. They might not be traditional interventions, because, as you have acknowledged, it is difficult to intervene on a member who is online.

What discussions have there been with the Convention of Scottish Local Authorities on amendment 226 and its implications for local authorities, given the duties that it would impose on them?

Fulton MacGregor: I have not had any direct discussions with COSLA, because of the timing of pulling together and lodging the amendments, and I do not think that, at that stage, SASW had had full discussions with COSLA, either. I believe from our discussions with its representatives that SASW was keen to have such discussions, but I do not have any update on those just now.

The Convener: Has there been any costing of the implications of imposing the duties on local authorities?

Fulton MacGregor: There have not been any full costings done, but the principle that I have tried to reflect is that the approach should be integrated into existing systems. On the proposed duty to respond within 48 hours, every local authority has emergency social work services that would be able to do the proposed checks, even at weekends. Given the number of requests that might be made under this legislation, we do not think that it would be overly onerous on local authorities to build that approach into the systems that they already have in place for protecting vulnerable adults across Scotland.

The Convener: I want to unpack that just a little bit. You said that there have been no final costings, so have some costings been done?

Fulton MacGregor: There have been no official costings. I am sorry—“final” was probably the wrong word.

The Convener: My next question is about the duty to respond within 48 hours that would be imposed on local authorities. Is it the expectation that that 48 hours would cover weekends and public holidays?

Fulton MacGregor: Yes.

The Convener: Therefore, the burden would probably fall on out-of-hours social work services, which already have statutory obligations.

Fulton MacGregor: Having worked various shifts in emergency social work services, I can confirm that I do not think that this would be a particularly difficult task for them to pick up. Every weekend, the emergency social work services in local authorities pick up various requests for information on a wide spectrum of seriousness. Given the nature of the bill and what is being required, I do not think it would be difficult for an emergency social work team to check the system to see whether there were any notes of concern about an individual within that 48-hour period. Indeed, I think that social work services would be quite happy to take that on.

Obviously, if a vulnerability were noted, and we were to go into the 14-day assessment period, that would be a different matter, because it would then go back to an area team to carry out a full assessment. However, given the serious nature of the bill, I do not think that the actual process of checking the system would be too difficult a task for emergency social work services; they should be able to manage that. As I have said, having worked in those emergency services before, I know that it is quite common to get requests from police and health professionals to do checks on vulnerable adults.

The Convener: Thank you for that clarification, Mr MacGregor.

Jackie Dunbar: Fulton MacGregor talked about the vulnerability assessment. Can you explain what would happen if the person were not known to social services? How would they be protected? To me, it sounds as if there might be a two-tier assessment process.

Moreover, if what you propose were to be put in place, would it be in line with what is currently in place for other end-of-life decisions? Do people who want to put a “Do not resuscitate” notice on their records, or who decide that they do not want to go forward with other treatments, have to go through such a process just now?

Fulton MacGregor: I thank Jackie Dunbar for what is another really good question. What the amendment would do is ask that social work and local authority records be checked for any vulnerability. If the social work department had no concerns, or nothing had been noted, the matter would simply be referred back, and that would be the information that was given back. At that point, it would come back to the principles of the bill in relation to identifying vulnerability. It would be a check to see whether the local authority was aware of any vulnerability. If the answer was “No, we’re not aware of any vulnerability”, that information would be given back when the check was carried out.

I am sorry—what was your other question, Ms Dunbar?

Jackie Dunbar: It was whether what you were looking to put in place would be in line with what is currently in place with regard to decisions that are made at present. Someone might want to put a DNR notice on their record, which they are quite entitled to do, but would what is in your amendments be in line with the procedures that they would have to go through?

Fulton MacGregor: We do not believe that they would have any impact in that respect. I believe that SASW has spoken to the member in charge of the bill at various points of this process, too, and we believe that it is okay for these amendments to be built into the framework of the bill and that they should not result in any additional bureaucracy. This is all about putting an extra safeguard into systems that are already in place, as I have already highlighted. We are just asking that the good laws that this Parliament has passed—the good legislation that is already in place—be used for this, too.

The Convener: Have you concluded, Ms Dunbar?

Jackie Dunbar: Yes. I never got an answer to my question, but it does not matter.

The Convener: Is there anything else that you wish to add, or have you completed your contribution for the moment, Mr MacGregor?

Fulton MacGregor: I have completed my contribution. I just want to say to Ms Dunbar that I feel that I did give her an answer, but I am happy to speak to her at any time outside of this meeting, or when I come back in.

Bob Doris: Amendment 100 seeks to ensure that any co-ordinating medical practitioner carrying out an assessment must request a statement from the local authority where the applicant resides about whether it knows or believes that the person is an adult at risk, within the meaning of section 3 of the Adult Support and Protection (Scotland) Act 2007.

For clarity, section 3(1) of the 2007 act defines adults at risk as adults who are

> “unable to safeguard their own well-being, property, rights or other interests”,

are

> “at risk of harm,”

and

> “because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.”

Crucially, all three of those criteria must apply. I believe that that is a reasonable prerequisite before any co-ordinating medical professional can consider taking an informed position on whether to progress further any application under the assisted dying legislation that we are considering.

Amendment 101 seeks to ensure that a co-ordinating medical practitioner carrying out an assessment must refer the person for a social work assessment if the person says that they want one, if a statement from the local authority raises a concern or if the co-ordinating medical practitioner has any doubt as to whether the person is being coerced.

That last point is crucial, because balance comes into play right across this legislation. The co-ordinating medical practitioner would not take an on-balance position on whether there was coercion. Rather, if there was any doubt, a social work referral would have to be made.

Amendments 102 and 103 would give powers to the Scottish Government to specify timelines for local authorities to produce a statement and to conduct any assessment. I have heard the interaction between Fulton MacGregor and other MSPs on the committee and I think that that is a very reasonable way to do it—with no timescale specified and using the affirmative procedure to introduce more details. That would allow discussions to take place with COSLA, the Scottish Association of Social Work and others, as you would expect. I think that the convener has made that point during her observations.

More generally, however, Scotland has a well-established legal and procedural framework for protecting adults who might be vulnerable, including the maintenance of records of such individuals. My amendments and the substantial amendment by my colleague Fulton MacGregor—to which I am sympathetic, as I can see what Mr MacGregor is trying to do—should be viewed in that context.

The Scottish Partnership for Palliative Care and its membership are clear that such protections should be put in place as a key safeguard in the legislation. The partnership takes no view on whether the bill should pass or otherwise—this is about putting in place a robust series of protections. The SPPC has noted that, in addition to pre-existing vulnerabilities, a terminal diagnosis can often create new vulnerabilities, which might be due to physical, psychological or circumstantial changes. Elder abuse, for instance, is distressingly common, and care costs might provide a motivation for implicit or explicit pressure towards assisted dying. I will not list other factors that can be taken into account, because of time constraints, but you can see the importance of ensuring that there is not a vulnerability.

As drafted, the bill leaves the potentially difficult assessment and judgment as to whether any individual seeking assisted dying is being coerced to the co-ordinating medical practitioner and the second medical practitioner.

Sandesh Gulhane: For clarification, does amendment 100 mean that if somebody has been diagnosed with a terminal illness, that could lead to them being vulnerable just because they have that diagnosis, which would then preclude them from being able to access assisted dying for people with terminal illnesses?

Bob Doris: That query is really helpful, because that is not how the amendment is drafted and it is not the policy intent. Having a terminal illness in itself does not debar someone from seeking assisted dying. That would be counter to the policy intention of the bill, so that is not the intent.

However, you could imagine a whole range of situations such as when someone loses their job, there is a marital breakdown, there is estrangement from family members, or there are significant care costs—you could imagine a series of factors that could then be pieced together to create additional vulnerabilities and, if the adult is at risk under current legislative frameworks, that should be identified. That is the policy intent that we are trying to get at here. A narrow, purely medical-based process is not the strongest safeguard—that is the point that I am trying to make.

That is backed up quite strongly—I will not quote all these organisations because of time constraints—by the Royal College of Physicians, the Royal College of General Practitioners and the British Geriatrics Society in its position statement on assisted dying. The Royal College of Psychiatrists in Scotland has stated:

> "Assessing coercion is not a medical skill, though evidence of it may emerge during medical assessments."

If assessing coercion is not a medical skill, we have to look at other ways of assessing it, and the risk register is surely one key way of doing that. It is surely reasonable that all requests for assisted dying should trigger a search of local authority data to identify any grounds for considering the person to be vulnerable or at risk.

Pam Duncan-Glancy: Given that amendments that define coercion have, so far, been rejected, does the member think that this proposed additional provision would be a further safeguard, so that people can recognise coercion?

11:45

Bob Doris: The proposed safeguard, which I and the Scottish Partnership for Palliative Care are trying to put into the bill, is a key tool. I also note that there are a variety of amendments in relation to coercion, not all of which have been disposed of yet, including some in my name, which I hope that the committee will be persuaded to vote for later today or at another time.

My amendment 101 would ensure that, where a person is at risk, a social work assessment would be mandated. The same would be required if a qualified medical practitioner had any doubt at all. To do otherwise would allow the assisted dying process to operate outwith the existing frameworks and without drawing on well-developed expertise. Irrespective of our views on assisted dying, I do not believe that that is something that any of us wishes to see, and I hope that committee members will be persuaded by my amendments.

Liam McArthur: I thank Bob Doris and Fulton MacGregor for setting out their rationale for amendments that would add elements to the assessment process. I understand very well, not least from my discussions with the SPPC and the Scottish Association of Social Work, the intention behind the amendments.

Amendments 100 to 103 and 92, and consequential amendments 133 and 134, in the name of Bob Doris, would require a registered medical practitioner who is carrying out an assessment under section 6 to request a statement from the relevant local authority as to whether the person who is seeking an assisted death is a known adult at risk. Amendment 101 sets out the circumstances in which the assessing practitioner would be required to refer the person for an assessment by a registered social worker, and amendment 92 would require that the person be informed that they can request to be referred for such an assessment.

The Scottish Government commented on amendment 100 and related amendments, stating:

> "The proposed amendments, taken together, present deliverability challenges as drafted, and issues with their compatibility with the existing Adult Support and Protection system, including the legislation underpinning it. They seem

> to conflate a general social work assessment/referral with an Adult Support and Protection (ASP) referral, which is only triggered under specific statutory criteria. Requiring that medical practitioners 'must' refer or request statements from local authorities may also create legal and operational issues considering, in particular, interaction with existing duties to co-operate with ASP processes under the ASP Act, in particular as they apply to GP independent contractors."

As I said, the Government also points to deliverability challenges.

Similarly, Fulton MacGregor's amendments 226 and 233 would require that, at the point of the first declaration, the co-ordinating registered medical practitioner must request information from the relevant local authority as to whether the person who made the declaration is vulnerable, lacks capacity or might be experiencing coercion or abuse. The Scottish Government noted its concerns with those amendments, stating:

> "There may be technical issues with this amendment, for example it provides for 'vulnerable' to be determined with reference to a number of other Acts not all of which make reference to such terminology".

Bob Doris: I am conscious that the Scottish Government said that there are deliverability challenges, but it did not take a view on whether the amendments should be supported or otherwise. Of course, the bill process is a three-stage process, and, notwithstanding that I intend to press my amendments, will Mr McArthur work with me either to lodge fresh amendments at stage 3 or to refine these amendments, if they are passed at stage 2, to deal with some of those challenges? Does Mr McArthur agree with the principle of what the amendments are trying to achieve?

Liam McArthur: There are deliverability challenges, but the other issues that the Government has raised in relation to the interaction with the existing adult support and protection system go beyond simply technical issues. I am always happy to work with Bob Doris on those and related issues. However, as I will come to suggest, the amendments that I have lodged in this area open up the potential for much of what Bob Doris and Fulton MacGregor are seeking to achieve, and in a proportionate and appropriate way.

Mr Doris earlier made a point about the non-medical nature of assessments relating to coercion—and, I would argue, capacity—that aim to provide a better understanding of the full range of options that are available to an individual who may be seeking to make a request of this nature. The point is well appreciated and well understood, but that will not be appropriate in every instance, which is the slight issue here. If there is a blanket approach, the way in which we target and support those assessments will be diluted, which will potentially put individuals at risk in a way that would not be the case with my amendments.

Bob Doris: Mr McArthur wants a more targeted approach to the situation. However, how could a practitioner know, in advance of asking local authorities to search their records for those who are at risk, that the person may be at risk? Surely you cannot target that; you have to ask in every instance, or we would never know.

Liam McArthur: Taking a blanket approach has superficial attractions, but I am not sure that it would necessarily be as effective. I will go on to explain the intent behind the amendments that I have lodged, which I hope will significantly bridge some of the gaps—if not all of them—between where I am and where Mr Doris is at the moment. I am happy to continue working with him ahead of stage 3, to see whether we can bridge the final short spans.

The convener intimated that the Scottish Government has raised concerns in relation to the burden that Mr MacGregor's amendments would place on local authorities—that seemed to be the implication in the questions that she was asking—and I do not think that that burden would necessarily improve or strengthen the safeguards that are already in the bill. The assessment process allows assessing registered medical practitioners to refer any doubts on matters of capacity to psychiatry specialists or those who otherwise hold qualifications or have experience in the assessment.

The Convener: Mr MacGregor is indicating that he wishes to intervene. It is very difficult to see that on the screen.

Liam McArthur: Apologies, convener. I had my head down.

Fulton MacGregor: Before I decide whether to press my amendments, I want to ask the member in charge of the bill whether he is willing to have a discussion with me—as he is with Mr Doris—ahead of stage 3. I know that Mr McArthur has met SASW before and has a good working relationship with it. I would like to see whether something can be worked out in relation to my amendments and how they link with his own, whether they are agreed to or not.

Liam McArthur: As I said to Mr Doris, I am happy to have those discussions. It would probably be helpful to see where the bill is at the end of stage 2 and what further refinements are necessary. I would be happy to work with Mr MacGregor and the Scottish Association of Social Work, which I have, as he suggested, had the benefit of speaking to on a couple of occasions.

In relation to the required social work assessment, I have lodged amendments that, if agreed to, would see assessing doctors being able to make inquiries and seek the views of health, social care and social work professionals, as well as those who have provided, or are providing, care to the person. I believe that those are appropriate safeguards that will ensure that only those with the capacity to make the decision are deemed eligible to receive assistance.

I would urge caution against adding processes that duplicate what is already in the bill and risk adding burdensome processes that could delay those seeking assistance from accessing it while not necessarily offering meaningful additional protection. I appreciate the attempt in subsection (5) in amendment 226 to set out reasonable timescales, but I again caution against mandating additional processes that could potentially add undue delays to the process.

I also consider that, in line with existing clinical practice, health professionals can—and do—undertake such approaches to the local authority where that is warranted. Nothing in the bill would prevent that practice from continuing should it be felt necessary in relation to particular patients.

Should amendment 226 be agreed to, it would be sensible that the registered medical practitioner must take account of any assessment made by the local authority, as is set out in amendment 233. I also note that aspects of the amendments in this group overlap with processes and requirements that are already considered and provided for in the bill.

As I said, I am happy to continue to work with Bob Doris and Fulton MacGregor, at the end of stage 2 and ahead of stage 3, to see whether we can make further refinements and improvements. I thank them for lodging and speaking to their amendments.

The Convener: I ask Fulton MacGregor to wind up and to press or withdraw amendment 226.

Fulton MacGregor: On the basis of the offer from Liam McArthur, I am inclined not to press my amendments in this group, as they need a wee bit of work. However, I would still like the principle of them to be embedded into the bill. I do not know that those that Liam McArthur has lodged go far enough to improve the safeguards, but I will work with him ahead of stage 3 to see whether there might be some sort of compromise position. Therefore, I seek to withdraw amendment 226.

Amendment 226, by agreement, withdrawn.

Section 6—Medical practitioners' assessments

Amendment 227 not moved.

Amendment 228 moved—[Pam Duncan-Glancy].

The Convener: The question is, that amendment 228 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

FitzPatrick, Joe (Dundee City West) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
Sweeney, Paul (Glasgow) (Lab)

Abstentions

Gulhane, Sandesh (Glasgow) (Con)

The Convener: The result of the division is: For 6, Against 2, Abstentions 1.

Amendment 228 agreed to.

Amendment 86 moved—[Bob Doris].

The Convener: The question is, that amendment 86 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Haughey, Clare (Rutherglen) (SNP)
Sweeney, Paul (Glasgow) (Lab)

Against

Dunbar, Jackie (Aberdeen Donside) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)

Abstentions

Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 2, Against 6, Abstentions 1.

Amendment 86 disagreed to.

The Convener: Amendment 229, in the name of Pam Duncan-Glancy, is grouped with amendments 88, 50, 89, 69, 90, 231, 91, 29, 157, 92, 93, 158, 94, 232, 95, 96, 159, 98, 99, 160, 51, 234, 235, 75, 236, 5, 106, 6, 109 to 117, 117A, 239 to 241, 121 to 134, 58, 59, 135 and 273.I draw members' attention to the information on pre-emptions as set out on the groupings paper.

12:00

Pam Duncan-Glancy: Amendment 229 requires a medical practitioner to ask the patient for their primary reason for requesting assisted dying. If the reason is not related to the terminafl illness or if it falls outside the scope of the act, the assessment must stop, ensuring that assistance is only considered for lawful appropriate motivations.

The bill sets out a defined pathway for assisted dying—who qualifies, under what circumstances and by what process—but it is silent on what happens when a person seeks assisted death for reasons that are outside that framework. We know from experience in other jurisdictions that people sometimes request assisted dying not because of their illness but because of their circumstances—they feel lonely, abandoned, impoverished or trapped in unsuitable housing. Under the bill as written, a person could begin the assisted dying process even if their motivation stems primarily from such factors. In other words, a cry for help could be mistaken for a considered request for death. That is a legal failure that we cannot afford to repeat.

When people suffer because of poverty, isolation or inadequate care, our response should be to fix those conditions, not to offer them an exit from life itself. Amendment 229 would ensure that such mistakes would not happen and that assisted dying remained within the narrow bounds that its proponents describe as an option for those truly at the end of life, not as a response to social or emotional suffering. I say that in the context of some amendments on proximity to death having, sadly, already been rejected.

The question, “Why do you want to die?” is not a bureaucratic formality but an act of clarity. It separates compassion from convenience and care from abandonment. Amendment 229 reminds us that the role of medicine and of the Parliament is not to end lives that have become difficult but to support lives that could remain vulnerable, even in difficulty.

Amendment 231 would make further provision on the inquiries that the medical practitioner must undertake. It would require medical practitioners to

> “enquire about and discuss with the person being assessed what advice and support that person has received from the local authority within which they reside to enable that person to live independently in accordance with article 19 of the UN Convention on the Rights of Persons with Disabilities.”

The amendment would act as a further safeguard against societal coercion.

Amendments 234 and 235 would make provision on referrals to disability organisations and to local authorities for assessments. Amendment 234 would specify that

> “A registered medical practitioner carrying out an assessment under section 6 may refer the person being assessed to disability organisations for further advice about support for living with”

their medical condition.

Amendment 235 would specify that

> “A registered medical practitioner carrying out an assessment under section 6 may refer the person being assessed to the local authority within which that person resides for further assessment of support to enable that person to live independently in accordance with article 19 of the UN Convention on the Rights of Persons with Disabilities.”

Brian Whittle: I have a point of clarification. Is it not already in law that a medical practitioner may refer a patient to authorities that might be able to help with a vulnerability?

Pam Duncan-Glancy: No, it is not. There is no requirement on practitioners to refer to such organisations, nor for those organisations to be supported to exist. That is one reason why I find the legislation to be particularly worrying and why my amendments could be quite important. Some of those organisations could really open the consciousness of someone who is experiencing a loss of function that could be associated with an illness, terminal or otherwise.

In my experience, those organisations have been hugely important in helping people to understand the emancipation and, conversely, the oppression that is experienced by disabled people. It is those organisations that often support disabled people to participate in society and lead an ordinary life. A referral at the point when things have reached the extent that somebody wishes to die, if not before, is really important.

The amendments would act as safeguards to ensure that the person requesting an assisted suicide had been able to access, or had been offered, appropriate support that allowed them to live a full and independent life.

Amendment 236 would require the Scottish ministers to ensure that disability organisations are properly resourced to provide further advice and support to individuals to live with their condition. That is really important, because those organisations are already hugely stretched by existing legislation, some of which does not support disabled people’s rights to independent living to the extent that we around this table might expect. Nonetheless, those organisations are working tirelessly, day in, day out, to support disabled people to live independent lives. It is important that, if the bill is added to the statute books, such organisations are supported to help people understand the consequences of their choices in that context.

Finally, with third sector organisations on their knees, it is pivotal that sufficient resources are in place to allow them to provide support and advice. That would provide another opportunity to ensure that individuals are aware of the support that they can access to help to live with their terminal illness. Many organisations operate without the back-up of necessary funding; nonetheless, they are crucial. If we are looking to legislate to support people to take their own lives, we should be genuinely looking to support and resource organisations to help them make that decision.

I think that Sandesh Gulhane wants to intervene.

Sandesh Gulhane: Thank you. There are people who would want to access assisted dying but who would not want to go through with it straight away after being deemed to be eligible. They would like to have it as an option that they could take a bit later—for example, if they are unable to breathe properly and that is one of the reasons why they want to access it. Under your amendment, would those people be told, “You are not in that position right now, so you cannot access assisted dying and have it as one of the things that you could do”?

Pam Duncan-Glancy: As it stands, there is no right for individuals to get a referral to such organisations, nor are such organisations resourced to the extent that many members in the room would hope or expect that they might be. We exist in a situation where that support is not readily available to disabled people. That is one of the reasons why I and others worry about the bill.

Sandesh Gulhane’s point is about difficulty with breathing. Many people have difficulty breathing, and it can cause great distress. My mum had chronic obstructive pulmonary disease and died as a result of it, and I saw some of the incredible distress that that caused. There are also people who live with support to help them breathe, such as Baroness Jane Campbell, who sometimes uses a ventilator while she is giving speeches in the House of Lords. With the right information, support and care in place, people have different tolerances of what they are able to live with or not live with. Having advice and support on what is available to people is incredibly important, which is why I think that amendment 229 is really important.

I move amendment 229.

Bob Doris: Before I get into the meat of the four main areas that I seek to amend, I will identify some amendments in this group that are consequential to amendments that we have previously debated. As the convener mentioned, amendments 88 and 89 are part of the group on assessment, but they are consequential to my section 7 amendments 100 and 101 on vulnerable adults. Likewise, my amendment 92 is a consequential amendment to the same section to afford a proxy the right to request a social work assessment. I wanted to put that on the record.

I turn to my amendments in this group, which cover new themes to be explored. They aim to strengthen the assessment process and they are proportionate and sensible safeguards. Together, the intent and effect of the amendments is to make the assessment process more robust, transparent and consistent. I have worked closely with the Scottish Partnership for Palliative Care on the amendments. It believes—and I agree—that significant amendment is required in those areas.

I will try to put my amendments together in such a way as to allow proper scrutiny while being as concise as I can, despite the fact that I need to explore four chief areas. The first is that amendment 90 would require assessing practitioners to inquire about and discuss the person’s reasons for wishing to be lawfully provided with assistance to end their own life. Understanding people’s reasons and motivation for seeking an assisted death is vital and central to assessing whether the process can safely and legally proceed. It is also central to understanding how the bill operates in practice, and I will return to that. However, the assessment process set out in the bill says absolutely nothing about eliciting and documenting the reasons why a person is seeking an assisted death. Amendment 90 would simply require that there is a discussion around that reason.

Amendment 106 would add to the bill a requirement that the statement made after assessments by medical practitioners

> “must specify the reasons given by the person for wishing to be lawfully provided with assistance to end their own life.”

We assume that that would happen anyway, but there is nothing in the bill to say that it should, and amendment 106 addresses that.

Amendments 110, 111 and 113 to 115 would amend schedule 2, which sets out the form of the statements by the co-ordinating and the independent medical practitioners, so that both statements would document appropriately the reasons for requesting assisted dying.

Importantly—this is the bit that I wanted to return to—section 24 of the bill sets out what information Public Health Scotland must report, which includes

> “the reasons given by persons wishing to be lawfully provided with assistance to end their own lives.”

However, it will not be possible for Public Health Scotland to do so unless the reasons have been identified and documented during the assessment process. Those amendments would address that particular gap.

I move to the second area that I wish to see amended, which is around the discretion that is afforded to the assessing medical practitioners. As drafted, the bill provides sweeping discretion and there is not a clear baseline for clinicians to start from when seeking to make assessments. As things stand, assessing practitioners do not have to discuss any of the following at all with the patient:

> "diagnosis and prognosis ... treatments available, palliative ... care",

or

> "the nature of the substance that might be provided to ... end their ... life."

Amendment 91 would rectify that and ensure that such matters were discussed with the person being assessed. I point out to members that, of course, that is not to say that the person who applies for assisted dying would engage with that discussion. However, at the very least, a practitioner should ask about those matters.

Liam McArthur: I remind Mr Doris and the committee that section 7(1)(a) of the bill would require the registered medical practitioner to assess, among other things,

> "(i) the person's diagnosis and prognosis,
>
> (ii) any treatment available and the likely impact of it on the person's terminal illness,
>
> (iii) any palliative or other care available,
>
> (iv) the nature of the substance that might be provided to assist the person to end their own life"

and, in section 7(1)(b), to inform the person

> "(i) of the further steps that must be taken before the lawful provision of assistance".

There is a lot of detail there already. I appreciate that the member and others might wish to see more, but those provisions are in the bill as introduced.

Bob Doris: I appreciate that intervention, which allows me to make a distinction: you just referred to what is implicit in the bill, Mr McArthur, but my amendments would make it explicit. The important thing from that intervention is that you appear to agree with the amendments, irrespective of whether they are required.

If the Scottish Partnership for Palliative Care, which has a huge range of practitioners around the country who do excellent jobs, believes that that addition would be beneficial and if the member agrees with it—even if he feels that it might be a bitty duplication—it would be helpful if he could give a steer that he would be willing to accept those amendments, notwithstanding the points that have been made.

In a similar vein, amendment 94 would introduce a requirement that the registered medical practitioner must advise the person seeking assisted dying to inform a doctor at their GP practice and to discuss their request with those close to them. Currently, there is no requirement for the practitioner to do so.

Amendment 95, along with amendments 96 and 98, respectively, is particularly crucial: it would require that the registered medical practitioner must refer the person who requested assisted dying to a specialist in the particular terminal illness if the practitioner had any doubt as to whether the person was indeed terminally ill and, if they had any doubt as to the capacity of the person being assessed to request lawfully provided assistance to end their own life, refer the person for assessment by a registered medical practitioner with the relevant specialism in psychiatry. As the bill stands, there appears to be no requirement to do so in those circumstances, and I very much hope that we can agree with that amendment. Irrespective of individual members' views of the legislation more generally, it must surely be an obligation in the bill.

Amendment 99 is consequential to amendment 95. An individual clinical judgment is important, but it should operate in a clear framework that ensures minimum standards. We would expect that in any other field but, in my view, the bill does not take that approach. My amendments in that area seek to address that issue.

The third area that I wish to address is that of palliative care. Amendment 116 would require that

> "The coordinating ... medical practitioner must, as soon as reasonably practicable after the first declaration is made, refer the person for assessment of their palliative care needs by a registered medical practitioner who is registered in the specialism of palliative medicine in the Specialist Register kept by the General Medical Council."

The amendment also clarifies that palliative care needs include social care needs. In current medical practice, if a person with a terminal illness presents to a healthcare professional with thoughts of ending their life, it is good practice for the professional to refer the person for a specialist palliative care assessment. If that happens at the moment without assisted dying being in law, surely, it will become more important than ever if we institutionalise assisted dying.

12:15

In the experience of palliative care specialists, with exploration of a person's fears and concerns, improved management of their symptoms and by addressing practical issues, often, that person will not continue to wish to end their life. Indeed, they often say later that they are glad that they did not end their life. I acknowledge that many people who seek an assisted death may have already been in receipt of palliative care. However, a new referral should be made because their circumstances may have changed between the time that the palliative support was initially put in place and when a request is made for an assisted death.

Furthermore, receipt of palliative care is vague and imprecise, as people often receive palliative care that is not of the required specialist expertise. Indeed, some people will not have been in receipt of palliative care at all, particularly not specialist palliative care. Accordingly, the medical practitioner would simply be acting in accordance with existing good practice by making a referral for a specialist palliative assessment—that is what would happen now, and the bill is not passed into law.

Of course, some people may still have a settled wish to seek to have an assisted death. My amendments would not remove any of the rights that Mr McArthur is seeking to legislate for within the bill. It is also crucial to put that on record.

The convener will be relieved to hear that my final area of consideration in the group makes provision for a medical practitioner's report to be part of the decision making and recording process on assisted dying, as opposed to the current provisions, which are that medical practitioners should simply make what I feel is a standard pro forma statement as provided for in schedule 2 to the bill. Amendment 117 and related consequential amendments 121 to 123 and 135 would require the assessing medical practitioners to produce a report detailing the information that is

"gathered as part of the assessment"

and their reasons for approving, or not approving, the assisted dying request. Amendment 117 also states that the Scottish Government must make regulations under the affirmative procedure on the form of the report and that the report should be put into the person's medical records.

As the bill stands, it contains what feels as though it is a tick-box exercise to record the outcome of assessments, although I do not think that that is the intention. However, there should also be a requirement for the co-ordinating medical practitioner to compile a meaningful report that documents the outcome and sets out how it has been arrived at. It should document the person's reasons for wanting an assisted death, the evidence that was gathered and used to inform the decision, and the practitioner's reasons for reaching their judgment. Such a report would protect the practitioner in case of complaints and would be in their interests. It would also inform the understanding of the bill, if passed, in operation, as it would be reviewed.

The evidence behind each assisted dying decision should be clear. That would aid transparency and protect all who were involved in the process.

The Convener: I call Daniel Johnson to speak to amendment 50 on behalf of Jackie Baillie, to amendment 5 in his name and to all other amendments in the group.

Daniel Johnson: It is useful to follow Bob Doris. My amendments fall, like his, in multiple parts of the bill, so I ask for the committee's forbearance.

This group of amendments is very important. It is entitled "Assessments of the terminally ill adult", and those are at the heart of what the legislation is about. Indeed, they are critical to its operation. We have already heard that there will be a need for careful consideration by the co-ordinating medical practitioner, who will not always be able to deliver everything by themselves and will need to refer to other professionals or seek other information. It is important that we are clear about how that will work, and not just with regard to what is in the bill. Ultimately, we must recognise that it will need to be based on professional judgment, no matter how good the legislation, the guidance or the training might be. It will all boil down to medical practitioners and doctors making careful decisions in consultation with the person concerned and ensuring that that happens in a fully informed way.

The first set of amendments that I will speak to has been prepared in conjunction with CHAS. As we have already discussed with regard to previous sections, when it comes to situations involving young adults, there needs to be more careful consideration both of the nature of their illnesses, which can look very different, and of their vulnerability.

Amendment 50 provides for amendment 51, which sets out that, when someone is under the age of 25, there will be a referral to a registered social worker and a registered medical practitioner who is a specialist psychiatrist. That is to ensure not just that there is a vulnerability assessment, but that the young adult is making the decision in an informed way. It is important that, in such situations, there is referral to those specialists, because the decision involves a critical judgment, and such referrals will be critical in ensuring that the young person has capacity and understands fully what is inevitably going to be a very complex decision.

CHAS's judgment is that the current assessment process does not make sufficient provision for assessing that capacity or providing the safeguards that it believes are needed for young people. I know that the numbers are likely to be very small, but it is important that we take the proposed approach, which I do not think would put undue pressure on social work or psychiatry systems.

Critically, the approach would not change the decision-making process, which will ultimately rest with the medical practitioner; there is simply a request that those referrals be made and those additional points of information be sought. As I set out at the beginning, these will be delicate judgments that are based on the relationship between the patient and the co-ordinating practitioner, but it is important that, in particular circumstances, additional points of information and professional judgments can be brought in.

Like some of the amendments that Bob Doris has lodged, amendment 93 has been prepared in conjunction with another organisation—in this case, Hospice UK. It is absolutely essential that anyone who requests an assisted death be fully informed of all the options, not just the one that they are requesting. In other words, when they make their request, they must be fully informed of the palliative options that are available to them. There can often be complex issues, and there might be other connotations that people might not have perceived in advance. In particular, not all doctors will have expertise in such care, which is why Hospice UK has asked that anyone who makes such a request be provided with that information and have the option of being referred to palliative care.

Amendment 75, which has been prepared in conjunction with the Royal College of Psychiatrists, is, in a sense, an extension of the amendments that were previously debated on the proposal for a register. In the royal college's view, it is important that, where there are questions about capacity and in any borderline cases—especially complex cases such as those involving dementia or other complex mental health disorders—there is an avenue for further exploration of those issues and further consultation.

Finally, I turn to my own amendments, 5 and 6. We have heard a great deal from Bob Doris about the nature of the decision that is to be made by the co-ordinating practitioner and what that will look like. For me, that judgment is absolutely at the apex of the bill. As Bob Doris put it, we need to take great care that we do not turn this into simply a tick-box exercise.

My amendments are probing amendments. The fact is that we can put as much as we want in the bill, but we must ensure that the relationship in question is as effective as possible and that any judgment is made in as full a way as possible. To achieve that, I ask members to explore the nature of that relationship.

At the moment, co-ordinating practitioners are asked to sign the form in schedule 1, and they can literally just put their name and a date at the end of a block of text. The form does not ask any questions about the nature of the relationship or what has been explored, and it does not ask for an assessment. Bob Doris's amendments are interesting, because they require a report, but I am simply asking the committee to think about whether we want to ask co-ordinating practitioners to declare any other information. The length of time for which a physician has known a patient is not a terribly good or accurate way of measuring the relationship, but—this is why amendments 5 and 6 are probing amendments—it is one way of getting a sense of how well the practitioner knows a patient.

Let me draw in some other examples from a health context. It is important that, although we are discussing a particular situation, the wider health system is not divorced from the discussion. I have been in a situation in which a physician whom I have known for only a very short time has provided me with an excellent level of in-depth information, which has allowed me to understand it. In particular, when my daughter was born, I was dealt a medical situation that I found quite overwhelming. However, I have also been in a situation in which I had surgery and, to this day, I am not clear about which physician performed the procedure on me.

I have also been in situations in which I have had to fight to get physicians to understand the full, broad range of circumstances, because they have been so busy. It might be that a physician ultimately signs off or authorises a procedure but, actually, a team of physicians is involved and the overstretched nature of the system means that no one person has a relationship with the individual.

We need to ensure that that is not the case under the bill—there must be a positive relationship that is well understood. The physician must not only take the time to understand the individual, their needs and why they are seeking to make this decision, but draw in other professional opinions and ensure that the person has the information that they need.

Amendments 5 and 6 do not ensure that. I am asking whether the declaration and the duties and obligations that we set out are sufficient. More needs to be done to ensure that they are, which cannot be a tick-box exercise, as we have seen happen time and time again. We can create a pro forma and a set of tick boxes, but that does not always mean that a relationship of the quality that we want, the information that we require people to have and the empowerment that we seek are provided. More needs to be done in the bill on that point.

Liam McArthur: You might not know which physician operated on you, Daniel, but I am glad that they were clearly up to the task.

I thank Daniel Johnson, Bob Doris and Pam Duncan-Glancy for setting out the detail that lies behind their amendments and for providing justification for my taking some time to go through them, for which I apologise.

I will start with my amendments. Amendment 69 would require an assessing registered medical practitioner to make inquiries—for example by seeking input, if they consider it appropriate—from any

> “professionals who are providing or have recently provided health or social care or social work services”

to that person. Beyond that, it would require assessing registered medical practitioners to consider seeking input from health, social care or social work professionals on any “matter relevant” to the assessment carried out.

Following stage 1 evidence and further engagement with social work, health and social care representatives, I lodged amendment 69 to ensure that there is provision that requires assessing doctors to seek the input of social work and social care professionals and other health professionals—in addition to those whom the process already provides for—who know the person because they have treated them or provided care to them or because they might have a relevant contribution to make to the assessment process.

The formal parts of the process would be well supported by ensuring that the assessment process is able to take a multidisciplinary approach, particularly because those who have provided social care to a person might have knowledge, insights and expertise from which the assessing doctors and the safeguards in the process would benefit.

I note the points that were raised by social work professionals and organisations at stage 1, suggesting that there is potentially a need for additional specialist expertise in assessing capacity. Such input might also be helpful on matters relating to the person’s illness, in assessing coercion and, as I said earlier, in understanding the fullest range of options available to the terminally ill adult.

12:30

Therefore, amendment 69 would further strengthen what I believe is an already robustly safeguarded assessment process and would provide further reassurances that any issues of coercion will be picked up. The amendment continues to respect the role of both assessing registered medical practitioners and therefore allows for their professional judgment, as referred to by Daniel Johnson, as to whether they should make inquiries or seek input and, if so, from whom. Further details around that multidisciplinary input, as well as other aspects of the assessment process, will be addressed in guidance that is provided for under section 23.

Following reflection on the stage 1 evidence, I lodged amendment 29, which would amend the provision in the bill that requires the assessing registered medical practitioner to explain to, and discuss with, the person being assessed any palliative and other care that is available and appropriate. That includes hospice care, symptom management and psychological support. As has previously been discussed, my policy has always been that the assessment process for any terminally ill adult who decides that they wish assistance to end their own life must include the person being given as much information as possible about care options, so that they can make an informed choice at the second declaration stage and on the day that they intend to use the substance.

Bob Doris: Mr McArthur, you are making some really important points. With regard to making an informed choice and the information that the practitioner may give to the person who is seeking an assisted death, if the practitioner is not a palliative specialist or if the individual does not have a palliative care package or has a non-specialist palliative care package, how can the individual make an informed choice unless there is a referral to a specialist palliative care practitioner, to see what options there are to assuage their suffering or mitigate some of their concerns?

Liam McArthur: Some of that will have to be captured in training, but, as I said earlier, it is unreasonable to expect all GPs or consultants to be specialists in the areas that have been referred to. That is why the option to refer on is available under the bill, the need for which would emerge from discussions with the individual. To an extent, there is a balance to be struck between what a medical professional believes that an individual should take forward, in their own best interests, and the right of the individual to say, “I understand that, but that might not be for me,” for a variety of reasons. It is about getting the balance right, and it is an uncomfortable balance for legislators, because it leaves the option open. However, patient-centred care is at the heart of the principles and ethos of the bill.

On the other amendments in the group, although, for the most part, I understand the reasoning behind them, many appear to duplicate each other or ask for very similar information to be included, as both Daniel Johnson and Bob Doris acknowledged.

Pam Duncan-Glancy’s amendment 229 would require that, in carrying out their assessment, the co-ordinating registered medical practitioner must ask the person who they are assessing what their primary reason is for seeking an assisted death. If it is determined that the reason is not related to the person’s terminal illness or otherwise falls outwith the bill’s provisions, the assessment must cease immediately and not proceed. I understand the reasoning behind the amendment, and I again remind the committee that section 7 of the bill requires discussions to take place with those requesting assistance about their illness and available care and support, so that they can make an informed choice.

Amendment 69, in my name, would further strengthen the safeguards in that regard, and section 24 already addresses the reasons for choosing an assisted death or, indeed, the reasons for withdrawing that request. I am concerned that amendment 229 might go further than is desirable in placing subjective eligibility judgments in the assessment process; therefore, I do not support that amendment.

Pam Duncan-Glancy: Does the member think that financial difficulty or the fact that someone is unable to get in and out of their own home—two examples of things that could make someone’s life intolerable when they have a terminal illness—are conditions for which it should be considered acceptable to seek assisted suicide?

Liam McArthur: With regard to a request for an assisted death, if it was evidenced that someone was experiencing financial difficulties, issues around housing or whatever else, there would be an opportunity during those discussions to make interventions that would allow those issues to be addressed. However, I think that it would be problematic to introduce subjective judgments to that assessment process, which would cut across the relationship between doctor and patient. Doing so might even make the individual reluctant to declare that they have concerns, whether about their financial situation, their housing situation or otherwise. That would not be in the interests of protecting those who are vulnerable. As I said, I understand the intention behind the suggestion, but medical judgment would need to be applied in such a case, with the practitioner deciding whether they were comfortable with proceeding with the process in such circumstances, as opposed to seeking to engage with other professionals who may be able to provide support—which, as Pam Duncan-Glancy suggests, would not necessarily always be medical.

Pam Duncan-Glancy: It is one thing to have those discussions, but it is quite another for those issues to be resolved. Nothing in the bill says that such issues must be resolved in order to consider that the decision is being made with all things being equal. Surely, a protection against such circumstances driving somebody’s decision to end their own life is an alternative to a provision saying that such situations—for example, financial or housing situations—must be resolved.

Liam McArthur: Again, I understand the intention behind the suggestion. My concern is that putting such a provision in the bill would make it more likely that individuals would be reluctant to declare, or be open with the medical professionals about, such circumstances. Therefore, the amendment is unlikely to provide the very protection that Pam Duncan-Glancy—understandably and justifiably—seeks to pursue.

I will turn to amendments 88, 89, 92, 101 to 103, 109, 110, 113 and 114, all in the name of Bob Doris, some of which set out what information should be included in the co-ordinating registered medical practitioner’s statement as set out in schedule 2. I understand that the amendments relate to his amendment 100, which would require an assessing registered medical practitioner who is carrying out an assessment under section 6 to request a statement from the relevant local authority as to whether the person seeking an assisted death is a known adult at risk. In the interests of time, I will not rehearse the concerns that were expressed in relation to similar amendments in the earlier group, but, for many of the same reasons, I urge the committee not to support those amendments.

Bob Doris’s amendments 90, 106, 100, 111 and 115 provide that, in carrying out an assessment under section 6 of the bill, RMPs must

> “enquire about and discuss the person’s reasons”

for seeking an assisted death and that the reason must be recorded in the appropriate statements in schedule 2. I appreciate the reasons for lodging those amendments, but I am mindful of the need to respect privacy and to avoid placing pressure on those who wish to request assistance. Section 7(1) requires discussion of a person’s diagnosis and prognosis, as well as other treatment options, making it likely that what those amendments provide for is already covered. However, I am content to support Bob Doris’s amendments, which might help to reinforce those provisions.

I am less convinced by Mr Doris’s amendments 91 and 94. The bill allows for discretion to be applied by assessing doctors in line with their professional judgment in explaining and discussing certain matters that are set out in section 7(1). The BMA has strongly advocated that approach in the context of similar amendments tabled in relation to the bill at Westminster.

Regarding Mr Doris’s amendments 95, 96, 98 and 99, again, the bill allows assessing doctors to exercise their professional judgment and discretion in determining whether to seek input from specialists regarding assessment of a person’s illness and/or capacity. The amendments would require the assessing doctors to make such referrals if they had doubt about a person's illness or about their capacity to make the decision. I believe that that would be the consequence of the existing provisions in the bill, but, on balance, I see no harm in supporting the amendments.

I am afraid that that is not the case with amendment 116, which would provide that, at first declaration, the co-ordinating registered medical professional must refer the person to a palliative care specialist for a palliative care and social needs assessment. The bill requires options to be discussed and would not prevent the registered medical practitioner from recommending a palliative care assessment. However, for the reasons that we have already discussed, including last week in relation to earlier amendments, that must remain a choice for the terminally ill adult, so I urge the committee to reject amendment 116 if it is moved.

Daniel Johnson: I understand Liam McArthur's reluctance in relation to a full referral, but does he acknowledge that simply discussing options can sometimes be a little narrow? There needs to be the practical ability to act on those options. Does he agree that there is scope for looking at positively signposting options rather than simply discussing them or having a default referral? In a medical context, discussing options can sometimes be very narrow and about mere possibilities rather than actual things that a person can avail themselves of.

Liam McArthur: I get Daniel Johnson's point that the process of discussion needs to be meaningful and the options have to be laid out and comprehensible. He made the point previously that, sometimes, the way in which medical professionals engage with patients does not necessarily leave them as well informed as they might be about the nature of the options and what the implications are.

The richness of those discussions is important, and I am happy to consider whether more can be done. However, I think that, ultimately, that will still rest on a patient-centred approach that must give primacy to the desire, the will and the choice of the patient in relation to how they wish to proceed.

Brian Whittle: Will the member take an intervention?

Bob Doris: Will the member give way?

Liam McArthur: I am conscious of the time. I will take Brian Whittle's intervention and maybe let Mr Doris in later.

Brian Whittle: We rehearsed this a bit last week. My concern about what has been discussed is around the medical practitioner's discussing palliative care options and giving the choice to the patient. It is only a choice if there actually is a choice. If palliative care is not available, how can it possibly be a choice? How can the medical practitioner discuss palliative care options if the patient is never going to be able to access them?

Liam McArthur: I welcome that point from Brian Whittle. It goes to the heart of a lot of this. It is why so much discussion around palliative and hospice care has happened alongside the consideration of the bill. Although I have always taken the view that that issue cannot be resolved through the provisions of the bill, the bill has opened up a debate about the current situation. The quality of palliative care generally is seen to be very good across most specialisms, but I think that we would all acknowledge that access can be patchy, particularly in certain parts of the country.

Nevertheless, the process opens up a discussion that is not happening at the moment. It is about providing protections for those who are not necessarily protected as well as we might wish them to be or think that they are. Therefore, when the medical professional has concerns that the option that the individual would prefer is not available, there is an opportunity to take steps to try to address that, which is what the process seeks to achieve.

I now turn to Mr Doris's amendments 117, 121, 122, 123 and 135. The bill requires the assessing doctors to make a statement recording that the person assessed is terminally ill, eligible for assistance to be provided and making the decision voluntarily. The forms are set out in schedule 3 and must be signed and dated by the assessing RMP and recorded in the person's medical records. The form captures the required information resulting from the assessment process and allows a person to make a second declaration for assistance to be provided if they wish. If either registered medical professional is not satisfied and does not complete the assessment form, the process stops. I therefore believe that the reports provided for in the amendments are unnecessary, as all required and relevant information will already have been captured. I am happy to work with Mr Doris to see whether any additional information might usefully be captured.

Bob Doris: I feel Mr McArthur's pain in debating such a massive group. These discussions are substantial and substantive in relation to whether the legislation passes. In relation to schedule 2, it would appear that, at the moment, simply stating that the medical professionals are content, that criteria have been met and that there is no coercion, and signing off on that, is effectively it. From what I can see, there is no rationale requirement whatsoever. The report would give a rationale argument and show the working, if you like, Mr McArthur, which would protect the medical practitioners as well as supporting any post-legislative scrutiny work to consider how robust the process is.

Liam McArthur: I appreciate Mr Doris's point. If additional information could usefully be added to the process, I am happy to consider it. In relation to schedule 2, a practitioner would already need to be satisfied that quite a lot of details had been met before those forms were signed.

Stuart McMillan's amendment 117A amends Bob Doris's amendment 117 and states that, if a report under Mr Doris's amendment sets out why a statement has not been made,

> "no registered medical practitioner may carry out an assessment in relation to the same request before the end of the period of six months beginning with the day the report is recorded in the patient's medical records."

I cannot support the amendment, which appears to be arbitrary and disproportionate and does not appear to take account of the potential for circumstances to change.

12:45

I now turn to Jackie Baillie's amendments 50, 51, 58 and 59. Amendment 51 would require both assessing doctors, if the person being assessed was under 25, to refer the person to a social worker and a psychiatrist and to take account of their specialist opinions. The amendment would also allow Scottish ministers to make regulations on any qualifications that the social worker or psychiatrist must have, and it would provide that the regulations must be consulted on. Amendment 59 would require the first regulations made to be subject to the affirmative procedure, and amendment 58 would require subsequent regulations to be made under the negative procedure. Amendment 50 would add to section 6 the requirement that the assessing doctors carry out the steps that are set out in amendment 51.

I note the Scottish Government's concerns regarding the potential time commitment for practitioners and the risk of creating barriers to access for individuals in the affected groups, which could potentially result in delays or inequitable access. Daniel Johnson sought to address that in his remarks, but I think that it would still be a matter of concern. As I have said, the way in which the process will work for younger adults, who are likely to be living with, or who have been living with, complex conditions for some time—this was set out very well by Mr Johnson—will reflect that complexity and will invariably involve a wider range of medical and other professionals, who, in turn, will require the appropriate training. A separately established and distinct process might be seen as arbitrary and open to challenge, so it might be better to set out in the relevant guidance what Jackie Baillie seeks to achieve, including in relation to training. I remain willing to work with Jackie Baillie and Daniel Johnson on those issues ahead of stage 3.

In the meantime, I have no objection to Jackie Baillie's amendment 93, which would require the assessing doctors to inform the terminally ill adult that they could be referred for a palliative care assessment. The bill already requires assessing doctors to explain and discuss with the person their diagnosis, prognosis, available treatment, palliative care and other care that is available. My amendment 29 would require them also to discuss psychological support and symptom management. Although amendment 93 appears to replicate part of that, I have no objection to it.

Jackie Baillie's amendment 75 would enable assessing RMPs to refer a person who is being assessed for an additional second opinion in a psychiatric assessment on capacity. The amendment would also allow the person being assessed to request a second opinion in relation to their capacity. In either circumstance, the referral would have to be to someone on the register of psychiatrists, which would be established by amendment 80, which we have already debated, and the assessment would have to be taken into account by medical professionals. I refer members to the comments that I made earlier on that issue. I also note that the Government has stated that, should amendment 75 be passed, it could raise concerns around consistency and increase the risk of "doctor shopping". The Government also suggests that

> "This may also place significant strain on staff resources, as additional referrals and second opinions would require more specialist availability and coordination."

Let me turn to Pam Duncan-Glancy's amendments 231, 234, 235 and 236. Amendment 231 might be a helpful addition to the list of things that assessing doctors should explain to and discuss with the person being assessed. However, assessing doctors would benefit from having discretion in such matters. For example, the inquiries and discussion provided for by amendment 231 would not be appropriate in every case being assessed, as I am sure Ms Duncan-Glancy would accept.

I appreciate the intention behind amendment 234 in seeking to ensure that any terminally ill adult who requests assistance and who has a disability has access to the support that they need. I also appreciate that the amendment frames any referral as being discretionary for the assessing doctors. There might be issues to consider in relation to which disability organisations could be involved in something of that nature, how reasonable it is to expect them to be involved in the way that is envisaged and how well placed they would be to provide support.

That brings us to amendment 236, which would require ministers to ensure that disability organisations are adequately resourced to provide that support function. It is obviously for the cabinet secretary and the Scottish Government to comment on duties that amendments would place on the Government to deliver funding. However, that consideration might add to concerns about whether such an amendment would make a proportionate difference to the bill and to the robust safeguarding measures that are already in place and that can be delivered.

With regard to amendments 234 and 236, the Scottish Government has stated:

> "... this would require discussion with disability organisations to understand in what form this support would take; how it would be funded; and how it could be delivered consistently".

The Government further notes that amendment 236

> "would place an open-ended, and potentially significant, resourcing ask on Government."

Amendment 235 also aims to provide support to any terminally ill adult with a disability and, again, allows discretion, so the provision can be used if deemed necessary or helpful. However, I again have concerns about how that would fit within the overall assisted dying process provided for by the bill, and I am also unsure how well positioned local authorities are to meaningfully provide the kind of assessment that is provided for and envisaged by the amendment.

Stuart McMillan's amendment 232 appears to duplicate the policy intent of the provision in section 7(2) of the bill, which allows the assessing doctors, if they have any doubts about whether an illness is terminal, to refer to an expert in the particular illness in question.

On Mr Balfour's amendment 157, I note that section 7 sets out further provision for assessments to be carried out by registered medical practitioners. Amendment 157 would add a requirement that the registered medical practitioner must refer the person seeking an assisted death to a registered social worker and a registered medical practitioner who is registered in the specialism of psychiatry for an assessment and must take account of any view provided following that assessment.

In terms of amendments that relate to a required social work assessment, I have lodged amendments that, if agreed to, would see assessing doctors being able to make inquiries and seek the views of health, social care and social work professionals and those who have provided or are providing care to the person. I further note that the bill does not limit assessing doctors to seeking the views of only one specialist on either illness or capacity, so there is nothing to prevent other opinions being sought if that is considered necessary. I therefore do not believe that amendment 157 is required, and nor are the consequential amendments 159 and 160.

Sue Webber's amendment 158 would add a requirement that the medical practitioner must inform the person of any potential side effects of using approved substances that may be provided to assist them to end their own life and of any potential risks or complications, including pain. I would expect such information to be shared by the RMPs as part of the requirement under section 1 of the bill, which requires assessing doctors to explain to and discuss with the person seeking assistance

> "the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death)."

I therefore consider that the amendment may not be essential, but I certainly do not oppose it.

I note Daniel Johnson's comments about his amendments 5 and 6 being generally probing amendments. Amendment 5 would require the assessing doctors' statements to record how long they have known the person, and amendment 6 is consequential. I am not necessarily clear as to what extent that would strengthen the bill, as it would simply record, and only for the co-ordinating registered medical practitioner statement, how long they had known the terminally ill adult. I have always acknowledged that there may be a value in the co-ordinating practitioner having a pre-existing relationship with the terminally ill adult, particularly when assessing for coercion. Indeed, the explanatory notes accompanying the bill state:

> "It is expected that this will usually be the terminally ill adult's GP or primary care doctor."

However, I understand the rationale behind the amendments and there is probably scope for further discussion ahead of stage 3.

Finally, I will address Paul Sweeney's amendments 239, 240, 241 and 273, regarding the establishment of an assisted dying panel to determine eligibility once the assessing doctors have both made statements of eligibility, as is set out in the bill. I note that the amendments would prevent a terminally ill adult from making a second declaration until the panel had granted a certificate of eligibility and would require the panel to hear from one or more of the assessing doctors and the terminally ill adult and others. In my view, the amendments would add a burdensome and unnecessary step to the assessment process, which is already robustly and proportionately safeguarded. Two doctors must assess eligibility with input from others, if and as required, before a person is allowed to be provided with assistance. Having to then pass to a further panel would inevitably delay the process and potentially deny assistance to many who met the eligibility criteria. As such, I cannot support the establishment of an additional review panel, which I believe would not strengthen safeguards but would rather act as a potential barrier to those accessing the choice that they wish, having met the stringent eligibility criteria set out in the bill.

Apologies for the length of time that I have taken to speak to the group, but I hope that that is helpful to the committee.

Jeremy Balfour: Convener, could I seek clarification on when the committee expects to stop today, so that I can let others know for meetings?

The Convener: We will stop once Ms Webber has spoken to her amendments.

Jeremy Balfour: I am grateful. Thank you.

The Convener: So, it is entirely in her hands.

Sue Webber (Lothian) (Con): Oh, my goodness. The convener used my Sunday name. [*Laughter*.] I assure the committee that I have just one amendment in the group.

I thank Mr McArthur for referring to my amendment 158 following some of the remarks about how patients must have as much information as possible and how the nature of the options and their implications must be provided to them. My amendment 158 would strengthen the safeguards by ensuring that applicants are fully informed about the potential side effects and risks, including the pain that is associated with the substances that would be used in assisted dying. As we have heard, the period of reflection will begin when the person makes their first declaration, and the assessment that is carried out by the co-ordinating registered medical practitioner is to take place as soon as is reasonably practical after the first declaration is made. At that point, they must inform the person of various matters. My amendment would add specifics to the various matters that are listed in the bill.

I believe that my amendment addresses a serious moral and medical flaw, which is the bill's presumption that the substances that are used in assisted suicide will always deliver a swift and painless death—that is not the case. Everyone is different, and the way in which they interact with medication will be individual. The bill's assumption is not supported by evidence. Experience from other countries shows that such substances can have severe side effects. In places where assisted suicide is legal, there have been reports of vomiting, choking and fluid in the lungs—

Would Ms Harper like to intervene?

Emma Harper (South Scotland) (SNP): I am looking at your amendments—

Sue Webber: I have one amendment in the group, which is amendment 158.

Emma Harper: I am looking at amendment 158 and listening carefully to what you are saying. I am not aware of the evidence that you are speaking about, and that evidence was not presented to the committee during stage 1. I am a health practitioner who has given patients strong medication such as fentanyl and morphine, among other things, and I am not clear on the side effects that you are talking about. I apologise for having a sidebar with my colleague, Joe FitzPatrick, but thank you for letting me in.

Sue Webber: I am aware of medical professionals who will tell you that the medications that you have listed can induce vomiting and all sorts of concerning side effects. Any medication can do that, depending on the individual. The risk could be one in 10, one in 100, one in 1,000 or one in 100,000, but there are risks for anyone who is taking medicine of any kind. Frankly, Ms Harper, you should be aware of that.

The Convener: Brian Whittle has a point of order.

Brian Whittle: I seek the convener's clarification. I am pretty sure that questions about what can happen when medication does not work were asked when we heard evidence from other parts of the world. I am pretty sure that the answer was that those instances were very rare but that it has happened. I disagree with Ms Harper, because I am sure that we heard about that during evidence.

The Convener: Mr Whittle, that is a point of debate and clarification rather than a point of order, but you have put it on the record.

Sue Webber: The bill as drafted does not require individuals to be informed of those risks before making their decisions. It merely states that the registered medical practitioner who is performing the assessment under section 6 of the bill must advise and explain to the terminally ill adult matters relating to their diagnosis and prognosis and the available treatment and care options, as well as clearly explaining that taking those substances will end their life. After all, that is why they are there.

The omission undermines one of the core principles that the Parliament should uphold, which is informed consent. My amendment would correct that by requiring the co-ordinating medical practitioner to inform the adult of any potential side effects or complications, including the risk of pain, as I have already said, and to be satisfied that the adult has understood them. That would ensure that people are given not simply a choice, but an honest choice. It is not about endorsing assisted suicide or not; it is about recognising the reality that, if the Parliament passes the bill, we have a duty to minimise harm and prevent any unnecessary suffering. Even those who support the principle of assisted suicide should want the public to know what they are choosing—not the idealised version, but the reality as it has played out elsewhere.

Sandesh Gulhane: First, I agree that nothing is risk free and that everything has risks or side effects. In amendment 158, you expressly state:

> “including any potential risks of pain.”

I wonder whether you would be amenable to working with Mr McArthur to change that, so that it says that full informed consent is required in the same way as I would be expected to get full informed consent if I were to give somebody antibiotics.

13:00

Sue Webber: That is the very point, Dr Gulhane. When anyone else undergoes a consultation with a medical professional, they are given the full facts. Right now, my other half is having eye surgery, and he was told the full risks and benefits of the operation so that he could weigh up the choices. Such information is given in any interaction with a medical professional, and I expect it to be given in this instance as well. If amendment 158 does not pass today and Mr McArthur seeks to work with me, I will, of course, work with him.

Joe FitzPatrick: Will you take an intervention?

Sue Webber: I will not, Mr FitzPatrick, because I am conscious of the time. I promised the clerks that I would speak for only four to five minutes.

The Convener: You can take Mr FitzPatrick’s intervention—I am not here to stifle debate.

Sue Webber: Okay. Thank you, convener.

Joe FitzPatrick: Sue Webber’s point about the eye operation was pertinent, but I am not aware that such advice is in statute. My question is this: why do we need to put something into statute, via this particular bill, when it happens routinely in other areas without being in statute? The issue is what should be in statute, what should be in regulations and what should be part of training, and those are different things. Putting everything into statute is not necessarily the best idea, particularly given that techniques change and things advance. Is there any suggestion that such a process is in statute for anything else?

Sue Webber: I am not aware of the specifics that you have raised, Mr FitzPatrick, but why not put it into the bill? We are doing something that is really challenging for many people around the table, and the bill might pass at stage 3. I want every safeguard in place, and I want full consent to be given by anyone who considers ending their life. We must ensure that that is the case, and it is our obligation to do that.

If the bill passes, we cannot allow people to walk into the process blind. Amendment 158 is about damage limitation. It is completely about ensuring that 100 per cent informed consent is given. It is a safeguard against ignorance and a reminder that, even when we legislate for death, the Parliament still bears responsibility for life.

The Convener: Thank you, Ms Webber, and thank you for allowing that intervention at the end.

At our meeting next week, we will continue our stage 2 consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

Pam Duncan-Glancy: Forgive me for asking, convener, but have we come to the end of the group on “Assessments of the terminally ill adult”?

The Convener: No.

Pam Duncan-Glancy: Thank you.

The Convener: That concludes our meeting today.

Meeting closed at 13:02.

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