OFFICIAL REPORT
AITHISG OIFIGEIL

Meeting of the Parliament

Tuesday 10 March 2026

Session 6

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Pàrlamaid na h-Alba

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Tuesday 10 March 2026

CONTENTS

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TIME FOR REFLECTION 1
BUSINESS MOTIONS 3
TOPICAL QUESTION TIME 5
Glasgow Union Street Fire 5
Football-related Disorder (Glasgow) 10
BUSINESS MOTION 13
ASSISTED DYING FOR TERMINALLY ILL ADULTS (SCOTLAND) BILL: STAGE 3 14
COMMITTEE ANNOUNCEMENT (STANDARDS, PROCEDURES AND PUBLIC APPOINTMENTS COMMITTEE) 188
Ruth Maguire (Cunninghame South) (SNP) 188
DECISION TIME 189

Scottish Parliament

Tuesday 10 March 2026

[The Presiding Officer opened the meeting at 14:00]

Time for Reflection

The Presiding Officer (Alison Johnstone): Good afternoon. The first item of business is time for reflection. Our time for reflection leader today is the Right Rev Rosie Frew, Moderator of the General Assembly of the Church of Scotland.

The Right Rev Rosie Frew (Moderator of the General Assembly of the Church of Scotland): Good afternoon. Sunday past, 8 March, was international women's day. It is always on 8 March, and it is a global day celebrating the social, economic, cultural and political achievements of women. There have been many throughout history and in the present day.

There is a lot to celebrate, but there is still much work to be done, both in Scotland and worldwide, to raise awareness and advance gender equality—be that in tackling the gender pay gap, lack of representation in leadership roles, gender-based violence or unequal access to education and opportunities—and, quite simply, to show basic respect to girls and women.

On Sunday coming, 15 March, we will remember some particular women. It is mothers' day. In nurseries and primary schools the length and breadth of the land, cards are being created and presents are being made. By the weekend, the shops and supermarkets will be filled with cards, gifts and overpriced bouquets in shades of pink. Hotels and restaurants will be fully booked. There will be an air of expectation and anticipation on the part of both children and mothers.

While the date for international women's day is fixed, the date for mothers' day changes each year. It is all tied in with the timing of Easter: the first Sunday after the first full moon occurring on or after the spring equinox of 21 March.

Mothering Sunday, the fourth Sunday of Lent, is three weeks before Easter Sunday. It was the day when those working away from home—those in service—were given time off to return home to visit their family and to worship in their mother church, the place where they were nurtured in their faith. I like that wider meaning: it is a time to remember those who nurtured us, those who helped to mould us into the people we are today; it is a day to show our appreciation.

Have a think. Who are those people for you? Who are the people who nurtured you, shaped you and inspired you? Parents, grandparents, aunts, uncles, teachers, youth leaders, faith leaders, people in positions of power and influence, neighbours and friends: remember them, give thanks for them, and show your appreciation.

We are now these people in positions of power and influence. So, think again. Who are those you nurture, those you influence, those you may inspire? What do they see and hear? What should they see and hear—in this place, at home, in your neighbourhood, in your constituency, in your local schools, on the telly or on the socials?

I will leave that one with you.

Business Motions

14:05

The Presiding Officer (Alison Johnstone): The next item of business is consideration of business motion S6M-21032, in the name of Graeme Dey, on behalf of the Parliamentary Bureau, on changes to business.

Motion moved,

That the Parliament agrees to the following revisions to the programme of business for—

(a) Wednesday 11 March 2026—

delete

followed by	Stage 3 Proceedings: Crofting and Scottish Land Court Bill

and insert

followed by	Stage 3 Proceedings: Assisted Dying for Terminally Ill Adults (Scotland) Bill

delete

8.00 pm	Decision Time

and insert

10.00 pm	Decision Time

(b) Thursday 12 March 2026—

delete

followed by	Stage 3 Proceedings: Building Safety Levy (Scotland) Bill
followed by	Stage 3 Proceedings: Greyhound Racing (Offences) (Scotland) Bill

and insert

followed by	Stage 3 Proceedings: Assisted Dying for Terminally Ill Adults (Scotland) Bill

delete

5.25 pm	Decision Time

and insert

10.00 pm	Decision Time

(c) Tuesday 17 March 2026—

after

followed by	Topical Questions

insert

followed by	Ministerial Statement: A Year of Progress in Bringing Down Long Waits - Driving Continued Improvement and Building a Stronger NHS

after

followed by	Stage 3 Proceedings: Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill

insert

followed by	Stage 3 Proceedings: Building Safety Levy (Scotland) Bill

delete

8.00 pm	Decision Time

and insert

10.00 pm	Decision Time

(d) Wednesday 18 March 2026—

after

2.00 pm	Portfolio Questions: Deputy First Minister Responsibilities, Economy and Gaelic; Finance and Local Government

insert

followed by	Stage 3 Proceedings: Greyhound Racing (Offences) (Scotland) Bill

(e) Thursday 19 March 2026—

after

followed by	Stage 3 Proceedings: Visitor Levy (Amendment) (Scotland) Bill

insert

followed by	Stage 3 Proceedings: Crofting and Scottish Land Court Bill

delete

6.20 pm	Decision Time

and insert

9.05 pm	Decision Time—[*Graeme Dey*]

Motion agreed to.

The Presiding Officer: The next item of business is consideration of business motions S6M-21033 and S6M-21034, on variations to standing orders.

Motions moved,

That the Parliament agrees, for the purposes of consideration of the Crofting and Scottish Land Court Bill at stage 3, that Rule 9.10.2A be varied to replace the word "fifth" with "eleventh", so that the deadline for lodging a stage 3 amendment was Wednesday 4 March 2026.

That the Parliament agrees, for the purposes of consideration of the Greyhound Racing (Offences) (Scotland) Bill at stage 3, that Rule 9.10.2A be varied to replace the word "fifth" with "ninth", so that the deadline for lodging a stage 3 amendment was Thursday 5 March 2026.—[*Graeme Dey*]

Motions agreed to.

Topical Question Time

14:06

Glasgow Union Street Fire

1. **Annie Wells (Glasgow) (Con):** To ask the Scottish Government what its response is to the fire at Union Street in Glasgow. (S6T-02943)

The First Minister (John Swinney): Let me begin by paying tribute to our emergency services—in particular, the Scottish Fire and Rescue Service—for their response to that major incident. Two hundred and fifty firefighters were involved and, at the fire's height, 18 fire appliances plus specialist resources were deployed. From 8 o'clock this morning, the SFRS scaled back the response to four fire appliances and two high-reach vehicles, although it is important to point out that it remains a live incident. When I visited the site yesterday, I commended the work of the SFRS and others to the commanders and partners who led the response. It is a huge relief that there were no injuries, which is thanks to the efforts, professionalism and dedication of the emergency services.

A huge effort is under way to identify any safety issues in the train station, which must remain closed for now. The Cabinet Secretary for Transport has been briefed constantly and, yesterday, met Network Rail and ScotRail as they assessed the on-going challenge of restoring services.

Above all else, let me be clear that the Scottish Government will stand with the city of Glasgow as it recovers from the fire. Given the significant cost that the city faces, we will back those words with cash. To get the work started, a ministerial oversight board has been established, chaired by the Cabinet Secretary for Justice and Home Affairs. We will rebuild, we will restore and Glasgow will flourish again.

Annie Wells: I thank the First Minister for his response. I place on record my sincere thanks to and admiration for the firefighters, first responders, paramedics and police, who worked tirelessly throughout the night. Their professionalism and bravery undoubtedly prevented an even greater tragedy.

I remember going to Glasgow Central station on every fair Friday of my childhood to get the train down to London, Bristol or Derby to visit family. It is a place that people in Glasgow hold most dearly. The fire has caused serious damage to a historical part of Glasgow's city centre, including the loss of an amazing Victorian building.

The First Minister has said something about support, but can I get a further commitment that all necessary support will be provided to restore that important part of Glasgow?

The First Minister: I acknowledge the significance of the site in Glasgow. It is iconic in the city. A number of steps will have to be considered as part of the recovery process that is under way, but the Government will work collaboratively with Glasgow City Council to enable that to be the case. A whole sequence of decisions will require to be taken by the council for that to be done. I reassure Annie Wells that the Government will be partners with Glasgow City Council in enabling that to be the case.

Annie Wells: I again thank the First Minister for his response. However, as we know, many small businesses have lost everything as a result of the fire. The owner of Wig Chapel has lost specialist tools and stock, while local businesses such as So Glow, Hundred Demons and Amber Rose Nails have also suffered. Those are people's livelihoods, so will the First Minister outline what immediate practical support can be offered to those businesses in the area?

The First Minister: I am acutely conscious of the impact on a range of businesses, not only in the buildings affected by the fire but in the surrounding areas where there is an exclusion zone and where access is difficult. That situation might persist for some time to come and I am clear about those impacts. Kaukab Stewart, the local member, has briefed me on the dialogue that she has had with individual businesses, and the city council will be in dialogue with them as well.

When I visited the site yesterday, I made clear that I recognise the impacts. We have discussed with Glasgow City Council the support that can be made available by the Government to ensure that business owners—many of them owners of small businesses who were, as Annie Wells said, just getting on with making their living but have had their world turned upside down—get support to assist them at this difficult time. The Government will look to work with the city council to do that.

Bill Kidd (Glasgow Anniesland) (SNP): I have been contacted by a number of constituents who are concerned by the huge proliferation of vape shops and by the obvious dangers that they pose due to the highly combustible and reactive substances contained in vapes, as was evidenced by the fire. Will the First Minister say whether the Scottish Government will consider the need for further regulation of such premises?

The First Minister: It is important to stress at this stage that a full investigation of the site is under way. I am, obviously, conscious of the clear images that have been circulated and that appear

to show that the fire started within a vape shop. It is important to allow the investigation to be carried out to establish the facts about the issue and to identify the lessons that must be learned.

I also understand public concern about the safety of vape shops. As I indicated yesterday, I am open to the need for further regulation and legislation to ensure the safety of people and buildings, especially with regard to the storage and disposal of combustible products.

Pauline McNeill (Glasgow) (Lab): I sincerely thank the First Minister for being here today and for the strong statement that he has made about Glasgow. I add my sincere thanks to the fire and rescue workers and to everyone else who is still ensuring that the fire has been dealt with, and I thank the senior officers who briefed me last night.

The situation is truly heartbreaking for Glasgow. I am probably Glasgow's longest-serving elected member and I find it deeply emotional.

We are still waiting to find out about the damage to Glasgow Central station. Recent media reports indicate that that there is no major damage, although the architect of the glass roof has expressed some concern about that. I am sure the First Minister agrees that things must be difficult for the thousands of commuters who rely on the station, and for the network itself. I know that he has been having discussions about the implications and I presume that the Cabinet Secretary for Transport, Fiona Hyslop, will also be having such discussions. Have there been any talks about what more could be done—including running more buses—to help people get to work or to appointments until we know when Glasgow Central station will be fully open?

The First Minister: I entirely understand the deep emotional connection that Pauline McNeill sets out. That is why I am here today: I understand the depth of sadness experienced in the city of Glasgow about what has happened and, for those reasons, it is right for me, as First Minister, to answer this question today.

In relation to Glasgow Central station, I make it clear that every effort is being made to open the station as soon as possible, but that can be done only when we are assured of the safety of the station. Colleagues will understand the potential vulnerabilities that exist after such a major incident so close to the station.

It must be said that the efforts of the Scottish Fire and Rescue Service, which were explained to me yesterday, were astonishing and avoided the spread of the fire into the Central hotel—as I will always call it—and into Central station.

Its efforts were intensely targeted to make sure that that was avoided. Although the sight is devastating, we have avoided a much greater incident through the skill and professionalism of the firefighters.

The safety assessment will be undertaken. I give Pauline McNeill and other members of Parliament the assurance that that has the highest priority, but it can be concluded only when the investigation has been carried out and we are satisfied that it is safe for access to the station to be delivered.

Sharon Dowey (South Scotland) (Con): Although we must wait for the outcome of official investigations to confirm the exact cause of the fire, it has been widely reported that the fire originated in a vape shop. Such premises often contain large quantities of products powered by lithium-ion batteries that are stored on shop floors and in back rooms. Following the proactive decision to ban disposable vapes from June 2025, it is worrying to see the continued impact that the industry is having in our communities. Despite the risks, minimal responsibility is placed on vape manufacturers and retailers for the hazards that their products can create. Can the First Minister tell us more about what the Scottish Government will do to address that?

The First Minister: I understand the concern that Sharon Dowey expresses, but I want to take issue with one point that she raised, which was about the responsibility of business owners. Business owners are intensely responsible for the safety of their businesses. There is an obligation on any business owner, and particularly an owner of a vape shop, to make sure that their business is safe. We may well be looking at the implications of that failure on other adjoining buildings.

A regulatory infrastructure is in place but, as I said in my answer to Annie Wells, I am open to further consideration of these issues. Legislation is going through the United Kingdom Parliament at this time, and the Government is engaging constructively on that question to ensure that the provisions will extend to Scotland. However, we have to be very clear about the responsibility of business owners to make sure that their businesses are safe.

Kenneth Gibson (Cunninghame North) (SNP): The fire and the closure of Glasgow Central station have exposed how dependent Ayrshire communities are on rail. The last X36 service leaves Glasgow Buchanan Street bus station for the Garnock valley at 17:15, and the final bus from the Garnock valley, which has a population of 20,000, leaves Dalry as early at 15:32. There are no other buses serving those communities. Given that Stagecoach will not enhance the service and neither will Strathclyde Partnership for Transport, what can the Scottish Government do to ensure

that there is a decent and reliable service between my constituency and Scotland's largest city?

The First Minister: I recognise the importance of travel connections from Ayrshire, including Mr Gibson's constituency, and I recognise that greater challenges will be arising as a consequence of the fire. Transport Scotland will continue to engage with its public transport partners and stakeholders to see what measures can be put in place to mitigate the impacts and to build up the resilience of services. That will support Mr Gibson in his efforts to ensure that there are stronger public transport services in Ayrshire.

I apologise for omitting to respond to Pauline McNeill's point about more bus connections. ScotRail is operating a range of services that are coming into, for example, Paisley Gilmore Street, and onward bus connections are available from there. Other intermediary stops are being made to try to maximise the connections. The transport secretary is working with the rail service providers and other agencies to make sure that we maximise bus connections to replace rail services for as long as the incident goes on.

Paul Sweeney (Glasgow) (Lab): The building was one of the most iconic Victorian architectural set pieces in Scotland, and it is truly heartbreaking to see its loss. It stood there for 175 years. Can the First Minister give his assurance that conservation-accredited registered engineers with the right expertise will assess the remaining elevation to Gordon Street for any possibility of the preservation of that frontage and commit to a faithful reinstatement with the building owners, bringing together the ministerial oversight board?

The building is critical to Glasgow's built heritage. In 1987, the Ca d'Oro building right across the road was faithfully reinstated after a major fire, so it can be done. Will there be the political will and commitment at the highest level to do that?

The First Minister: I understand Paul Sweeney's long-standing interest in these issues, and I welcome the comments that he has made. Every effort will be made to progress the site and live up to the aspirations that he has set out. The Government will work with Glasgow City Council in that respect. However, we are at the very early stages of working out what can be undertaken.

In the short term, there will be particular challenges in stabilising what is a very vulnerable site to enable access to Central station. If we are to have access to that station at the earliest opportunity, which is certainly my priority, there will be difficult decisions to make in relation to the existing site. However, all the issues of the protection of the historic environment that are part of the legal framework in Scotland will be applied in this case, and members will be kept up to date on the developments.

Football-related Disorder (Glasgow)

2. **John Mason (Glasgow Shettleston) (Ind):** To ask the Scottish Government what discussions have taken place with football authorities concerning the recent deplorable fan behaviour after the match between Celtic and Rangers. (S6T-02941)

The Minister for Victims and Community Safety (Siobhian Brown): I join John Mason in condemning the appalling behaviour of those who invaded the pitch and acted in a violent and disorderly manner, ruining what had otherwise been an exciting football experience for fans. Disorder of that nature is not acceptable; it risks the safety of players, fans, stewards and police officers.

I spoke to Police Scotland yesterday evening and have this morning spoken to both the Scottish Football Association and the Scottish Professional Football League. We are of one mind in saying that such behaviour is not acceptable and that action must be taken to prevent its recurrence. We all need to play our part, and I am reassured that the police, football authorities and football clubs want to work with us to ensure that there will be no repeat of the scenes that we witnessed on Sunday.

John Mason: The minister used the word "prevent", which is important. The police said that some individuals had "armed themselves" before coming into the stadium—so, clearly, they had not been searched. The stewards had not been checking on who was carrying what, including pyrotechnics. Surely there needs to be better stewarding at games so that everyone is checked. For example, when I went to a Napoli game, I was checked at security. Does the minister agree that everybody who goes to a Scottish game should be checked too?

Siobhian Brown: Yes, absolutely. However, it is quite complex to find hidden masks or pyrotechnics, for example, when people enter stadiums. Those are the sorts of challenges that are faced.

Just before every game, the clubs, Police Scotland and local authorities make sure that robust measures are in place, through the safety advisory group process. Despite that, when people are determined to engage in disorder, it is difficult to prevent it entirely. The speed with which Police Scotland and the stewards dealt with the issue on Sunday suggests that appropriate levels of policing and stewarding were in place. However, there are lessons to be learned, and they will be looking into what happened on Sunday.

John Mason: I associate myself with the minister's comment in that, from what I could see, the police and the stewards handled things well once the problems had started. However, we have to look further than that.

My colleague James Dornan has frequently raised the issue of strict liability. I wonder whether the Government would consider introducing that; I feel that, over the years, it has dragged its heels on doing so. Fans do not want it, and the clubs do not want it, but, as happens in European competitions, clubs should surely take some responsibility for the behaviour of their fans.

Siobhian Brown: Our preferred solution has always been that football should proactively shape and deliver a robust and meaningful solution to tackle unacceptable conduct by supporters. For example, over the past year, clubs have instituted solutions on the misuse of pyrotechnics. The SPFL is taking a strong stance on that, and over the past couple of years it has been instrumental in examining how we could strengthen football banning orders, especially in cases that involve pyrotechnics.

George Adam (Paisley) (SNP): The behaviour of some fans after Sunday's match between Celtic and Rangers was completely unacceptable. Does the minister agree that all fans must exercise personal responsibility—as the vast majority already do—to ensure that those around them can enjoy the game safely, and that football clubs also need to take some responsibility for the behaviour of their fans?

Siobhian Brown: Yes, of course—just as everyone has a responsibility to behave appropriately and in line with the law, no matter where they are. Just because they are at a football match does not mean that the rules of society and the rule of law are not in place.

No one should feel that being in a stadium on a match day somehow gives them permission to act in ways that they would not do in other parts of society. It is clear that a minority of people who attend football matches believe that they can behave in any way that they want, without any thought for the safety or security of the vast majority of fans who go to matches to support and enjoy watching their football team. With regard to the minority of fans who behave illegally and irresponsibly, action will be taken by Police Scotland, and action should be taken by the clubs.

Graham Simpson (Central Scotland) (Reform): The scenes at the match were absolutely horrific. It was not just the pitch invasion; we saw scenes of fans bursting through a disabled access point, there was vandalism at the ground and innocent people were hurt. Then we had the pitch invasion by masked yobs wearing balaclavas and what appeared to be uniforms. Does the minister plan to speak to both clubs? I ask because I think that there is an issue with the way in which clubs allocate tickets to both home and away fans, and maybe that is what should be addressed.

Siobhian Brown: As I said, I spoke to the SFA and the SPFL this morning, when the SFA confirmed that it would be speaking to both clubs to establish the facts of Sunday's events. I am keen to let that process play out. There is also the judicial panel process, and I do not want to interfere with that. The SPFL has confirmed that it is considering very carefully its scheduling of the remaining old firm fixtures, in consultation with Police Scotland. The Scottish Government speaks to both organisations very regularly. We will continue to do that on this issue. As the member said, behaviour such as invading the pitch, engaging in violence, setting off and throwing pyrotechnics and carrying out vandalism is appalling and completely unacceptable.

Business Motion

14:27

The Presiding Officer (Alison Johnstone): The next item of business is consideration of business motion S6M-21024, in the name of Graeme Dey, on behalf of the Parliamentary Bureau, setting out a timetable for consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill at stage 3. Any member who wishes to speak to the motion should press their request-to-speak button now.

Motion moved,

That the Parliament agrees that, during stage 3 of the Assisted Dying for Terminally Ill Adults (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limits indicated, those time limits being calculated from when the stage begins and excluding any periods when other business is under consideration or when a meeting of the Parliament is suspended or otherwise not in progress:

Groups 1 and 2:	1 hour 45 minutes
Groups 3 and 4:	5 hours
Groups 5 and 6:	6 hours 30 minutes
Groups 7 and 8:	10 hours 30 minutes
Groups 9 and 10:	12 hours 30 minutes
Groups 11 to 14:	15 hours 30 minutes
Groups 15 to 17:	18 hours
Groups 18 to 20:	21 hours—[*Graeme Dey*].

Motion agreed to.

Assisted Dying for Terminally Ill Adults (Scotland) Bill: Stage 3

14:27

The Presiding Officer (Alison Johnstone): The next item of business is stage 3 of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

In dealing with the amendments, members should have the bill as amended at stage 2—that is, Scottish Parliament bill 46A—the marshalled list and the groupings of amendments. The division bell will sound and proceedings will be suspended for around five minutes for the first division. The period of voting for the first division will be 30 seconds. Thereafter, I will allow a voting period of one minute for the first division after a debate. Members who wish to speak on any group of amendments should press their request-to-speak button or enter RTS in the chat function as soon as possible after the group is called.

Members should now refer to the marshalled list of amendments.

Section 2—Terminal illness

The Presiding Officer: Group 1 is on the meaning of "terminal illness". Amendment 136, in the name of Daniel Johnson, is grouped with amendment 1. I call Daniel Johnson to speak to both amendments in the group and to move amendment 136.

Daniel Johnson (Edinburgh Southern) (Lab): Thank you, Presiding Officer. It is with a great deal of trepidation that I rise to speak to and move the first amendment.

I begin by paying tribute to Liam McArthur for the way in which he has stewarded the bill through the Parliament. It is not an easy topic, but it is one that everyone in the chamber has considered with a great deal of care. That is why I have lodged amendments 136 and 1 on the definition of "terminal illness", with a view to tightening the definitions, improving the clarity of their scope and providing clarification.

The provisions that are proposed by amendments 136 and 1 are very much in addition to the existing provisions on the definition, rather than being alternatives to them, because I believe that the Parliament has a choice about the kind of bill that it wants Liam McArthur's bill to be. Do we want it to be simply about enabling an act—making the act of assisted dying as straightforward as possible, which is an absolutely valid view—or do we want it to provide a dispensation in very particular and precise circumstances?

14:30

At stage 2, the Health, Social Care and Sport Committee undertook its work diligently, but its view of the bill seemed to be that it was much more about the former rather than the latter. As someone who voted for the bill at stage 1 because I believed in the principle, I am very much of the view that, if we are to progress, we must progress with caution, which is why we need clarification, particularly around what is meant by "terminal" and "progressive". In my view, as the bill stands, it is open to interpretation. That is why, in amendment 1, I seek to provide expanded definitions that would provide greater clarity.

However, over and above that, I believe that simply having a terminal and progressive condition that is likely to shorten someone's life is not a sufficient condition for the possibility of an assisted death to be extended to them. In addition, they must be approaching the end of their life—I will deal with that in the next grouping, which is on being within six months of death—and the condition that they find themselves in must be intolerable, without the possibility of improvement.

Martin Whitfield (South Scotland) (Lab): I have great interest in Daniel Johnson's amendment, for the reasons that he has already set out, but does he share my concern that we would end up with a subjective test that would sit on top of what have previously been, in the main, objective assessments, which would be the same? Can he deal with that point?

Daniel Johnson: I am happy to deal with that point. I actually disagree with it, because I believe that we must be frank about the fact that all the decisions and judgments that we are asking professionals to make in the course of the assisted death process will be subjective. There is no possibility of true objectivity. We could set some standards, expectations, values and conditions, but, ultimately, it will boil down to doctors and other medical professionals making judgments. Those judgments will be based on their experience and knowledge of the person, but they will be subjective judgments. All that we can do is to ask for qualifications in addition to those judgments.

Throughout the stage 2 process, much was made of international comparison. It is important to note what international comparison tells us about this.

Patrick Harvie (Glasgow) (Green): I wonder whether Daniel Johnson can tell us a little bit more about his reasoning for choosing the following form of words in amendment 1:

"that treatment that can relieve or improve this condition … is no longer providing relief or improvement".

It seems to me that that implies that a treatment that could theoretically provide even the most marginal, barely registrable improvement would rule out the individual being able to make their own choice. Surely it is for the individual to decide whether a treatment provides sufficient improvement for them to change their mind.

Daniel Johnson: The member makes a fair point, but I would also argue that, without that, if there is the possibility of a treatment that would improve the person's condition, would we want to allow them to proceed? Somebody could have a terminal condition and be at the end of their life but have a good quality of life or have that possibility. We need to ask ourselves whether we think that it is appropriate in those circumstances.

I draw members' attention to both the New Zealand legislation and the Australian Capital Territory legislation, which provide similar conditions. In both sets of legislation, there are additional qualifications in relation to whether someone's condition could be improved by treatment and whether they are approaching the end of life; those qualifications are both present in the way that that legislation is set out. It is important that, when we make such international comparisons, we are clear about what they involve.

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): I think that we would all be drawn to the notion of making intolerable suffering part of the criteria—certainly, I am drawn to that—but we are doing more than just legislating for a form of words; it must have a legal interpretation. I see that an attempt is being made to do that in amendment 1. Mr Johnson has referred to legislation from other parts of the world, but is there anything that can be drawn from law here in Scotland in relation to the notion of intolerable suffering? Is there anything else in Scots law that relates to that?

Daniel Johnson: I would simply draw on the legislation in the two jurisdictions that I mentioned for comparison, both of which have similar or comparable forms of wording. In addition, the fundamental definitions of "terminal illness" and "progressive" in the bill would similarly require legal interpretation. I acknowledge that, in many ways, I would prefer that the definitions had been looked at further—indeed, much of the bill could have done with a great deal more deliberation and scrutiny.

To go back to the amendments that I have lodged, amendment 136 would introduce the concept of intolerable suffering. I stress that that would be in addition to the two conditions already in the bill with regard to having a terminal illness that is progressive.

Amendment 1 would provide the expanded definitions, because I believe that clarification is

needed, not only of the meaning of intolerable suffering, but of what the terms “terminal” and “progressive” mean. Without clarifying the definitions, we would simply be relying on two lines of legislation. I note that that is considerably less than in most of the pieces of legislation in international jurisdictions that are available for comparison, if members choose to look at them.

I move amendment 136.

Jeremy Balfour (Lothian) (Ind): I thank Daniel Johnson for lodging the two amendments in this group.

I rise to speak with serious concern about the bill, in particular with regard to its impact on disabled people. For many disabled people, the debate around assisted dying feels not abstract or theoretical, but deeply personal. At its heart, the bill sends a deeply disturbing message that some lives, especially the lives of disabled people, are more eligible for ending than others.

Many disabled people fear that the bill could, implicitly, make them feel that their lives are automatically considered eligible for ending, simply because they live with a disability. That is a message that the Parliament must never, ever send.

Supporters of the bill will point out that it is framed around terminal illness, not disability. I see what Daniel Johnson is seeking to do with the two amendments in this group, but the reality is that many who are terminally ill will also be disabled, and the line between the two can become blurred in practice. Disabled people in Scotland already face serious inequalities and barriers, higher rates of poverty—

Liam McArthur (Orkney Islands) (LD): I am grateful to Jeremy Balfour for taking my intervention. We had some of these exchanges at stage 2, but I wonder whether he would reflect on the evidence in the detailed research that was carried out by Professor Ben Colburn at the University of Glasgow, which indicated that, across all the international jurisdictions with assisted dying laws of this type, there is no evidence of a disproportionate impact on those in the disability community. Moreover, there have been no detrimental impacts in terms of wider rights or perspectives of disabled people as a result of the introduction of such laws.

Jeremy Balfour: I have to say that that is not the evidence that the disability community has presented to me, and it is not the evidence that is coming loud and clear from those with lived experience, in particular in Canada and parts of Australia.

I have to say that I disagree fundamentally with the presumption that Mr McArthur puts forward.

As I was saying, people with disability face higher rates of poverty, limited access to healthcare, social isolation and, at times, a sense that society does not fully value their lives. Against that backdrop, the bill would risk compounding those pressures and subtly signalling that the lives of our most vulnerable are less worthy of protection. How we treat those with terminal illness and disability speaks volumes about the type of people and the type of society that we are, and we should make no mistake about it—we will be judged by that.

I welcome what Daniel Johnson has tried to do, because, just recently, Lord Falconer, who is taking forward the bill in the House of Lords, said:

> “Your financial position might be an element in what makes you reach a decision.”

He went on to note:

> “The evidence from abroad is that it is people from perhaps more financially secure circumstances who make this sort of choice.”—[*Official Report, House of Lords,* 16 January 2026; Vol 851, c 2019-20.]

His argument is that assisted dying is framed around choice.

However, again, the disturbing implication is that difficult circumstances such as poverty, vulnerability or domestic abuse might make assisted dying an option for some. Let me be clear—I believe that that is outrageous and not the type of society that I want to live in. Being poor or living with disability is not a choice, and it should never be used as a reason to facilitate the ending of someone’s life.

Many people have told the Parliament that their fear is not just of overt coercion but of subtle pressure—the sense of being a burden, the worry about consuming scarce resources and the feeling that others might be better off without them. Those pressures, let me tell members, are real, and legislation that treats disability as a factor in eligibility risks legitimising those fears.

We heard from Daniel Johnson about making the legal definition clearer. We all know that, if the bill becomes an act, it will be interpreted by the courts over time, and even the safest safeguards could well be eroded by the courts.

The measure of a society is not only how it protects autonomy but how it safeguards those who are most vulnerable. If the bill is passed, it will define us as a Parliament and Scotland as a society by the way that we treat those who are weakened, most at risk and often overlooked. We have a duty as parliamentarians to ensure that no disabled person ever feels that their life is conditional or less valued, or that assisted suicide could be considered as something that brings economic benefit. Every life must be respected,

protected and affirmed without compromise. How we act and how we stand is a measure of the integrity and moral character of this Parliament and our society—not just in the eyes of history, but in the judgment of the people of Scotland and, most importantly, of the most vulnerable among us.

Pam Duncan-Glancy (Glasgow) (Ind): I thank the member in charge of the bill for the way in which he has taken it through Parliament, and I thank other members for the way in which they have engaged in the very sincerely personal debate. I know that members are taking very seriously the weight of these decisions. I also thank the legislation team, which has done a power of work in getting us through many amendments, and Parliament staff for the time that they will put in to help us get through the amendments.

As currently drafted, the bill defines someone as terminally ill

"if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death".

That definition is, as my colleague Daniel Johnson has pointed out, incredibly broad. It includes many disabled people—indeed, as I said at stage 2, it could include me. I recognise that the amendments in this group try to provide greater clarity, but I do not believe that they resolve that fundamental issue. The provisions in them are highly subjective. I acknowledge that the member who has lodged them recognises that, but I will talk briefly about why that is important.

People's experiences and their views about what they can live with change over time. They are shaped by the society in which we live, as well as our views of ourselves. Absolutely everything that I have, I have had to fight for. I had to fight to get overnight care so that I could go to the toilet, because the council had said that it would be cheaper to use incontinence pads. That fight in particular nearly broke me. I was ill, I was crying daily, and the pain from my advanced stage arthritis, which will likely result in early death, got worse, because I was worn down by fighting. I am one of the most empowered disabled people in the country—one of 129 people who have the privilege of sitting in this Parliament—and I have been broken by how hard it is to live, or to try to live, like everyone else. Even when pain is intolerable, it is the everyday ableism and discrimination that make me feel like I cannot go on.

14:45

When I have the support that I need and when I am not fighting, I and people like me can live well, and we can thrive. We believe that life, at that point, is tolerable and even well worth living. We even believe that in circumstances in which others do not think that a life like ours would be worth living.

I want to take a moment to talk about other people's views on tolerating loss of function and why that is also a complex and subjective concept. People often portray the lives of disabled people or people who have lost function as being intolerable. Paralympian Tanni Grey-Thompson, who members recently had the opportunity to meet, was told by someone that they would rather be dead than incontinent, as she is. They said that to a Paralympian who sits in our House of Lords.

People question daily how people live with loss of function—for example, how I cope. They feel that it is acceptable to assume that a life like ours would be intolerable and not worth living. People question that regularly.

Presiding Officer, someone has to shower me. Someone has to take me to the toilet and help me in the toilet. Someone has to do almost everything for me. Many people find that to be undignified and are not afraid to tell me that. On occasion—for example, if I have no care or the toilet is not accessible—it can be quite undignified.

The point that I hope that I am making is that I have learned to live with the good, the bad and the ugly of my life. That does not mean that I am not scared of loss of function, as I imagine that everyone is—of course I am. I want to keep the little function that I have left, and I am worried about what would happen if I do not.

However, I have seen people face adversity on a daily basis, overcome it and enjoy life. With the right support, people can lead great lives despite otherwise intolerable pain or suffering. What is intolerable for me has moved over time and might not be tolerable for someone else. We must be very cautious about the message that will be sent if help, aids, adaptations, significant care from others and the inability to use the loo or shower by ourselves are circumstances that could be interpreted as indicators that someone's life has become intolerable.

Others often view disabled people's quality of life as being lower than the disabled people themselves do. When we ask people to rate their quality of life, even in difficult circumstances, disabled people often rate it higher than the professionals in their lives. That is an important fact for us to remember when we are considering the details in this bill.

Martin Whitfield: From a personal point of view, these amendments are swings and roundabouts. Having listened to Pam Duncan-Glancy's powerful

speech, my question to her is this: would she say that the fear of that sort of unintentional reinforcement by others of an assumption about her quality of life challenges the wording that has been chosen for the amendment? When we consider the issue from a human rights basis, or even when we consider the Children (Care, Care Experience and Services Planning) (Scotland) Bill, which will come before the Parliament at stage 3 next week, should the choice be to try to give dignity and autonomy without such prejudice?

Pam Duncan-Glancy: Martin Whitfield gets to the heart of why I am concerned about these amendments. I fundamentally believe that they have been drafted with good intentions and I can see what Daniel Johnson is trying to do. However, an individual's subjective view of tolerability and suffering can change at any time, and so too can someone else's view about that person. It would be a difficult objective test to have in law, which is why the amendments in this group will not give the safeguards that I think that Daniel Johnson is seeking, nor will they provide the safeguards that are required make the bill less of a risk.

We know that disabled people's quality of life—and sometimes that of people at the end of life and people who have lost function, too—is often viewed by others as being lower than they would rate it themselves. We cannot, therefore, rely on those views as an objective measure when considering the bill or, indeed, considering whether assisted dying is safe. It is the subjectivity of quality of life, and all that comes with it, that makes the well-meaning amendments in the group impossible safeguards.

I ask members to think carefully and recognise that, although the additions appear to offer extra protections, they are fraught with difficulty and would still leave many people at risk.

Jackie Baillie (Dumbarton) (Lab): I listened carefully to Daniel Johnson when he spoke to his amendments. There is concern that they expand rather than restrict the definition of those who would be considered as eligible for assisted dying, which I understand is not his intention.

However, I wanted to share an email from a constituent about his sister. This is what he had to say:

"My sister is in a nursing home in Helensburgh and I have … power of attorney for her so I speak on her behalf. She has had a severe form of psychotic depression, which has caused her much suffering for nearly 45 years. She has been near death at least once from refusing food and drink. She … can be strongly influenced by outside suggestion. However the last eight years have probably been among the happiest of her life. Previous to that … advice as to assisted suicide would have, at times, been accepted by her, and I think that if she had lived in Canada or Holland she would now be dead."

I am concerned that that person would fit into the definition as proposed by Daniel Johnson, and I would be grateful for his comments on that when he sums up.

The Cabinet Secretary for Health and Social Care (Neil Gray): I would like to set out to Parliament the Scottish Government's position on stage 3 of Liam McArthur's Assisted Dying for Terminally Ill Adults (Scotland) Bill.

The Scottish Government remains neutral on the bill. We also consider that we have a duty to assess the technical, legal and deliverability implications of amendments in terms of whether the bill would be workable in practice if passed. We therefore published a commentary on some amendments at stage 2 and a similar document on the stage 3 amendments yesterday. That approach reflects the Government's neutral position as we provide no comment on ethical matters; that is for MSPs to decide on.

However, we consider that members should be made aware when there are implications for deliverability or for the public purse in relation to some amendments being agreed to and forming part of the final bill, if passed.

It is my intention to speak only in relation to amendments where the Scottish Government has identified potential issues to do with legislative competence or significant legal or deliverability challenges, including where it is felt that amendments will have major financial implications.

On some amendments, I will speak to where Scottish Government work is already in progress. I will also speak to my amendments, which were lodged in consequence of the section 30 order that the Parliament approved last month.

As Parliament is aware, it is the Scottish Government's view that the bill in its current form is outside the legislative competence of the Scottish Parliament and that there is a responsibility to maintain the integrity of the devolved statute book. Therefore, in relation to the stage 1 vote and the wishes of this Parliament, and in recognition of the fact that the Scotland Act 1998 order process is intergovernmental, I committed to engage with the United Kingdom Government to try to address the legislative competence issues that were identified. That engagement has taken place in good faith, and the amendments that I have lodged—as well as some that I have provided to Mr McArthur—are the outputs of that.

For my part, I have lodged amendments that I deem necessary and consequential to the section 30 order that has been agreed by the Scottish and UK Governments to cover the identification and regulation of substances and medical devices for use in assisted dying.

I am of the view that section 18 should be removed from the bill in its entirety, as the provision may relate to the H1 employment reservation, and possibly to the G2 regulation of health professions reservation, of the Scotland Act 1998. Likewise, I am of the view that the training provisions in the bill should be removed, as they may relate to the G2 reservation.

Ross Greer (West Scotland) (Green): In the letter from UK ministers to the Westminster Scottish Affairs Committee, the phrases "training, qualifications and experience" and "qualifications and experience" are used interchangeably. It is the view of some outside this place, including a number of organisations that have engaged extensively on the Assisted Dying for Terminally Ill Adults (Scotland) Bill and have sought legal advice, that training is not subject to the G2 reservation in the 1998 act, although they acknowledge that qualifications and experience are.

Will the cabinet secretary provide a bit more detail as to why the Scottish Government believes that training is covered by that reservation? That certainly was not my understanding before we began dealing with the bill.

Neil Gray: I appreciate the intervention from Ross Greer. At this stage, I can say only that provisions in the bill may, or could, be outwith the competence of this Parliament, because ultimately that would be a decision for the Supreme Court to take. I have set out the Government's position on those areas in the legislation that we feel are beyond our legislative competence, and I will speak to those issues as we go through the bill.

As I will come to shortly, the UK Government has also published its approach to the negotiations around the issue of the requirement for a section 104 order, which will come about if the bill is passed. I am happy to liaise with Mr Greer or anyone else during the course of the debate on the bill with regard to issues of legislative competence.

Jamie Hepburn: On the issue of the section 104 order, we have had sight of the letter that went to the Scottish Affairs Committee, which I note was not sent to MSPs directly—I think that it should have been, but that is an aside. The cabinet secretary has already set out that the elements of the bill that relate to medicines can be dealt with through a section 30 order. Can the cabinet secretary set out what reasons the UK Government gave, if any, that this area could not be dealt with through a section 30 order rather than a section 104 order? I think that a section 30 order process would have been much more preferable.

The Presiding Officer: Before the cabinet secretary responds, I remind members that we will come on to these issues, and it is very important that we continue to focus on the issue that is in front of us at this moment.

Neil Gray: Of course, Presiding Officer. The issue that Mr Hepburn raises is important, because I know that MSPs are concerned about the elements that are to go through the section 104 process. It is clear that it would have been preferable for all those issues to have been dealt with through a section 30 order. That would have been neater, given what we are wrestling with in relation to some of the elements of the section 104 process.

We negotiated in good faith with the UK Government. Its position was that the elements that are to be dealt with by a section 30 order fall within the ambit of section 30, and it was clear that it wanted the remainder to be dealt with through a section 104 process. It will be for the UK Government to explain why that was the case.

It is important to set out the Scottish Government's approach to the bill, and, for the sake of transparency and clarity, to set out how I, on the Government's behalf, will approach these proceedings over the coming days. As Mr Hepburn has already stated, the UK Government has agreed in principle to resolve legislative competency issues via a section 104 order. The UK Government has sent a letter to the UK Parliament's Scottish Affairs Committee confirming that, and the letter has been published by that committee. Should the bill pass, Scottish and UK Government officials will continue to engage on the final form of the order.

Stephen Kerr (Central Scotland) (Con): Can the cabinet secretary confirm that the use of a section 104 order means that part of the bill will be subject to secondary legislation?

Neil Gray: How the section 104 process is to be delivered depends on the vehicle that is decided on. That could potentially be through secondary legislation, but it could be through other means. It depends on the vehicle that is negotiated on and on what the UK Government agrees to by negotiation, if the bill is passed.

Although amendments that are lodged are not required to be competent, I encourage members to consider our responsibility for ensuring that legislation is within our competence. As members are aware, there will be a gap between the stage 3 amendments being debated and the final debate and vote on the bill next Tuesday. We intend to provide an assessment of the bill as amended ahead of that final vote—as we have done at the stage 2 and stage 3 amending stages—and to provide commentary only on areas of legislative competence, legal or deliverability challenges and major financial implications.

Now that I have given that explanation, I confirm that I have no specific comments on the amendments in the group.

Liam McArthur: I start by echoing Pam Duncan-Glancy's comments about the way in which colleagues across the board, irrespective of their position on the bill, have engaged with it over the past four and a half years. I also echo her thanks not just to the legislation team but to the non-Government bills unit, which has been performing heroics. I also thank my own team, which has been supporting me and—over recent days and throughout the process—other colleagues and their offices in relation to the bill.

I reciprocate Daniel Johnson's generous comments by thanking him for the constructive engagement that we have had on the issue throughout the process. As he has ably demonstrated, he might be able to lay claim to being the only member of this Parliament who has read the legislation not only from the Australian Capital Territory and New Zealand but, I am fairly sure, from New South Wales, Western Australia and Oregon as well. He has lodged amendments at stage 2 and now at stage 3 that have enabled debate and allowed Parliament to take a view on some pretty key issues, and for that I am grateful.

15:00

I say all of that as a preamble to, I hope, softening the blow of confirming that I cannot support his amendments in this group. I remain of the view that the definition of terminal illness as set out in the bill is appropriate. Adding subjective terms such as "suffering intolerably", as amendment 136 would do, is likely to add confusion. Jackie Baillie's concerns are probably valid in that respect, too. That is perhaps illustrated by the attempt to define the term in amendment 1. The terms "advanced" and "progressive" are well understood by medical professionals, as the Health, Social Care and Sport Committee heard in evidence, and there are good reasons not to circumscribe those terms.

I understand Daniel Johnson's intention, but I am concerned that his definition includes a requirement that treatments that are

"reasonably available and acceptable to the person"

must

"have lost … beneficial impact".

I acknowledge that amendment 1 would place emphasis on what the person finds to be acceptable treatment. However, the requirement that those treatments have lost "beneficial impact" would mean that, if someone wished to refuse treatment such as chemotherapy because they no longer found it acceptable due to the side effects, the fact that the chemotherapy might still have a "beneficial impact" could mean that they might not be deemed eligible for an assisted death. We might be requiring an individual to undergo invasive and risky medical procedures that they had made a conscious decision not to undergo—I know that Daniel Johnson would not wish that to happen.

On the inclusion of the term "suffering intolerably", I am concerned that the definition is somewhat subjective and appears to be limited to physical pain.

Michael Marra (North East Scotland) (Lab): I ask the member to reflect on the evidence from the Royal College of Physicians and Surgeons of Glasgow, which has talked about the subjectivity of diagnosis and the fact that many people who are told that they have, for example, six months to live will be alive three years later. There is a core question relating to subjectivity and objectivity in diagnosis. We will deal with that issue in discussing future amendments, but it is key to the amendments in this group, too. According to those physicians, the terms that Liam McArthur uses are equally subjective.

Liam McArthur: The assumption that the fact that somebody is going through the process after having made a request means that they would then inevitably and automatically seek to exercise that choice immediately is not borne out by the evidence from other jurisdictions around the world. People go through a process, and it might be many months and possibly even years later that they seek to follow through with a request. At that point, there would still be the requirement to establish that capacity and consent are valid.

People's motivations are rarely singular, and symptoms that they find intolerable at the end of life might go beyond pain, such as vomiting and fungating wounds. Physical pain is not always the primary concern that is cited by dying people. In jurisdictions where assisted dying is legal, the top three end-of-life concerns that are recorded by the doctor on behalf of the patient are loss of autonomy, being less able to engage in activities that make life enjoyable and loss of dignity.

Taken together, amendments 136 and 1 risk narrowing eligibility in ways that do not reflect the complex and deeply personal nature of suffering at the end of life while potentially requiring individuals to undergo treatments that they would otherwise have refused. Throughout, my policy has been that it should be for assessing doctors, with input from other professionals where necessary, and supported by guidance under section 23, to determine those aspects of the terminal illness definition. As we heard during stage 1 evidence, doctors already regularly make such

assessments, and clinical judgment should prevail over fixed definitions.

On that basis, I ask Daniel Johnson not to press his amendments but, if he does, I urge Parliament not to support them.

Daniel Johnson: I thank everyone who has contributed to the debate. We all face a fundamental conundrum. We are being asked to ponder legislation in which the key definition is simply that a person is

"terminally ill if they have an advanced and progressive disease, illness or condition from which they are unable to recover and that can reasonably be expected to cause their premature death."

Save for perhaps that second last word—"premature"—that definition covers a huge range of conditions. One could say—I say this without any glibness—that we all suffer from a condition that is progressive and that will limit our lives: life. A great number of medical conditions fit that definition. Simply the prognosis or diagnosis that someone has a condition from which they will not recover and that will likely kill them is sufficient for them to exercise the capacities that are set out in the bill.

Liam McArthur: Will the member give way?

Daniel Johnson: I will in a moment.

It is really important that we add some additional protections. I regret that amendments 136 and 1 are not being considered alongside the amendments in the next group. To my mind, having a terminal condition is a necessary condition under the bill, but it is not sufficient. It must be that someone not only has a terminal condition but is nearing the end of their life, and that the condition that they find themselves in is one for which no other medical treatments can provide satisfaction. In the coming days, we will discuss other amendments that ensure that such treatments are extended to people. It is important to capture those points as best as we can in the definitions.

Liam McArthur: To some extent, and without wishing to give a spoiler alert, it sounds as though Daniel Johnson is teeing himself up for amendments that we are likely to come to very shortly around the prognosis period, which speak to the concerns that he has quite legitimately articulated.

Daniel Johnson: I acknowledge that.

I will deal with the points that have been raised. First, I say to Jackie Baillie that my amendments would certainly not expand the definition. My intention with amendment 1 is that the word "and" in the proposed new paragraphs makes it an additional requirement. It is not intolerable suffering instead of terminal illness or a condition's progressive nature—it is as well as, which is very important.

Regarding legal clarity, I point members to the definition in New Zealand legislation, which states that a person is eligible if they are

"in an advanced state of irreversible decline in physical capability; and … experience unbearable suffering that cannot be relieved in a manner that the person considers tolerable".

In the Australian Capital Territory, the legislation states that a person is eligible if they are

"diagnosed with a condition that, either on its own or in combination with one or more other diagnosed conditions, is advanced, progressive and expected to cause death"

and that they are suffering intolerably in relation to the relevant conditions. It further clarifies that the individual's condition is advanced if it has "declined" and is not expected to improve and if

"any treatments that are reasonably available and acceptable to the individual have lost any beneficial impact."

Those are the definitions in other benchmark bills, and they have been unproblematic.

My amendments 136 and 1 provide additional requirements and clarifications. It is also important to clarify what we mean by "progressive" and "terminal".

I thank Jeremy Balfour and Pam Duncan-Glancy for their observations. It is important that we seek to tighten the legislation. I do not wish assisted dying to be the default position, and, most important, I do not wish it to become the norm. As both members rightly pointed out, struggle and suffering are a part of many people's daily lives—indeed, one could argue that they are a part of everyone's daily life. Therefore, determining when someone's condition meets a threshold is incredibly difficult. I acknowledge that it is difficult; I also acknowledge the concerns that might be raised, but if we are to pass the legislation at all, we need to understand that we are dealing with matters of subjectivity. I urge members to take great caution in suggesting that these are matters of objectivity.

Ultimately, as I said in my opening remarks, we will rely on the judgment of professionals and the ability of individuals to make decisions for themselves about what they find acceptable and whether they wish to take such a significant decision. Subjectivity is at the very heart of the matter. To claim that amendments simply introduce subjectivity is to somewhat ignore what the vast bulk of the legislation will ultimately do.

Most important, I say to Jeremy Balfour that he is quite right. I do not believe that this is the last time that we will talk about the possibility of judicial

expansion. I am very worried that, unless we define more tightly what we mean by "terminal illness" and "progressive"—indeed, I think that we should put in some additional requirements; it is not just that the person has those conditions, but that they are causing them suffering—we potentially leave ourselves open to something that is essentially discretionary.

It is important that we provide these expansions. I also note that we have a short definition, whereas many other pieces of legislation have far more substantial descriptions of the conditions that make an individual eligible.

The Deputy Presiding Officer (Annabelle Ewing): The question is, that amendment 136 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

As this is the first division of stage 3, I will suspend the meeting for around five minutes to allow members to access the digital voting system.

15:10

Meeting suspended.

15:16

On resuming—

The Deputy Presiding Officer: We will now proceed with the division on amendment 136. Members should cast their vote now.

For

Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Clark, Katy (West Scotland) (Lab)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Golden, Maurice (North East Scotland) (Con)
Johnson, Daniel (Edinburgh Southern) (Lab)
McKee, Ivan (Glasgow Provan) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carlaw, Jackson (Eastwood) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Maggie (North East Scotland) (Green)
Choudhury, Foysol (Lothian) (Ind)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dowey, Sharon (South Scotland) (Con)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Findlay, Russell (West Scotland) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Gosal, Pam (West Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Griffin, Mark (Central Scotland) (Lab)
Gulhane, Sandesh (Glasgow) (Con)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hoy, Craig (South Scotland) (Con)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Martin, Gillian (Aberdeenshire East) (SNP)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McCall, Roz (Mid Scotland and Fife) (Con)
McLennan, Paul (East Lothian) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ross, Douglas (Highlands and Islands) (Con)

Rowley, Alex (Mid Scotland and Fife) (Lab)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Simpson, Graham (Central Scotland) (Reform)
Slater, Lorna (Lothian) (Green)
Smith, Liz (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Wells, Annie (Glasgow) (Con)
White, Tess (North East Scotland) (Con)
Whitfield, Martin (South Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Wishart, Beatrice (Shetland Islands) (LD)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Gray, Neil (Airdrie and Shotts) (SNP)
Mountain, Edward (Highlands and Islands) (Con)
Villalba, Mercedes (North East Scotland) (Lab)

The Deputy Presiding Officer: The result of the division is: For 8, Against 111, Abstentions 3.

Amendment 136 disagreed to.

Amendment 1 not moved.

Section 3—Eligibility

The Deputy Presiding Officer: Group 2 is on eligibility to be provided with assistance. Amendment 2, in the name of Daniel Johnson, is grouped with amendments 137 to 141, 143, 162, 316 to 318 and 322 to 324. If amendment 161, which is to be debated in group 7, on assessments, including support, of terminally ill adults, is agreed to, I cannot call amendment 162, because of pre-emption.

Daniel Johnson: I assure members that I will not be speaking at the beginning of every single grouping. It just happens that I got my amendments in early on these sections of the bill. In addition, I do not intend to rehearse much of what I said about the previous group of amendments, because much of that logic applies to my amendments in this group—amendments 2, 316 and 322.

We need to tighten the scope of eligibility through the definition. Through amendment 2, I seek to narrow the eligibility for accessing assisted dying to people who are reasonably expected to live no more than six months. What I am attempting to capture in the amendment is not about accuracy of prognosis but about the principle that access should be extended to people who are at the very end of their life. That is important.

One of my fundamental problems with the bill, especially after stage 2 consideration, was that, under the definition as drafted, simply having a terminal progressive condition would be sufficient for eligibility. That could mean that someone could have received such a diagnosis, have it deemed to be progressive and irreversible but still have many years left to live—perhaps even decades. That is simply not what I consider to be acceptable as concerns eligibility.

It is my view that, if the bill is to pass, it must be a narrow one that deals with exceptional circumstances when all other options are exhausted, and that it must deal with the end of life.

The Deputy First Minister and Cabinet Secretary for Economy and Gaelic (Kate Forbes): I am conscious of the argument that the member puts forward. I have been very struck by the work of Dr Scott Murray, the palliative care doctor who wrote recently in *The Times* that

"evidence from palliative care, primary care and prognostic research"

paints a picture of the impossibility of making a prediction that someone has only six months left to live. He writes that

"predictions are highly unreliable, and with modern treatments, such forecasting is pure guesswork."

How does the member square the appearance of a safeguard of a six-month prognosis with the reality that doctors, particularly palliative care doctors, say that that is, in their experience, uncertain?

Daniel Johnson: I thank the Deputy First Minister for raising the issue and note the concerns both from the individual that she cites and from others.

If we are considering passing the bill, we must understand what we are passing. Amendment 2 is not about forecasting and it certainly cannot be about accuracy, because we are dealing with matters that are inherently uncertain. I am asking for which individuals and in what circumstances we want assisted dying to be considered. Do we want it to be considered at any point in someone's life, simply by virtue of their having a terminal condition that is progressive and irrecoverable, or do we want to reserve it for those we think are very likely to be in the final stages of life?

In other words, amendment 2 is not about providing accuracy or a threshold but about providing a yardstick. We are saying that assisted dying is something that we wish to extend to those whose life can be measured in months, rather than

in years. In so doing, we must acknowledge that that is an imperfect and fallible measure but it is the best one available to us and it is one that is used elsewhere.

Maggie Chapman (North East Scotland) (Green): I have two questions for Daniel Johnson. Why does his amendment call for a period of six months and not 12? Also, what would happen if someone has multiple conditions? For example, they might have a terminal illness alongside something such as dementia that might mean that, within that six-month period, they might no longer have the capacity to make a decision, and so would want to make that decision while they still can, which would be outwith the six-month period.

Daniel Johnson: The member makes a fair and important point, because we are dealing with complexities. We may all need to wrestle with, and accept, the fact that the decision may not be available to all people, because of its serious nature. All members will have to understand that we must have thresholds and standards, which might well mean that we exclude some people. I acknowledge those problems.

The member asks why six months. That is simply the best way of capturing the important intent that assisted dying should be available to someone in the final stages of their life. It is also a measure that we see being used across many similar pieces of legislation in other jurisdictions.

Maggie Chapman: In response to my question, Daniel Johnson said that we need some sort of cut-off point. He used the word "threshold" although he had said earlier that the six months is not a "threshold" but simply a "yardstick". I am therefore a little confused about how definitive the member thinks the six-month yardstick, threshold or prognosis actually is.

Daniel Johnson: The way in which amendment 2 is drafted is certainly not definitive, because it talks about a reasonable expectation of six months. The idea of reasonableness is a concept that we use and invoke across all manner of legislation. Is that a threshold? It is not. I am saying that there are other thresholds in this legislation that deal with capacity, age or someone's ability to take the substance themselves. We have many other thresholds and we must acknowledge that we have them.

Brian Whittle (South Scotland) (Con): I have listened with great interest to what Daniel Johnson has had to say. I wonder whether he agrees that, whatever timescale we agree to—if we agree to one—it cannot be open ended. If we agree to six months, it will not necessarily mean that someone who tries to access assisted dying will do so within that time, but we cannot have an open-ended timescale in legislation.

Daniel Johnson: I quite agree. I am happy to give way to Alasdair Allan if he wishes to intervene.

Alasdair Allan (Na h-Eileanan an Iar) (SNP): I thank the member. I appreciate the motives behind his amendment, but I wonder whether he has a view on how the courts or others would be expected to interpret the six-month rule. One way that has been used to interpret the rule in the benefits context has been to ask, "Would you be surprised if this patient was alive in six months?" However, Marie Curie found that that measure has an error rate of 46 per cent. I do not doubt the reason why the member lodged his amendment, but does he accept that there are multiple ways of assessing against the criteria that he seeks to establish?

Daniel Johnson: I accept that but, for the reason that Brian Whittle gave, it would be dangerous to pass the bill in a completely open-ended manner. The six-months provision states, essentially, that we wish this to be used by those who are in the final stage of their life, and it is something that the courts in other jurisdictions have been able to interpret. At stage 2, we discussed whether such provisions are prevalent elsewhere. The Colorado legislation of 2016 has a six-months criterion; the legislation in Victoria in Australia has a 12-months criterion, as does Hawaii; and New Zealand has a six-months criterion, as do various other areas of Australia.

The jurisdictions that do not have such a criterion in legislation that has been passed recently are in the minority. The Australian Capital Territory was used as an example of somewhere that does not have a criterion. However, although it does not use a period of six months explicitly, it has a stipulation that, to be eligible, the person must be nearing the end of their life. That is always going to be a difficult decision, but courts in other jurisdictions have been able to interpret the criterion. The most important thing is that it says, "We wish this to be used only by those who are in the final stage of their life." That relates to Maggie Chapman's point.

I am glad that Brian Whittle intervened, because I note that we will discuss in later groups his amendments about advance care directives. They are really important in relation to having clarity of intent about future conditions, because we are dealing with people whose capacity may vary. This is not about people essentially making a decision at the time. In conjunction with some other amendments that we will consider today or in the following days, what I propose is a useful yardstick or measure by which we can define who we want to qualify to use the possibilities that are set out in the bill.

I move amendment 2.

The Deputy Presiding Officer: I call Stephen Kerr to speak to amendment 137, in the name of Sue Webber, and other amendments in the group.

Stephen Kerr: Sue Webber cannot be here to speak to her amendments 137, 318 and 324, so she asked me to present her remarks in the chamber, which I do gladly. Her amendments deal with a serious omission from the bill, which concerns what happens if a woman who is seeking an assisted suicide is pregnant. Whatever members' views on abortion might be, pregnancy raises profound legal, medical and ethical questions that the bill simply does not answer. In those circumstances, we are not dealing with one life alone. There is also the life of the unborn child. That alone makes the situation fundamentally different from the rest of the bill.

The problem becomes more acute when we consider the question of viability. In Scotland, a pregnancy beyond 24 weeks is legally understood to involve a viable child, yet the bill provides no clear guidance about what should happen if a woman who meets the eligibility criteria seeks an assisted death at that stage. Would the law allow a doctor to prescribe a lethal substance knowing that it would also end the life of a viable unborn child? Would clinicians be expected to proceed even where the pregnancy was well beyond the point at which abortion would normally be permitted? The bill is silent on that, and that silence is not a minor oversight. It is a fundamental gap in legislation that deals with matters of life and death. Without clarity, doctors would find themselves placed in an impossible position.

15:30

Emma Roddick (Highlands and Islands) (SNP): I am interested, because the proposed amendments also do not differentiate between a pregnancy prior to 24 weeks and one post 24 weeks. Why is that? Will Stephen Kerr explain a little more the justification for testing whether women who seek assisted dying are pregnant, as presumably would have to be done? To force somebody who is terminally ill and close to death to go through an abortion beforehand seems inhumane.

Stephen Kerr: I do not think that that is what Sue Webber's amendments suggest. The amendments as drafted would capture all women who are pregnant, for reasons of lack of clarity in the bill in relation to the subject in total.

As I was saying, without clarity, doctors would find themselves placed in the impossible position of being asked to facilitate an assisted suicide for a pregnant woman while knowing that doing so could also end the life of her viable unborn child. When the law places doctors in an impossible position, it is usually a sign that that law has not been properly thought through.

That concern is not purely theoretical. Serious illness during pregnancy does occur. Medical research suggests that cancer arises in around one in every 1,000 pregnancies. Although not all such cases would meet the bill's definition of "terminal illness", some clearly would. If the bill cannot explain how the law would operate in one of the most ethically complex situations imaginable, the legislation that is before us is not ready.

My colleague's comments seek to provide clarity by making it explicit that a woman who is pregnant would not be eligible for assisted suicide under the bill. Where legislation fails to confront questions of such gravity, we risk passing not careful law but bad law. For that reason, I ask colleagues to—

Liam Kerr (North East Scotland) (Con): I have been listening carefully, and I wonder whether Stephen Kerr might respond to the point that I think that Emma Roddick was making. Sue Webber's amendments in the group say specifically "are not pregnant", but Stephen Kerr has confined himself to talking about 24 weeks as a crucial part. He did not answer the challenge that Emma Roddick posed. I wonder whether he might do so now.

Stephen Kerr: In taking the intervention from my learned colleague Liam Kerr, I recognise that Sue Webber is trying to make clear the doubtful nature of the law that would be passed if we did not identify the issue of pregnancy as a consideration—hence the simple amendments that she has lodged.

Rhoda Grant (Highlands and Islands) (Lab): I am a little concerned about the precedents that that would set. It is the case that, if someone is pregnant and is suffering from an illness that requires medication, whether she has medication that could damage the unborn child or refuses it is a decision for that woman to take. It seems to me that Sue Webber's amendments in the group would take the choice away from the woman, which might be somewhere that the bill does not want to go.

Stephen Kerr: The nature of the amendments cover the viable pregnancy—the viable other life—which is recognised in Scots law. I am not entirely sure that Rhoda Grant's approach of restricting her view to the issue of a pregnancy before 24 weeks is the right one. My colleague's amendments seek to create the clarity in law that would be required about a woman who is pregnant and who would therefore—under the amendments to the bill—not be eligible for assisted dying.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): To clarify the question from

Emma Roddick, does the amendment mean that a pregnant woman who is in a palliative state would have to take a pregnancy test? Indeed, would any other person—who was possibly someone who identified as a woman but was a 90-year-old man—also then have to take a pregnancy test, if they were in palliative care?

Stephen Kerr: That is an incredibly hypothetical scenario. A 90-year-old man portraying himself as pregnant is stretching the point, if I may say so. The amendment is clear and straightforward, and it deals with women who are pregnant.

The amendments from Sue Webber arise because the bill as it stands fails to confront the grave question—

Jamie Hepburn: Will Stephen Kerr give way?

Stephen Kerr: I will happily give way to Jamie Hepburn.

Jamie Hepburn: The fundamental point that people are striving to get at is presumably the inverse of demonstrating that a woman is pregnant. Would they have to demonstrate that they are not? The only way that they could do that is by demonstrating that they have taken a pregnancy test. That introduces a whole area that I do not think that we expected to get into with this bill.

Stephen Kerr: I am sorry, but if someone is receiving medical treatment, it will be very clear to the doctors who are treating them whether the woman is pregnant. Again, we are reaching beyond the straightforward nature of a clarification in law that the amendments seek to produce.

I am grateful to all colleagues who have intervened while I speak to the amendments in the name of Sue Webber. For the reasons that I have outlined, I ask colleagues to support amendments 137, 318 and 324.

The Deputy Presiding Officer: I call Douglas Ross to speak to amendment 138 and other amendments in the group.

Douglas Ross (Highlands and Islands) (Con): I will speak to the three amendments in my name in this group.

At present, the bill requires a doctor only to inform a patient that they can be referred for a palliative care assessment. Section 7(1)(b)(iv) of the bill states that the assessment would

"explore whether any additional support could be provided to them".

For those at the end of their life, that is simply not enough. My amendment 138 goes further. It would ensure that a person was eligible for assisted dying only if they had been offered and, in fact, had access to a fully funded and costed palliative care pathway specific to their individual condition.

Emma Roddick: I agree with the amendment in principle and think that it is really important. However, I am curious as to why the plan would be fully costed and why that information would go to the patient, which would seem to be an unnecessary burden on them.

Douglas Ross: It is to provide reassurance. I will speak to later amendments during the stage 3 proceedings, but there are people at the moment who do not have access to the palliative care that they clearly require and seek because of location, geography or otherwise. It is very important that that information is made available to the patient, so that they can see it at the point at which they are seeking further help and support. It is unthinkable that anyone should feel pushed into ending their life early because they cannot afford or cannot access the care that they need. If the bill truly values individual care and autonomy, that choice must exist in reality and not only as a theoretical option.

Ross Greer: Like Emma Roddick, I sympathise with the outcome that Douglas Ross is aiming for. However, I am concerned that the phrase "fully costed" might have the opposite impact to what Mr Ross proposes in that it might make the patient feel like a financial burden on society. Does Bob Doris's amendment 23 not reach the same outcome that Mr Ross is aiming for but without the potential disadvantages of using the phrase "fully costed"?

Douglas Ross: I am listening to members' concerns about the term "fully costed". However, I do not share those concerns. We have an option: members can support my amendment or Bob Doris's amendment. However, if I am ever in such a situation, I would like to know that the work has been done to ensure that the costings have been fully sought, fully understood and fully laid out, and that they are clear to everyone. That is why they are included in my amendment, but there are alternative amendments that members can consider.

Kate Forbes: Maybe I was misreading it, but I read that line as meaning that it was essentially about having a fully resourced palliative care offering rather than about providing the accounting details to the patient. I wonder whether, in drafting the amendment, the member was struck by the research from Marie Curie that came out last week, which I know Miles Briggs took a particular interest in. The research is about the need to ensure that there is universal equity of palliative care, otherwise people might feel more inclined to opt for relief from their symptoms rather than getting the palliative care that they need.

Douglas Ross: I will come on to that when I speak to my amendments on the issue in group 18, but the briefing that we got from Marie Curie on it was very important.

I accept what Emma Roddick, Ross Greer and the Deputy First Minister have said. You can read this amendment in different ways. I tried to say in my response to Emma Roddick that the aim is to ensure that people get the palliative care that they should get. If Ross Greer reads the amendment in such a way that it is almost like a bill above someone's head, which could maybe then prevent their seeking to get that care, that is his interpretation. My view is the same as the view of the Deputy First Minister—the aim of including that phrase is to ensure that people get the care that they need, and there are some individuals who would want to know the cost of that care before going forward in that way.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): In debating group 7, we will address some similar amendments, in my name, which Ross Greer has referred to. Under the provisions in Douglas Ross's amendment 138, what would happen if the person was adamant that they did not want to explore further palliative care options? Could they opt out of a further palliative care pathway? Would that then debar them from going forward with assisted dying, or could they still go forward with assisted dying? I have no view either way; I am asking for clarity on the effect of the amendment.

Douglas Ross: We simply cannot force someone to do something that they do not want to do. If they choose not to hear, to consider or to accept the points made about palliative care, that is a choice and a decision that they have made. However, by putting it into the bill, we would be providing them with that opportunity. For the one person who did not want it, there could be 99 others who at least should have that information presented and made available to them.

We should ensure that, if the bill is passed, it is as robust as possible in relation to people getting the palliative care that they need. I believe that people should not be presented with a choice whereby they are forced to choose between unimaginable suffering and premature death. The Government must ensure that palliative care is fully funded and accessible, so that those who face terminal and debilitating illness can receive expert support, pain management and holistic care. As the Scottish Partnership for Palliative Care notes, the desire to hasten death can often disappear when the right care is available.

Moving on, I believe that my amendment 143 strengthens informed decision making by requiring that a first declaration includes a written statement from the patient confirming that they understand the nature and scope of palliative care and the pathway that is offered to them. Patients must know all their treatment options if assisted dying is to be offered at all. Without that, the bill risks fundamentally undermining the patient-doctor relationship and the integrity of our national health service.

Moreover, mental health support cannot be overlooked. Amendment 139, in my name, would require that those seeking assisted dying be offered psychological counselling and that they have not been treated for suicidal thoughts or self-harm. Without that, individuals whose autonomy is already compromised by depression, post-traumatic stress disorder or other mental health issues and conditions could be funnelled towards a premature death instead of receiving the support that they truly need.

Maggie Chapman: Will the member give way?

Alex Cole-Hamilton (Edinburgh Western) (LD): Will the member give way?

Douglas Ross: I will give way to Maggie Chapman.

Maggie Chapman: I am curious about the second half of amendment 139, which refers to people not having previously been screened or treated for suicidal thoughts or self-harm. There is no timescale for that, so somebody who might have had suicidal ideation as a young person and be seeking assisted dying much later in life might be ruled ineligible for that. I am wondering why there has not been some kind of time limitation on that, because those might be completely separate incidents—there might be a whole life lived in between—and yet there is no acknowledgment or understanding of that.

Douglas Ross: I have never personally experienced suicidal thoughts, but I do not think that they would end at a specific period in my life, so if I tried to put a time bar in the amendment—

Clare Haughey (Rutherglen) (SNP): Will the member take an intervention?

Douglas Ross: I will give way in a moment.

If I tried to put in a time bar, Maggie Chapman would rightly ask why it was just 10 years and not 15, why it was 15 years and not 30, or why it was one year and not one month. There would be complexity in putting a time bar or time limit in the amendment. It would suggest that, somehow, someone who has had suicidal thoughts would suddenly, at some point in their life, stop having those thoughts and reset, when actually many people who have suicidal thoughts will continue to have such thoughts but will just not take them forward—

15:45

Maggie Chapman *rose—*

Alex Cole-Hamilton: Will the member give way?

Douglas Ross: I know that Alex Cole-Hamilton wants to come in. I will then give way to Clare Haughey.

Alex Cole-Hamilton: We—all of us—have moments of profound mental crisis in our lives, and some of us may have had suicidal ideation. We may have shared that with a relative or even a clinician. The point is that we all have the capacity to get well, recover and move on with our lives. I understand the intent of Douglas Ross's amendment 139, but I do not think that we can legislate for a stigma that will then follow somebody for the rest of their life when they are as far as it is possible to be from that dark period in their life. I ask the member to reflect on that.

Douglas Ross: I do reflect on that, but I also say that, without this amendment, people who currently have suicidal thoughts here and now would, if the bill goes through, use the legislation to end their life. I do not think that the member is looking at that. I know that he will go on to talk about the other safeguards in the bill. As someone who opposes the bill, I question some of those safeguards.

Daniel Johnson *rose—*

Clare Haughey *rose—*

Douglas Ross: I will give way to Clare Haughey, who sought to come in earlier.

Clare Haughey: I am quite astounded by that characterisation of people who have thoughts of self-harm or suicidal thoughts—that they can never get over that and never recover. I am absolutely astonished at the stigmatisation of those people who express themselves in the most difficult moments of their life, or in the depths of mental illness, by saying that they cannot then get on with their lives. To try to use that to prevent people from accessing assisted dying at a time when they are suffering from a terminal illness—I make this point as someone who does not support the bill—is absolutely discriminatory. [*Applause*.]

Douglas Ross: I listened carefully to what Clare Haughey said in her role as the convener of the Health, Social Care and Sport Committee, which scrutinised the bill, and in her previous Government role as Minister for Mental Health. My point is that there is a difference between someone having suicidal thoughts at the moment and someone having had them in the past. I did not say—I would never say—that those thoughts could then never be cleared. What I said to Maggie Chapman was that I cannot put a one-year, one-week or one-month—or a 10-year or 20-year—time limit on that. Trying to do that in legislation would, I think, meet with the exact same opposition that I am hearing at the moment.

Members will take a different view on this, but I hope that we can have a respectful debate in which members articulate what other members actually say instead of jumping to conclusions about what was meant.

Sorry—I will go back to Daniel Johnson, who wanted to intervene.

Daniel Johnson: Further to Clare Haughey's point, we are dealing with extending the possibility of ending an individual's life. By definition, therefore, we are dealing with people who are contemplating ending their own life, so I fear that Douglas Ross is blundering into a tautology here. We may wish to use different terminology, but there is, in a sense, a real danger that we are talking about good contemplation of the end of life and bad contemplation, and stigmatising one form and one context as opposed to another.

I understand what the member is trying to get at in his amendment 139. We do not want the bill to be used by people other than those it is meant to cover. However, he is trying to create a distinction that might make it incredibly difficult for practitioners in the moment to delineate between someone who is contemplating assisted dying within the terms of the bill and somebody who is contemplating suicide. I think that that might be quite difficult to do.

Douglas Ross: I think that Daniel Johnson, in accepting what I am trying to do with the amendment, has got the point that there is a deficiency in the bill as it is currently drafted and that, if we do not have amendments that try to address it and at least have a debate about the issue, the bill will be deficient in that area. That is what I am seeking to do specifically with amendment 139. If the bill is to be about compassion and genuine choice, it must guarantee that both palliative care and mental health support are fully accessible and properly understood before any decision about assisted death is made.

Liam Kerr: Will the member take an intervention?

Douglas Ross: I will in one moment.

Failing to do so risks pushing people into an irreversible choice simply because care is either too expensive or unavailable.

I will take Mr Kerr's intervention now.

The Deputy Presiding Officer: Please be brief, Mr Kerr, because Mr Ross has been very

generous in taking interventions on his amendments.

Liam Kerr: He has. I will take Mr Ross back to amendment 138. It occurs to me that amendment 138 requires that, to be eligible for assisted death, someone would have to have access to

"a fully costed palliative care pathway".

Does he not think that that risks making eligibility dependent on the service provision rather than on the person's illness?

Douglas Ross: I believe that that service should be available to every single person who needs it in every part of Scotland. The fact that it is not available is one of the concerns that I have about the bill. People will be forced into a choice of taking their life early because the palliative care that they should have is not available, due to the cost, the general availability of people employed in that care or the fact that many of our constituencies do not even have a hospice within their boundaries. People could be forced to move far away from home if they sought that support. On that point, it is absolutely our ultimate aim to have that availability and accessibility of palliative care for everyone who needs it. The fact that we do not have that in Scotland in 2026 is a shame on all of us.

I have outlined my points on the amendments in group 2.

Emma Roddick: Colleagues who have heard my arguments throughout the bill's progress will know that, despite wishing that I could feel comfortable with the proposal and knowing that there are many situations in which I would want people to have the choice, my concerns about health inequalities, societal pressure and expectations on disabled people have led me to conclude that I cannot support it. I am concerned that it would remove more choice than it would offer.

I associate myself with comments made by Pam Duncan-Glancy and Jeremy Balfour about the pervasive negative attitudes that exist towards disabled people. I do not think that folk realise how common it is for someone regularly to hear everything from, "How do you cope?" to "I would have killed myself," when they lead a life that some people will readily describe as undignified.

My amendment 140 seeks to introduce additional safeguards for people with learning disabilities. That is not in any way intended to prevent a person with such a disability from accessing assisted dying if it were available in Scotland. I want to be very clear that I have no wish—and would not support efforts—to remove autonomy from that community, or any group, based on diagnosis.

My concerns stem from the way in which people with learning disabilities are often treated. The lessons that I have learned from those with lived experience have involved terrifying descriptions of individual rights and freedoms being belittled, ignored or even overridden during the Covid pandemic. We must legislate with the worst-case scenarios in mind. Should there be another pandemic at a time when assisted dying was legal, nobody should be in any doubt that people who were at risk back in 2020 would still be at risk then. In that case, the result could be pressure to end their lives early if we do not bake in protections now.

Amendment 140 would require that time be taken to ensure that an individual—not just their carers, advisers and family—fully understands what they are signing up to and that they have all the multidisciplinary support that can be offered ahead of their taking such an important decision.

Daniel Johnson: I am very supportive of the intent behind the amendments in this group that Ms Roddick has lodged. However, I have one concern about her framing of amendment 140, which includes developmental or cognitive conditions. I worry that that might encompass people with attention deficit hyperactivity disorder, dyslexia and other cognitive conditions. Such a provision might compound the stigma that those people face or might require additional support to be put in place for people who do not really need it. Although I totally accept that people with the vulnerabilities that Ms Roddick outlined absolutely need support, I wonder whether amendment 140 is drawn a little too broadly.

Emma Roddick: I would rather it be too broad than too narrow. An argument could probably be made that amendment 140 would capture me. If I were to be in the situation of seeking assisted dying, I would be happy to have a conversation with a social worker who would make sure that I had everything that I needed to make the right decision, to be confident in understanding the gravity and impact of that decision, and to understand what the other options were.

This is not about making somebody pass a test or making it more difficult for them to access assisted dying. However, if a person has a learning disability or is neurodivergent, they are, in many ways, marginalised and vulnerable to coercion and pressure. It would be better to include more people than fewer as part of an extra safeguard of having a conversation.

Amendment 140 would ensure that people have the time and space that they need, and that they have access to experts who are used to supporting people in difficult situations to have the time to think about their decisions. The amendment would

not exclude people, but it would recognise that a vulnerability attaches not to those with learning disabilities but to how they are often viewed and treated. Amendment 140 would also ensure that time and care are taken to ensure that the decision reflects the person's choice.

Amendment 141 would prevent eligibility where a request is influenced by "financial hardship". Disability costs money—a lot of money—and, when a person is terminally ill, the costs can be overwhelming and seem impossible for them or their family to overcome. Poverty, loneliness, domestic abuse, bereavement, homelessness, breakdowns of relationships and feeling like a burden are not uncommon experiences for those who are diagnosed with a terminal illness.

Maggie Chapman: I am sympathetic to what Emma Roddick is attempting to do with amendment 141, but I have a question about the process and how the amendment would work. Amendment 141 refers to somebody who is looking for

"assistance to end their own life if it is established that their request is influenced".

What would be the process for establishing such influence?

Emma Roddick: Again, it would come down to having a conversation. People who regularly have such conversations are trained to understand the responses that they get as part of their work. I have spoken with social workers about amendment 141, and I understand their concerns about not being too prescriptive or not being prescriptive enough. A lot of this is about making judgment calls. My amendments would simply add a step that provides an opportunity for people to notice when something else is going on or when there is coercion or influence that has not been picked up initially.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): I am satisfied with the bill as it is drafted as regards section 3(2)(b), which is about capacity. Capacity is well understood in Scots law. When people make a will or grant a power of attorney, or even when they buy a house, they need to demonstrate to an agent that they have capacity, that they are not being coerced, that they fully understand the consequences and so on.

The definition in the bill is that people

"are capable of … understanding information and advice about making the request, … making a decision, … communicating the decision, … understanding the decision, and … retaining the memory of the decision."

That covers the areas that Emma Roddick has quite rightly brought to the Parliament's attention. However, the definition of capacity has already been well tested in Scots law, and we do not need to—forgive me for saying this—clutter it with the amendments that have been suggested.

Emma Roddick: I appreciate that Christine Grahame is happy with the section as it has been drafted, but I am not, and I know that many others are not happy with it, either. My amendment is not simply about demonstrating capacity; it is about digging into the individual's social context. It is not just about ensuring that they are able to understand their illness or what assisted dying involves; it is about ensuring that, mentally, they are in a place where they can accept that there are other options and that they can fully understand what those look like. It is about having somebody—perhaps a person who is separate from their home life—who is able to take another look and make sure that the decision that an individual is making is entirely their own and that they understand the alternatives open to them.

Amendment 141 refers to issues that people with a terminal diagnosis will commonly experience. Our primary response to those issues should be to provide support and to try to tackle them, regardless of how long a person has left to live. Discussions about the reasons for a person seeking assisted dying—which, undoubtedly, will always be complex and multifaceted—might give us the opportunity to ease those burdens. However, I am clear that if they are the primary reason for making such a request, that is not what assisted dying is for.

We must be alive to societal context. For example, there is very strong evidence that, in the event of a terminal diagnosis, marriages and relationships are more likely to end when the person being diagnosed is a woman who is in a relationship with a man.

This is a difficult time for far more reasons than the diagnosis alone, and people may be suffering from elements of some or all the situations that I have listed, yet still genuinely wish to end their lives purely due to their pain and the symptoms caused by their illness. That can be clarified, but it should be clarified as being the primary reason.

16:00

Bob Doris: This is my first real opportunity to speak in this afternoon's debate. I clarify that many of the amendments that I will speak to over the next few days have been developed with the Scottish Partnership for Palliative Care, which is neutral on assisted dying. It has widely consulted its members—who will have their own views on the legislation—but what I am presenting is the partnership's balanced view on how to improve the bill, while its overall stance remains neutral. I also

put it on the record that I am the convener of the Parliament's cross-party group on palliative care.

In speaking to my amendments 162, 317 and 323, I offer my support for the substantive amendment in this group, which is Daniel Johnson's amendment 2. It is almost identical to an amendment that I lodged at stage 2, when I sought to introduce a condition that a person applying for assisted dying must reasonably be expected to die within six months. I sought to make the case that that reasonable expectation should sit within a section on eligibility criteria. At stage 2, Daniel Johnson sought to bring the six-month threshold into the definition of a terminal illness, which I disagreed with. I am pleased that the member lodged his amendment 2 under the section on eligibility, which means that I did not have to do so. It is the correct place for such a provision to sit. Therefore, I urge members to support amendment 2.

I remind members that paragraph 32 on page 8 of the policy memorandum that accompanies the bill—this is important—states:

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

That is in the policy memorandum, but the bill says something completely different. That is why, as imperfect as Daniel Johnson's amendment 2 is, it is very important for realising the policy intent of the member in charge of the bill.

Maggie Chapman: I pose to Bob Doris the same question about the six-month period that I posed to Daniel Johnson earlier. What if someone who seeks an assisted death has other conditions that would limit their capacity to make that decision within the six-month period, but they know full well what is coming and would want to make that decision outwith that period?

Bob Doris: Maggie Chapman is right to put that to me. I will answer in this way: irrespective of how the bill is passed—if it is passed—and irrespective of which amendments are agreed to, there will be a whole series of unforeseen, unintended consequences. Maggie Chapman has perhaps identified one, but a series of unintended consequences would also flow from not having some form of time restriction.

I also wrestle with the issue that Maggie Chapman raises, but I must say that, on balance, I do not think that it is appropriate for a bill whose policy intent is to apply to people in the last months of their lives not to specify how long they might have left to live if its provisions are to apply to them. That is not an appropriate way to pass legislation, if it is to be passed.

It is clear that the current definition and eligibility criteria are not an effective way to identify a narrow group of people who are near the end of life. As those provisions are drafted, assisted dying would likely include some people who would otherwise live for a considerable period, which would be at odds with the stated policy intent behind the bill. That is the point.

I do not pretend that any of this is easy, and, as we have heard, there are also challenges regarding a timeframe for any prognosis. However, I firmly believe that having a timeframe would be preferable to leaving the matter completely open ended. In that regard, my amendment 162 will be crucial if the policy intent behind Daniel Johnson's amendment 2 is to be fully delivered.

As the bill stands, a registered medical practitioner

"carrying out an assessment under section 6 must … if they have doubt as to whether the person being assessed is terminally ill, refer the person for assessment by a registered medical practitioner who holds qualifications or has experience in the diagnosis and management of the terminal illness involved".

Amendment 162 would ensure that, if the registered medical practitioner has any doubt that the person

"can reasonably be expected to die within six months,"

they must make a similar referral. Amendment 162 would, therefore, give the full policy intent to the substantive amendment, which is amendment 2.

Amendments 317 and 323 would ensure that both medical practitioners' declarations include the six-month requirement. I note that amendments 316 and 322, in the name of Daniel Johnson, have a similar policy intent, and I am content to support them. I do not intend to move my amendments 317 and 323, assuming that Daniel Johnson will move his own amendments

It is important that I draw members' attention to amendment 262, which will be debated when we reach group 19—my goodness, that seems like a long time away. It would require the Scottish Government to prepare and publish guidance on

"how to interpret and apply in practice the eligibility requirement that the terminally ill adult can reasonably be expected to die within 6 months."

It is important to make members aware of that amendment now—we will discuss the merits of it later, when we reach group 19—because it acknowledges the complexities involved for registered medical practitioners in this area, and the importance of the challenges that specific conditions present for non-specialist practitioners. It also illustrates why amendment 162 is of such importance.

Pam Duncan-Glancy: Amendments in this group get to the heart of some of my concerns about the bill as drafted. Without support to ensure the equality and human rights of all, we could end up legislating to make it easier to die than to live and to deepen some already entrenched inequalities.

Some amendments in the group highlight the societal factors that could lead to someone believing that it is easier to die than to go on living: a lack of care, poverty or financial hardship, social isolation or loneliness, feelings of being a burden, breakdown or loss of significant personal relationships, inadequate or unsafe and insecure housing, pain that is untreated, palliative support that is not there, or inequalities denying access to that support.

I recognise that members have lodged amendments in the group with the intention of tightening the criteria and clarifying them in an effort to strengthen safeguards in the legislation. I will address those amendments in turn.

First, I will talk briefly about the amendments in the name of Daniel Johnson and Bob Doris that would introduce a six-month timeframe until death. I would also like to associate myself with some of the comments that Bob Doris has just made on the record about what is in the policy memorandum for the bill, and I would note that, as the bill stands, it does not deliver on that.

I know that the amendments in this space are well intentioned. However, throughout committee scrutiny of the bill, we heard from a number of experts—whose evidence has been repeated in the chamber this afternoon—about the difficulty and, indeed, the near impossibility of accurately predicting how long someone has left to live. In evidence to the Health, Social Care and Sport Committee, Dr Sarah Mills said:

> "Any doctor who feels that they are able to adequately predict somebody's prognosis in months and years is usually mistaken. . . . Until we improve on the precision and accuracy with which we can identify somebody's prognosis, it is meaningless to include a timescale in the bill".—[*Official Report, Health, Social Care and Sport Committee*, 19 November 2024; c 44.]

Similar concerns have been raised more widely, including ones that are supported by research from the Association for Palliative Medicine, which says that

> "across thousands of prognosis assessments . . . doctors' assessments of which patients are likely to die in six or 12 months are correct less than 50% of the time."

Therefore, although we attempt to narrow eligibility—I take on board the points that my colleague Daniel Johnson has made about the need to have something in the bill that does narrow eligibility—it is very difficult to make that happen, so I am left worried that people could still end their lives prematurely.

I move to amendments in the group that seek to address the wider societal pressures that could drive someone to choose to die.

The amendments in the group that make provision available are important. They do not just compel a discussion or a recording of the discussion—as the bill currently provides for and as later amendments, particularly in group 7, suggest—but specifically require the delivery of support or that inequalities be addressed. A discussion or a signpost is not sufficient, and a plan that is not costed or funded—this speaks to some of the debate that we have had earlier about the bill—is not delivery of support.

In a bill such as this, we need a high bar, because it is a matter of life and death. If we do not require those issues to be addressed, we risk making it easier to choose to die than to choose to live. The question facing us is whether we believe that such support—crucial healthcare, social care and psychological support—is likely to be available, and available to all equally.

Amendments 138 and 143, in Douglas Ross's name, seek to ensure that terminally ill adults are eligible for assisted dying only if they have been

> "offered, and have access to, a fully costed palliative care pathway".

That is really important, given what we know about the significant unmet need that exists and the impact that that can have on quality of life.

The point about the pathway being costed is important, because we know that, often, people have identified what they think are their needs—or had their needs identified by other people in an assessment—but those things are not funded or provided. Support that is identified as needed but not provided is not support at all. That can be the difference between someone choosing to continue and not.

I listened carefully to the intervention from my colleague Liam Kerr about whether the decision should be based on support or illness. We are grappling with that very question throughout the discussion on the bill. Support is often what is needed and can be the difference between someone wanting to continue in a circumstance or not. Support is absolutely essential.

Even if amendments 138 and 143 are agreed to, however, I do not believe that they go far enough. We know that thousands of people have already been assessed as needing support yet are still waiting for care packages to be put in place. We know from all the excellent organisations, hospices, palliative care specialists and many more how unequal access to palliative care is. The

"Dying in the Margins" report from Marie Curie gives examples of that.

Amendment 139 would make eligibility dependent on someone having been offered and having access to psychological counselling, and on whether they had previously been screened or treated for suicidal thoughts or ideation, or self-harm. That amendment is crucial. Illness and loss of function can lead to the experience of low mood and mental ill health. That is due to a variety of factors, including societal ones, but they are there nonetheless. We must recognise that there is a relationship between mental and physical health, and we have to support that. Amendment 139 tries to do that.

Particularly given the exchanges that we have heard this afternoon on amendment 139, it is important to remind ourselves of the statement on the issue by the Royal College of Psychiatrists, which has said:

"suicide prevention remains a duty when someone is terminally ill".

That is incredibly important, and the amendment could help us to ensure that that is the case. The college went on to say:

"For someone given a terminal diagnosis, the inevitable loss and grief associated with the end of life should be acknowledged and supported".

That is another reason why the amendment is important. However, I am still concerned that it would fall short of making the bill entirely safe.

Emma Roddick: Does the member share my concern, in listening to the debate, that, if we required people not to have suicidal ideation to access assisted dying, that would encourage people not to be open about the suicidal ideation that they understandably face when dealing with a chronic illness? Should we not be encouraging people to talk about that, so that they can be offered alternative support if that will address the feelings that they are having?

Pam Duncan-Glancy: As many members across the chamber will know, thoughts of suicide and suicidal ideation are deeply complex and personal, and they can affect every aspect of people's lives. Indeed, we rightly spend quite a lot of time looking to support people with such thoughts, including at the end. It is really important that that is considered in the bill.

Lorna Slater (Lothian) (Green): One of the more upsetting things in our stage 1 debate was hearing examples of people who are unable to access assisted dying and therefore feel that they need to take action to end their lives. That is because they cannot get the medical help that they need, as assisted dying is not legal in Scotland.

Does the member not worry that, if the bill was made too narrow, we would be forcing people to take matters into their own hands and to cause themselves physical harm and increased injury because the medical assistance through the bill would not be available to them?

If we say, "If you try this—if you are so desperate that you attempt this on your own because, for whatever reason, we have not made it available to you—you can then never be eligible for that help," we risk forcing people down an even more desperate path, because we are pushing them away from the medical support that they want.

16:15

Pam Duncan-Glancy: It is incredibly important that, in all aspects of people's lives, we help them to understand the value of living and support them to continue doing so. That is one reason why the world-leading work that we do in suicide prevention in Scotland is incredibly important. That applies throughout the life course, including at the end of life.

Support at the end of life should not be limited to those who have identifiable psychological conditions, and support for psychological and mental health should not be limited to those who are at the end of life. As all members know from reading their inboxes, and from their families and neighbours, it is difficult for constituents to access the support that they might need for their mental health. Amendment 139 would help some people who consider the option of assisted dying, but it would not protect the thousands of people who need mental health support before that point. It would not give them the help that makes it easier to choose to live.

Amendment 140, in the name of Emma Roddick, would require specialist multidisciplinary information and support to be provided to people who have an intellectual disability or a developmental or cognitive condition. That would be an important safeguard, especially given that people with learning disabilities are likely to die 25 years earlier than others. Their social circumstances and other matters that impact them mean that, if they become terminally ill, they are less likely to access the care that they need.

There is a real risk that the bill creates an inequality that means that people with the most can see that life is an easier choice but others choose to die. The amendments cannot undo such deep-seated inequality, which also affects homeless people, disabled people and people who die early because of where they live—aspects that are related to society as opposed to their inherent health.

Although I urge members to support amendment 140, it would not go far enough to protect people or to ensure that it is easier to choose to live. The amendment is specific to the bill's provisions, but before someone who is covered by the amendment gets a terminal illness, society has already discriminated against them. They have already experienced significant inequality that will affect their life and their view of themselves, and that will have already shortened their life. To address such issues goes beyond the bill, but that is the risk that it carries: that we pass it in a world that makes it easier to choose to die.

Amendment 140 would provide specific groups with access to clear information, specialist advice and multidisciplinary support, which I welcome, but such support should not be limited to particular groups; it should be available to anyone who considers accessing the assistance that is set out in the bill. It is the general absence of such support that worries me. Until it is made available, it could be easier for people to choose to die than to live.

Amendment 141 recognises that individuals might seek an assisted death not solely because of their illness but because of external pressures of suffering. Although I support the principle behind the amendment, I remain concerned that we can never really be certain whether such factors have influenced a person's decision to seek assistance to end their life.

Research by Marie Curie highlights the scale of unmet need in Scotland. In 2022, around 18,500 people—roughly 30 per cent of those who died—experienced "unaddressed symptoms and concerns", while also lacking sufficient access to general practitioner care at the end of their life. Every five minutes, someone in the UK dies without the care and support that they need. Ahead of today's debate, the British Association of Social Workers said:

> "Societal and institutional pressures, including pervasive narratives around being a burden, the cost of care, or the emotional and financial toll on families, can shape a person's decision in ways that are profound and deeply difficult to detect."

We will come on to some of those pressures when we discuss the amendments in group 4.

I remind members that rights for disabled people are not yet realised. The amendments in group 2 seek to address the issue, but it is difficult to argue that amendments can do that. Research shows that disabled families are 62 per cent more likely to fall into deep poverty, one in four disabled people do not get the palliative care that they need, and 10,000 people are stuck in their own inaccessible homes.

Taken together, the amendments in this group reflect a clear recognition that stronger safeguards and better support are needed. However, I do not believe that they can address the circumstances that lead to the deep-seated inequality that so many of our citizens face.

Stephen Kerr: I notice that, in her compelling remarks, Pam Duncan-Glancy has not addressed Sue Webber's amendments 137, 318 and 324. If nothing else, do those amendments not point out how incomplete the bill is in respect of the potential legal and moral dilemmas that we might be placing doctors in?

Pam Duncan-Glancy: I thank the member for that intervention. I think that Sue Webber's amendments highlight the inadequacies across the bill that we are being asked to discuss today.

There are many decisions that we will be asked to make, sometimes in cases where we do not know what the future could hold—and particularly in relation to some of the earlier discussion about the section 104 process.

As I was saying, I do not believe that the amendments in this group can address the circumstances that lead to the deep-seated inequality that so many of our citizens face—inequality that could result in them not getting a fair chance or an equal chance at life or, indeed, the care that they need at the end. Only concerted efforts to create a fair and equal Scotland could do that.

Until then, for me and for many people like me across Scotland, it is inconceivable to suggest that the introduction of assisted dying is about choice, when so many people do not have choice in life, nor indeed in death.

The Presiding Officer (Alison Johnstone): Members will note that we have passed the agreed time limit for the debate on this group to finish. I exercise my power under rule 9.8.4A(c) to allow debate on this group to continue beyond the limit in order to avoid the debate being unreasonably curtailed.

Ross Greer: I want to speak in favour of Daniel Johnson's amendment 2 and the other amendments in relation to the six-month prognosis limit, not because I think that that is a perfect system, but because there is no perfect way to design it. We are trying to balance harms here. There is no option that is free of suffering, even if we vote down the bill. To live is to experience suffering to some extent at some point in our lives. We heard a moment ago from Lorna Slater about the desperate situations that some people find themselves in and the far-from-dignified ways in which their lives end.

Much as the potential flaws and drawbacks of using a six-month prognosis have already been laid out, there was a majority in the Parliament at

stage 1 in favour of the principle that people should have more agency over how their life ends, while there was clearly not a majority for the definition that is currently contained in the bill.

I am sure that we have all wrestled with hypotheticals about what kind of people in what situations would or would not be eligible for an assisted death under the bill. More than those hypotheticals, we have all had correspondence with constituents, and most, if not all, of us have met constituents, who have put their situations to us, so we have had to judge whether they would or would not be eligible.

The current definition would capture all those who I personally believe should be eligible to make that choice at the end of their life, but, on balance, it would probably risk capturing those who I do not believe—and, I think, a majority in the Parliament do not believe—should be put at that level of risk. Yes, a six-month prognosis would narrow down the number of people who would be eligible, but it would do so by balancing the risks. It would take out people who, we believe, would be at greater risk of an assisted death in a manner that we would not support.

Kate Forbes: I am grateful for the balanced way in which the member has outlined those arguments. How would he respond to some of the concerns that palliative care doctors have raised? They have expressed worry and concern about how the legislation might make them find it harder to do a proper prognosis when they know that a six-month prognosis is not accurate and that it might risk somebody accessing assisted dying far ahead of their natural death, even by years?

Ross Greer: I take on board the concerns that those palliative care doctors have raised, but I would say that individuals in that situation for whom they made such a prognosis would be eligible regardless, under the definition that is currently in the bill. If we agreed to the proposed six-month prognosis provision, it would narrow the definition and would remove people who would be at risk and who we would not wish to access the service.

I am not claiming that that approach is perfect, but I think that it is an improvement on what is currently in the bill. I think that, without it, the bill would pose an unacceptable level of risk. On that basis, I urge members to support amendment 2 and the other amendments related to the six-month prognosis.

Neil Gray: As I set out during the debate on group 1, I will address amendments in group 2 only where there are technical, legal or legislative competence issues that the Government wishes to highlight.

In this group, amendment 138 does not specify who should produce a palliative care package or what is meant by

"this pathway has been … made available".

The amendment does not detail whether that is a reference to the document itself or to the services and support detailed within it being made available.

More generally, I highlight that the Scottish Government's palliative care strategy, "Palliative Care Matters for All", sets out the aim that

"People of all ages with life shortening conditions and their families and carers receive palliative care, care around dying and bereavement support based on what matters to them."

As part of that, we are working to ensure that person-centred future care planning is discussed as early as possible following diagnosis in a person's care journey. Where appropriate, that will include planning and making arrangements to ensure that they receive the palliative care that is right for their circumstances.

Ruth Maguire (Cunninghame South) (SNP): The cabinet secretary outlined the aim that everyone receives palliative care, which I am sure that everyone would support. Does the Scottish Government have numbers on how many people are actually receiving palliative care?

Neil Gray: I recognise the challenges that have been set out in the debate about people receiving palliative care. I point out that there are differences, as Ms Maguire will understand, between palliative care, end-of-life care and wider bereavement support. I hope that a distinction can be drawn as to whether it is an either/or discussion in the bill. We are deciding on the merits of assisted dying, but we as a Government have already set out our work in respect of progress on palliative care.

We recognise that planning ahead can help people to manage or avoid crisis situations and that it improves people's experiences of urgent or emergency health and social care. We also recognise, however, that people's wishes often change over time, and it is important that their plans are regularly updated as part of on-going conversations between clinician and patient on their care needs. Our work to deliver on the palliative care strategy, including in relation to future care planning, will continue regardless of the outcome of the vote on the bill.

I understand the sensitivities on amendment 139—we heard about many of them in interventions on Mr Ross—and the difficulties of the subject matter at hand. However, I caution that the absolute restriction that is proposed in the

amendment could raise legal issues regarding its proportionality, unless it can be fully justified.

Amendment 140 would introduce provisions that would apply

"Where a person has an intellectual disability or developmental or cognitive condition".

Although the amendment appears to be intended to capture individuals with learning disabilities or other conditions that affect cognition or development, the terminology that is used does not clearly align with the statutory definition that was used in the Mental Health (Care and Treatment) (Scotland) Act 2003. There is therefore an inconsistency with existing statutory frameworks, which could result in a lack of clarity and might create interpretive uncertainty for clinicians and decision makers applying the legislation.

Likewise, the assessment in amendment 140 closely resembles the functional test of decision-making capacity that is used in the adults with incapacity framework, but the amendment does not explicitly link to it, nor does it state whether that framework is intended to apply. That might create uncertainty as to whether the amendment establishes a separate capacity test or whether the existing incapacity framework is intended to apply. It is also not clear how long the period of reflection and consideration that is cited in the amendment is intended to last.

Jamie Hepburn: Will the cabinet secretary give way?

Neil Gray: I will come to Mr Hepburn in a second.

There is a risk that amendment 141 conflates eligibility for assisted dying with matters that are currently addressed through existing statutory frameworks, including the Adult Support and Protection (Scotland) Act 2007, which relies on professional judgment, defined thresholds and proportionate intervention rather than automatic exclusion.

Jamie Hepburn: I want to pick up on the cabinet secretary's remarks and on the helpful note that the Government has made available online, which provides explanations of the impact of each amendment. I want to understand what might be felt to be a difference between what the Government has said about amendment 138—the cabinet secretary made a compelling argument for not supporting amendment 138—and what it has said about amendment 143, which also refers to a pathway for palliative care. Does that have a legal definition? Before we decide whether to support the amendments, can the cabinet secretary tell us whether such a thing as a "pathway" is recognised in law?

16:30

Neil Gray: It is fair to say that there are similar concerns about amendments 143 and 138.

The Scottish Government has no comments to make about the remaining amendments in the group.

Liam McArthur: I remind members of my declaration of interests, in that I am supported by three campaign organisations: Dignity in Dying, Friends at the End and the Humanist Society Scotland.

Members will be aware that I was not initially minded to include a period for which a terminally ill adult was expected to live in the definition of "terminal illness" in the bill, for many of the reasons that Alasdair Allan articulated in quoting Marie Curie and to be consistent with previous decisions taken by this Parliament. Instead, I rested on the definition of an "advanced and progressive" terminal illness. However, I have since reflected that including a prognostic timeframe would bring the bill in Scotland into line with other assisted dying laws internationally, as well as with the bill that is currently being debated at Westminster and the one that was recently passed in Jersey.

Many jurisdictions that have undertaken subsequent reviews of the operation of their legislation have not sought to remove that criterion, suggesting that it can be managed in a way that does not present unreasonable obstacles to patients accessing choice and does not lead to unmanageable decisions for clinicians, including palliative care clinicians. I hope that that speaks to the interesting exchange between Bob Doris and Maggie Chapman and to some of the concerns that Ross Greer was wrestling with, which are entirely valid.

Patrick Harvie: I will be brief on the point about prognosis. I was in a similar position of not being convinced that we should include a prognosis period, and so voted against that at stage 2. However, as the debate has continued, it has become clear that there is an expectation across Parliament that we need something to fill that space.

Liam McArthur says that the legislation in other jurisdictions has been reviewed. The bill includes provision for a complete review of the operation of the act once it is in force. Does he agree that we should expect such a review to cover how the prognosis period is being applied and is working in practice, and that the review should give those of us who were sceptical a little more comfort, so that we can be more relaxed about accepting something that we all recognise is imperfect? Does he agree that we need something to fill that space?

Liam McArthur: That is an entirely valid point and probably speaks to how many other concerns that we will hear being raised in the next two or three days might also be addressed. We can draw on international evidence, but until we implement legislation of this type in Scotland, we cannot be entirely sure of how it will work in practice.

Kate Forbes: I do not want to cause Patrick Harvie and Liam McArthur any fear by saying that I used to agree with them on that point.

I again raise the point about accuracy. At stage 2, Liam McArthur made some compelling arguments about the arbitrary nature of accuracy. Does he accept that his safeguard might make MSPs feel reassured but that palliative care doctors are still not reassured? Dr Scott Murray, whom I quoted earlier, said that the likelihood of predicting how long someone with advanced cancer has left to live to within 33 per cent of the actual time left was as low as 20 per cent. Is the safeguard for MSPs or for doctors?

Liam McArthur: Two things can be true at the same time. It is an additional layer of assurance for members in speaking to what has always been the policy intention of the bill, which is to give access to those at the very end of life. I know that palliative care professionals have expressed concern. For the reasons that I set out at stage 2, and at stage 1, I accept how arbitrary a prognosis can be in some instances, but I point again to the experience of clinicians, including palliative care clinicians, in many jurisdictions that have prognosis periods, who seem to be able to work with those in a way that respects the intention of the legislation and allows access and choice where the eligibility criteria are met and which seems broadly to command public confidence.

While I acknowledge the challenges that can arise in some cases, I have carefully considered Daniel Johnson's amendment 2 and think that it adds to the eligibility criteria and is more appropriate than having a definition of terminal illness. Bob Doris made an important point about that, and I certainly corroborate the fact that he took a more appropriate approach at stage 2.

A terminally ill adult should be considered eligible for assistance only if the co-ordinating doctor is satisfied that they have six months or less to live from the point of the assessment taking place. It is also important that the amendment uses the wording "can reasonably be expected", for obvious reasons. I am therefore minded to support amendment 2 and the consequential amendments 316 and 322.

Bob Doris's amendment 162 would require the assessing doctor to refer a person for assessment by a specialist not only if there was doubt about whether they were terminally ill, but if there was doubt about whether they may reasonably be expected to die within six months. Given the difficulties around prognosis, which we have already discussed, that seems a reasonable addition to make alongside Mr Johnson's substantive amendment.

I note what Mr Doris said about his consequential amendments 317 and 323 and I welcome the fact that he will not move them. Daniel Johnson's amendments 316 and 322 are more tightly drawn.

I do not support Sue Webber's amendments 137, 318 and 324, which relate to a person being eligible only if they are not pregnant. As would happen now, any end-of-life decision—for example, a decision to cease chemotherapy—would undoubtedly require detailed conversations with a terminally ill person who was pregnant, but they would depend on the nature of the person's illness, the stage of their pregnancy and their plans. A blanket prohibition would be too blunt for what will likely be extremely rare but very individual and specific circumstances.

It is also unclear whether those amendments would compel every applicant to provide a negative pregnancy test. That would mean doctors having to assess every person who was seeking assistance to ascertain whether they were pregnant or not—a shock, no doubt, to the 80-year-old gentleman with advanced-stage bowel cancer. The amendments would undermine the bill's aim to provide compassionate, safe, patient-centred care. I do not believe that they are necessary or even particularly well intentioned and I urge Parliament to reject them if they are moved.

I turn to Douglas Ross's amendments 138 and 139. On amendment 138, I am fully supportive of people who seek an assisted death having access to palliative care and psychological counselling if required. However, I do not agree that a person should be ineligible for an assisted death if they have not been offered and have not accessed

"a fully costed palliative care pathway … including symptom management, psychosocial support, and specialist palliative care services",

or have not been offered and given access to psychological counselling. That would risk adding a barrier to a terminally ill adult who could otherwise be deemed eligible and able to access assistance.

Brian Whittle: On palliative care, the issue is that, if we agree that we want to give people choice, it has to be a proper choice and a real choice, and that must include, if the person so wishes, a basic palliative care package that speaks to their needs. It is possible that they will then decide to choose assisted dying, but it has to be a proper choice.

Liam McArthur: I entirely agree with Mr Whittle. That is already reflected in the bill to a large extent, but other amendments that I will come on to discuss capture the point that he entirely fairly makes.

Section 7(1) of the bill requires the assessing doctor to

"explain to and discuss with the person being assessed",

in so far as they consider appropriate,

"any palliative, hospice or other care available, including symptom management and psychological support".

On amendment 139, adding to the eligibility criteria that the person had not

"previously been screened or treated for suicidal thoughts or self-harm"

would mean that a person would be ineligible for assistance in, say, a situation where they had, decades previously, been not even treated but "screened" for suicidal thoughts or self-harm—matters that may have no bearing at all on the person seeking assistance.

I acknowledge what Mr Ross is getting at with his amendments, but I am not inclined to support amendments that would limit eligibility in that way rather than letting such matters be picked up in the already robust assessment process. Eligibility for assisted dying should focus on a person's current capacity to make the decision, and the requirement for doctors to discuss with the person their reasons for requesting an assisted death provides medical practitioners and terminally ill adults with the opportunity to explore motivations and identify any underlying concerns.

I further note the Scottish Government's concern that such an absolute restriction could raise legal issues regarding its proportionality unless it can be fully justified. That also applies to Mr Ross's amendment 143, which is related to amendment 138.

On capacity, when it comes to Emma Roddick's amendments 140 and 141, the bill already contains strong safeguards. As Christine Grahame identified, a person is eligible under section 3 only if they

"have capacity to request … assistance … are not suffering from any mental disorder which might affect the making of the request"

and

"are capable of … understanding information and advice",

"making", "communicating" and

"understanding the decision, and … retaining the memory of the decision."

Further safeguards are built in throughout the process.

Emma Roddick: I appreciate that capacity is covered. My amendments 140 and 141 are not simply about capacity. There is a difference between being able to understand information and having that information actively offered. Does Liam McArthur appreciate that?

Liam McArthur: I certainly do, but the safeguards are there in order to protect those rights. I was expecting Ross Greer in his contribution on the group to talk about the advocacy provisions that he added to the bill at stage 2, which provide very welcome further protections and safeguards in that respect.

Michael Marra: To take us back slightly, I have been listening carefully to what Liam McArthur has said across the amendments, and I think that he has made a pretty fundamental shift between stages 2 and 3 in conceding ground on the six-month rule. Having previously called it

"arbitrary, inflexible and in some cases 'very difficult to establish with any … degree of certainty'",

he has changed direction. It feels to me that the situation that he set out at stage 2 is probably his view and the view of people who support the bill, and that that ground has been ceded in order to win support. Perhaps he would see that as a legitimate tactic, but does it not talk to the possibility of the slippery slope approach, whereby people will come back again to try to open up eligibility further, given that, at the start of the debate, we talked about whether the question that the Parliament was asking itself was about a closed or an open bill? My question is about how that has been pursued and whether the bill will be opened again in the future.

Liam McArthur: I am not sure that it is a slippery slope. It is the Parliament doing what it should, which is to scrutinise legislation, engage with those on both sides of the debate—which I think we have managed to achieve—and take on board ideas that reflect concerns that are genuinely expressed. I still hold to the view that there are issues of arbitrariness with a prognosis period, but I also acknowledge, as I have said, that, in international evidence, even in those jurisdictions that have gone through a five-year review, any concerns around arbitrariness appear to have been allayed, such that patients are able to access the choice to which they are entitled and medics are able to operate within that system.

Further safeguards are built in throughout the process. Assessing doctors must refer a person who requests assistance to a specialist if they have any doubts about capacity, and capacity is checked at every stage, including before an approved substance is provided. Contrary to the interests of patients and clinicians, amendment 140 may complicate and confuse that process.

The same can be said for amendment 141, which would add to eligibility 14 further conditions, any of which would preclude a person's being considered eligible. That would duplicate the provisions on issues of capacity and coercion that are already in the bill, while adding other factors, some of which risk interfering in a person's autonomous decision making—something that Emma Roddick has a good track record of fiercely protecting.

I support the principle of ensuring that doctors explore a person's reasons for requesting an assisted death, but amendment 141 risks oversimplifying a decision that is often complex and deeply personal. As I said, people's motivations are rarely singular, and they may relate to a mix of physical, psychological and existential factors. The ability of a healthcare professional to rule out various influences in accordance with the requirements of amendments 140 and 141 would be unworkable in practice, and those amendments risk policing open and honest conversations between doctors and their patients.

For example, the Scottish Government's campaign to increase awareness and understanding of autism, which has been co-produced with autistic people, recognises that not all autistic people are the same and that many autistic people see autism as integral to their sense of self. To deem somebody ineligible for an assisted death because of an autism spectrum condition is in conflict with that approach.

The bill already contains strong safeguards to ensure that a person is eligible, has capacity and is acting voluntarily. I will therefore not support amendments 140 and 141, and I ask Emma Roddick not to move them.

Daniel Johnson: Again, I thank members for a thoughtful discussion on the grouping. I did not intend to cover off every amendment in it, but I find myself somewhat compelled to comment on the discussion of Douglas Ross's amendments. With regard to their focus and objective, they are well made, and many of us want to ensure that palliative care options are fully explored.

16:45

However, I have profound concerns with some of the framing. Contemplating mortality and the end of one's own life is a pretty fundamental part of human existence. I think that most people have done that. Personally, I have contemplated the end of my life at certain times. It has not been for a prolonged period of time, but it has certainly occurred. We should not stigmatise people or put them in a different category because they have contemplated such things—I think that that is normal. In fact, that is why I am saying this: we need to be a bit more open about the fact that many of us will contemplate those situations at points in our lives and then carry on and continue to be happy, content and fulfilled individuals. It is important that we talk about these matters in an open way. However, some of the points made about palliative care are really important.

I will now turn to my amendments. I have concerns about the bill. Ross Greer summed up the position at stage 1 perfectly, because many of us voted for the bill at stage 1 because we agree with the fundamental principle that people should have the right to choose, especially when they are facing an incredibly difficult situation at the end of their lives—facing a condition from which they cannot recover and are suffering absolutely intolerably. On whether that person should be able to consider the option to end their life at the point of their choosing, providing them with one last element over which they have a degree of control, when all other control has been removed from them, I think that that is an important principle but one that requires balance. Personally, I have been struggling with the balance, which is why I believe that simply having a terminal condition—a condition that is progressing and that will end your life—cannot be sufficient in and of itself. That cannot be right, because many people with such a diagnosis will live for many years, if not decades. There are many people for whom there are good effective treatments that can allow them to have fulfilling lives. We should create conditions that exclude those people from these provisions. Although the moment for achieving that aspect might have passed, we can ensure that those considerations are made only at the very end of people's lives.

Michael Marra was right. Do we want the bill to be as open and broad as possible or do we want it to be tight and focused? I am worried that, as it stands, the legislation falls into the former category, rather than the latter. I acknowledge Bob Doris's work. I thank him for his contributions and concede that I am perhaps mimicking his approach from stage 2. However, the provision in my amendments that the option of assisted dying can be considered only for people who are at the end of their lives is really important. We can debate the best way to capture that. I do not think that there is a perfect way, and I fully and freely admit that, by setting a limit of six months, there is a sense that we are placing a marker that will require judgment and a judgment that will be fallible. However, at least the legislation would state that the option is to be considered only for those who are at the very end of their lives—lives that would reasonably be expected to be measured in months rather than years. That is critically important, and, to be frank, that is the minimum condition on which I could support the bill in any way, shape or form.

I understand the concerns about such a limit, but, ultimately, if the Parliament were to pass a provision that could be used by people at any stage of their lives simply because they had a terminal condition, we would be doing something very irresponsible—and something quite unlike most other jurisdictions, because, as far as I could survey, the majority of such legislation has a six-month timeframe.

I understand Pam Duncan-Glancy's reservations, but I think that the question that she asked—it is a fundamental test that we should be using ourselves—was this: are we passing legislation that makes ending one's life easier than continuing with it? My amendment 2 and consequential amendments 316 and 322 would be a step towards ensuring that we have a safeguard against that. That safeguard is critical and the barest minimum that we should be considering.

I press amendment 2.

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

Members: No.

The Presiding Officer: There will be a division.

For

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carlaw, Jackson (Eastwood) (Con)
Clark, Katy (West Scotland) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dowey, Sharon (South Scotland) (Con)
Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gallacher, Meghan (Central Scotland) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Gulhane, Sandesh (Glasgow) (Con)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Johnson, Daniel (Edinburgh Southern) (Lab)
Kerr, Liam (North East Scotland) (Con)
Lennon, Monica (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
Mason, John (Glasgow Shettleston) (Ind)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Simpson, Graham (Central Scotland) (Reform)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitfield, Martin (South Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

Against

Adamson, Clare (Motherwell and Wishaw) (SNP)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Bibby, Neil (West Scotland) (Lab)
Burgess, Ariane (Highlands and Islands) (Green)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Maggie (North East Scotland) (Green)
Choudhury, Foysol (Lothian) (Ind)
Constance, Angela (Almond Valley) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Findlay, Russell (West Scotland) (Con)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Leonard, Richard (Central Scotland) (Lab)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Matheson, Michael (Falkirk West) (SNP)
McCall, Roz (Mid Scotland and Fife) (Con)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)

Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Sarwar, Anas (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Wells, Annie (Glasgow) (Con)
White, Tess (North East Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gray, Neil (Airdrie and Shotts) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Mountain, Edward (Highlands and Islands) (Con)
Stevenson, Collette (East Kilbride) (SNP)

The Presiding Officer: The result of the division is: For 70, Against 47, Abstentions 6.

Amendment 2 agreed to.

Amendment 137 moved—[Stephen Kerr].

The Presiding Officer: The question is, that amendment 137 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

The vote is closed.

Rachael Hamilton: On a point of order, Presiding Officer, I am having technical issues. I would have voted no.

The Presiding Officer: Thank you, Ms Hamilton. We will ensure that that is recorded.

For

Balfour, Jeremy (Lothian) (Ind)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Choudhury, Foysol (Lothian) (Ind)
Constance, Angela (Almond Valley) (SNP)
Dowey, Sharon (South Scotland) (Con)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Findlay, Russell (West Scotland) (Con)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Johnson, Daniel (Edinburgh Southern) (Lab)
Kerr, Stephen (Central Scotland) (Con)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
McNeill, Pauline (Glasgow) (Lab)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
White, Tess (North East Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Briggs, Miles (Lothian) (Con)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carlaw, Jackson (Eastwood) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Maggie (North East Scotland) (Green)
Clark, Katy (West Scotland) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Duncan-Glancy, Pam (Glasgow) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McLennan, Paul (East Lothian) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
Regan, Ash (Edinburgh Eastern) (Ind)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Simpson, Graham (Central Scotland) (Reform)
Slater, Lorna (Lothian) (Green)

Somerville, Shirley-Anne (Dunfermline) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitfield, Martin (South Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

Abstentions

Adamson, Clare (Motherwell and Wishaw) (SNP)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ivan (Glasgow Provan) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Mountain, Edward (Highlands and Islands) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Stevenson, Collette (East Kilbride) (SNP)
Sweeney, Paul (Glasgow) (Lab)

The Presiding Officer: The result of the division is: For 30, Against 76, Abstentions 13.

Amendment 137 disagreed to.

Amendment 138 moved—[Douglas Ross].

The Presiding Officer: The question is, that amendment 138 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Ind)
Clark, Katy (West Scotland) (Lab)
Constance, Angela (Almond Valley) (SNP)
Dowey, Sharon (South Scotland) (Con)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Findlay, Russell (West Scotland) (Con)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
McCall, Roz (Mid Scotland and Fife) (Con)
McKee, Ivan (Glasgow Provan) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Simpson, Graham (Central Scotland) (Reform)
Smith, Liz (Mid Scotland and Fife) (Con)
Sweeney, Paul (Glasgow) (Lab)
Wells, Annie (Glasgow) (Con)
White, Tess (North East Scotland) (Con)
Whitfield, Martin (South Scotland) (Lab)
Whittle, Brian (South Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Carlaw, Jackson (Eastwood) (Con)
Chapman, Maggie (North East Scotland) (Green)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Johnson, Daniel (Edinburgh Southern) (Lab)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)

Matheson, Michael (Falkirk West) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McLennan, Paul (East Lothian) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Wishart, Beatrice (Shetland Islands) (LD)

Abstentions

Adamson, Clare (Motherwell and Wishaw) (SNP)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
Mountain, Edward (Highlands and Islands) (Con)

The Presiding Officer: The result of the division is: For 50, Against 68, Abstentions 5.

Amendment 138 disagreed to.

Amendment 139 moved—[Douglas Ross].

The Presiding Officer: The question is, that amendment 139 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Bibby, Neil (West Scotland) (Lab)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Ind)
Dowey, Sharon (South Scotland) (Con)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Findlay, Russell (West Scotland) (Con)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
McCall, Roz (Mid Scotland and Fife) (Con)
McNeill, Pauline (Glasgow) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
White, Tess (North East Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Baker, Claire (Mid Scotland and Fife) (Lab)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Briggs, Miles (Lothian) (Con)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carlaw, Jackson (Eastwood) (Con)
Chapman, Maggie (North East Scotland) (Green)
Clark, Katy (West Scotland) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Johnson, Daniel (Edinburgh Southern) (Lab)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)

Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Sarwar, Anas (Glasgow) (Lab)
Simpson, Graham (Central Scotland) (Reform)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitfield, Martin (South Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

Abstentions

Adamson, Clare (Motherwell and Wishaw) (SNP)
Boyack, Sarah (Lothian) (Lab)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Mountain, Edward (Highlands and Islands) (Con)
O'Kane, Paul (West Scotland) (Lab)

The Presiding Officer: The result of the division is: For 31, Against 82, Abstentions 8.

Amendment 139 disagreed to.

Amendment 140 moved—[Emma Roddick].

The Presiding Officer: The question is, that amendment 140 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

The vote is closed.

Jackie Baillie: On a point of order, Presiding Officer. I had problems with the app. I would have voted yes.

The Presiding Officer: Thank you, Ms Baillie. We will ensure that that is recorded.

For

Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Ind)
Clark, Katy (West Scotland) (Lab)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dowey, Sharon (South Scotland) (Con)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Findlay, Russell (West Scotland) (Con)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Leonard, Richard (Central Scotland) (Lab)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McCall, Roz (Mid Scotland and Fife) (Con)
McKee, Ivan (Glasgow Provan) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Mundell, Oliver (Dumfriesshire) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Roddick, Emma (Highlands and Islands) (SNP)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Simpson, Graham (Central Scotland) (Reform)
Smith, Liz (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
White, Tess (North East Scotland) (Con)
Whitfield, Martin (South Scotland) (Lab)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Briggs, Miles (Lothian) (Con)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carlaw, Jackson (Eastwood) (Con)
Chapman, Maggie (North East Scotland) (Green)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)

Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McLennan, Paul (East Lothian) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
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Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

Abstentions

Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
Johnson, Daniel (Edinburgh Southern) (Lab)
Mountain, Edward (Highlands and Islands) (Con)

The Presiding Officer: The result of the division is: For 54, Against 64, Abstentions 3.

Amendment 140 disagreed to.

Amendment 141 moved—[Emma Roddick].

The Presiding Officer: The question is, that amendment 141 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Ind)
Clark, Katy (West Scotland) (Lab)
Dowey, Sharon (South Scotland) (Con)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Leonard, Richard (Central Scotland) (Lab)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McCall, Roz (Mid Scotland and Fife) (Con)
McKee, Ivan (Glasgow Provan) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Roddick, Emma (Highlands and Islands) (SNP)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Simpson, Graham (Central Scotland) (Reform)
Smith, Liz (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
White, Tess (North East Scotland) (Con)
Whitfield, Martin (South Scotland) (Lab)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Briggs, Miles (Lothian) (Con)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
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Carlaw, Jackson (Eastwood) (Con)
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Dunbar, Jackie (Aberdeen Donside) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)

Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
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Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McLennan, Paul (East Lothian) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Whittle, Brian (South Scotland) (Con)

Abstentions

Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Findlay, Russell (West Scotland) (Con)
Johnson, Daniel (Edinburgh Southern) (Lab)
Mountain, Edward (Highlands and Islands) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

The Presiding Officer: The result of the division is: For 51, Against 65, Abstentions 5.

Amendment 141 disagreed to.

After section 3

17:00

The Presiding Officer: We move to group 3, which is on participation in carrying out functions of the act. Amendment 142, in the name of Miles Briggs, is grouped with amendments 148, 7, 8, 226 to 228, 107, 17, 229 to 232, 302, 20, 21, 308 and 133. I call Miles Briggs to move amendment 142 and speak to other amendments in the group.

Miles Briggs (Lothian) (Con): The proposals for these amendments have come from the British Medical Association and the Royal College of Nursing. Both organisations are neutral on the principle of introducing legislation on assisted dying, but want to ensure that any legislation that may be passed protects the needs both of healthcare professionals, whether they choose to—or choose not to—provide assisted dying, and of their patients. If assisted dying were to be introduced by the bill, there would be a significant change for healthcare professionals. It is therefore vital that they are given the genuine choice about whether—and to what extent—they participate. That is why it is important to have an opt-in system, whereby only those who have positively chosen to opt in to provide the service are able to do so and it is not something that is expected of all healthcare professionals.

At stage 2, Liam McArthur, the member in charge of the bill, accepted that the bill should be based on an opt-in model, and tabled amendments aimed at bringing that into effect. An opt-in model has been accepted in other parts of the UK and in Crown dependencies, and all current legislative proposals in those jurisdictions are based on that opt-in model. In Jersey and the Isle of Man, the model is that doctors and nurses register their intention to provide the service. An opt-in model has several benefits. It reassures health professionals that they have a choice about whether they wish to participate and, if they do, the extent to which they do so. It protects the health professionals from being expected and/or persuaded to participate. It avoids healthcare professionals who do not want to participate—

Alasdair Allan: I appreciate that I have not given Mr Briggs much time to develop his argument, but many members will, like me, sympathise with the point that he makes about ensuring that professionals can opt out. Does his amendment 142 stray into reserved areas? How does he answer the question about the bill's competence?

Miles Briggs: This is why the drafting of amendment 142 has been modelled on the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003, which Parliament passed. That set up a register of approved medical practitioners who can carry out particular roles, which demonstrates that that approach is within the competence of the Scottish Parliament, and that is exactly how I have modelled my amendment 142. I believe that the proposal is within the competence of Parliament and that it would offer the opt-in model that we are all trying to achieve for the bill.

I totally recognise that there is sometimes a psychological difference between participation in

assisted dying being something that could be expected of all health professionals—unless they use formal processes of opting out—versus it being expected only of those who have chosen to opt in. I welcome the recognition of the importance of that to health professionals, but the bill does not currently say explicitly that it is an opt-in system. I have heard from the BMA and RCN that their members are concerned that the opt-in provision needs to be fully transparent and that they need those reassurances in the bill. In addition to providing that—

Jamie Hepburn: My question is just for clarity, and it picks up on Dr Allan's point. Mr Briggs has referred to a comparable register in the 2003 act. For absolute certainty, can he clarify that there was no interaction at the time between the then Scottish Executive and the UK Government to transfer any form of legislative competence, and that it was legislated for solely on the basis of devolved competence at that time?

Miles Briggs: Yes. That is why I want to make sure that we have used an identical model, and I have done so in modelling amendment 142. I tried to do that with the amendments that I lodged at stage 2, but, since they were not deemed to be within competence, I changed them and lodged amendment 142 at stage 3. I am interested to hear what the minister has to say in summing up this debate, but I do not understand why creating that opt-in provision would not fall within the competence of this Parliament, since it is identical in nature to the provisions in the 2003 act that I referenced.

Clare Haughey: I am intrigued by the piece of legislation that the member is using as an example. It is my understanding that the register of approved medical practitioners that the member refers to was concerned with detaining people and extending their detention under the 2003 act, as well as with compulsion of treatment under other legislation. I am not quite sure how he can use that particular piece of legislation as a model for an opt-out, because that was not an opt-out for anyone; it was about conferring powers on psychiatrists.

Miles Briggs: It is not an opt-out model that I seek, but an opt-in model. The 2003 act is the only clear piece of legislation that the Parliament has agreed to that has established such a register for healthcare professionals, which is why I sought to model the amendment on it.

Other options would have been available. I was part of the Health and Sport Committee—I think that Clare Haughey was as well—when it dealt with the Human Tissue (Authorisation) (Scotland) Bill and considered the issue of how we could get a group of healthcare professionals to undertake the work that the legislation was concerned with. However, I think that amendment 142 would provide the cleanest possible approach, which is to establish a register that people can opt in to. The amendment would provide clarification and reassurance by ensuring that an opt-in for healthcare professionals is explicit in the bill, allowing for patients to identify and be directed to a doctor who would fulfil the role of a coordinating registered medical practitioner. In the long term, the register would also help health boards to accurately map the staff who are available locally to provide assisted dying.

Clare Haughey: I thank Mr Briggs for his indulgence in allowing me to labour this point. I fail to see how having a register of psychiatrists who have undertaken additional training, who are at senior or consultant level and who have been conferred additional powers under the 2003 act can be compared with a register of healthcare professionals who will or will not participate in assisted dying. That seems to be counterintuitive.

Miles Briggs: I do not accept that. The 2003 act set up a registered group of approved medical practitioners to carry out a particular role. I do not see any problem in what I am proposing, which is to provide a similar register for those who would take forward work on assisted dying. Amendment 142 would provide an opt-in system for the medical professionals who will be looking to the Parliament to provide clarification, and I think that that would be within the competence of our Parliament, which is important.

I urge members to vote for the establishment of such a register. We need to make an opt-in system explicit in the bill to provide assurance, which is needed by the healthcare professionals who would positively choose to participate and by patients who would be able to know that they are being cared for by those who want to be involved in assisted dying and who are appropriately trained and supported to do so.

I move amendment 142.

The Deputy Presiding Officer (Annabelle Ewing): I call Michael Marra to speak to amendment 148 and other amendments in the group.

Michael Marra: The bill was amended by Liam McArthur at stage 2 to require doctors who are opposed to assisted dying to either refer a patient to another doctor who is willing to participate or to provide information on how to access assisted dying. My amendment would remove that requirement, so that no doctor would be forced to facilitate—either directly or indirectly—the ending of a person's life. It is not difficult to imagine—in fact, I know it to be the case—that that would be highly objectionable. Indeed, it would be a resigning matter for medical professionals who

have dedicated their working lives to preserving life.

As was highlighted at stage 2, the requirement to refer is not a neutral act, and it may be viewed as a compelled complicity. It would make the doctor an integral link in the chain that leads to a person taking their own life. We should do everything that we can to protect the choice of individual clinicians in that regard.

I know that others will argue that the duty to refer is necessary to ensure access to assisted dying and that a comparable duty already exists in the case of abortion. However, as Dr Mary Neal, an expert in medical law and ethics, told the Health, Social Care and Sport Committee, when creating a system for the first time, the onus is on those who are designing the system

"to design that conflict out of it".—[*Official Report*, *Health, Social Care and Sport Committee,* 12 November 2025; c 14.]

We must also listen to the clinicians who care most for people at the end of life—those who have dedicated their careers to relieving suffering and supporting patients at their most vulnerable, but who could, under the bill, find themselves being asked to facilitate a request for assisted dying.

According to a 2023 survey by the Association for Palliative Medicine of Great Britain and Ireland, the majority of palliative care doctors say that they would refuse to participate in any part of the assisted dying process if it was legalised, and seven in 10 would consider resigning if their organisation offered it. If such a significant proportion of palliative care doctors feel unable to remain in post under a system that would require even indirect participation, we must all take that extremely seriously. The implications affect not just the professionals but capacity levels in the NHS, which are already under extreme strain, as Parliament has recognised.

Liam McArthur, in his response last month to a letter from the medical bodies outlining their grave concerns about the bill, said:

"Choice and protection are at the heart of this Bill and I want to be very clear that means choice and protection for medical professionals as well as for dying people."

However, if doctors cannot fully opt out of the process, that promise is hollow.

Turning to other amendments in the group, I will wait to hear from the Government, but I believe that a number of well-intentioned amendments in the group will be deemed out of scope.

Bob Doris: I apologise for intervening just as you were moving on to other amendments. If Mr Briggs's amendment 142 were agreed to, under your amendment 148, would clinicians be able to make those seeking assisted death aware that an opt-in register was available for them to access?

The Deputy Presiding Officer: Always speak through the chair.

Michael Marra: It is reasonable to ask how the two amendments would interact, but I am not entirely sure how the two would operate together. However, it is absolutely clear to me that we must ensure that people have that choice and that we should protect it as best we can. I hope that that gives some clarification.

As I said, I will wait to hear from the Government, but a number of well-intentioned amendments in the group will, I believe, be deemed out of scope, including amendments from Miles Briggs, Fergus Ewing, John Mason, Pauline McNeill and Jeremy Balfour, along with Liam McArthur's amendment 133 and Jackie Baillie's amendments 229 and 308.

Liam McArthur's amendment 107 seeks to entirely remove section 18, which makes provision for conscientious objection. For those MSPs who are versed in the legislation, there are well-documented issues around legislative competence and the scope of the bill. I believe that professionals and the public will be astonished to hear that we are considering passing the bill without having in place cast-iron guarantees. Every physician I have spoken to would be of that opinion.

A section 104 order from the UK Government would be required to enact the provisions on conscientious objection that we are discussing. That would be negotiated by officials, not representatives of the public, ministers or the workforce.

Jamie Hepburn: Does the member agree that it would have been preferable and far better if the UK Government had agreed a section 30 order? I find myself having great sympathy for the arguments that have been deployed thus far in this area. Clearly, we have not heard yet whether there is a sense that the provisions fall out of scope, although we have all seen the Government's commentary. It is very difficult for those of us who believe that these are important areas to legislate for to then be told that they might fall outwith the legislative scope.

Michael Marra: The member makes a very good point. We find ourselves considering the bill three weeks from the end of the parliamentary session. If we had been looking at the matter two years past, there might have been more scope and time for the UK and Scottish Governments to have a more considered conversation about the matter and whether a section 30 order might have been a better alternative to a section 104 order.

The issue also highlights the limitations of using a member's bill in this Parliament to pursue this matter. It really requires both civil services and both Governments working together to address and resolve such issues.

The First Minister (John Swinney): Will Mr Marra further develop his argument about the uncertainty that is left for Parliament should the section 104 order route be pursued rather than a section 30 order? A section 30 order would provide the Parliament with the legislative competence to act and to define its position. I wonder whether Mr Marra would consider that a section 104 order leaves uncertainty for this Parliament about its legislative intent being followed.

Michael Marra: The First Minister makes a fair point, and I will come on to that. I am not going to stand here and advocate the position that the UK Government has taken in this regard, because the letter that I have from the Parliamentary Under-Secretary of State for Scotland does not set out the position as to why a section 30 order was declined.

The information that we have is on the means by which a section 104 order will be pursued, which is a different matter entirely. There may very well be a strong case for why a section 30 process was not deemed to be the correct vehicle for the UK Government to pursue the matter, but I do not believe that Parliament has heard it.

Martin Whitfield *rose—*

17:15

Michael Marra: I will complete this point and then take an intervention from Mr Whitfield.

I do not believe that Parliament has had that case set out to it by the UK Government sufficiently, and I would be willing to hear it. However, as I pointed out in my response to Mr Hepburn, if we had looked at this matter two years in the past, we could have pursued some form of negotiated settlement. This also speaks to the fact that we are trying to resolve very complex inter-Government issues when it is not a Government-to-Government process. That illuminates the limitations of using a member's bill in such an area.

Further to that, the letter from the UK Government to the Scottish Affairs Committee, which has also gone to the Health, Social Care and Sport Committee, is very much open to interpretation. It says that the UK Government is

"content in principle to take forward a section 104 Order. ... It is important to note the complexity of these matters and the detailed policy and legal work that would be required from both governments. This will require further consideration and analysis by respective officials. ... the UK Government is not yet in a position to agree to the specific form of the Section 104 Order."

Again, I am entirely sure that that it is a reasonable and legal means of setting out the limitations of the process. However, I think that, as parliamentarians, we would all ask whether that is a sufficient means for dealing with what is a central part of the bill. I have looked at the other areas where section 104 orders have been pursued, and they are used for reasonably technical issues. This issue is fundamental to the bill. It is about defining who can have a conscientious objection, so that people can have security in their employment, and it relates to the standards of training around those issues. I think that that is of the utmost importance, and I cannot believe that it will be dealt with sufficiently in this manner.

Martin Whitfield: I will take the member back slightly rather than address the question that he is discussing. Does he have concerns about the length of time that the bill will take? One of the challenges with the bill is that, if it is passed, when it will come into force and whether it can even be looked at as coming into force without this fundamental question being answered with regard to—

The Deputy Presiding Officer: Michael Marra.

Michael Marra: Mr Whitfield makes a very fair point. Clearly, given the timetable that we have, the bill will come under the auspices of a successor Parliament. It is not clear. In his initial statement to Parliament, Mr Gray set out that the Government would wish to prepare a memorandum for the UK Government within days on the effect of the stage 3 amendments that would be passed. However, the language in the letter that I read indicates to me that this is no four-day process. It is not a three-week process. This is a situation where people will have to give careful consideration to the interrelations.

Alasdair Allan: Will the member take an intervention?

Michael Marra: I will if I can complete this point, Mr Allan.

We should also all be cognisant of the fact that the UK Parliament is in the process of considering its own assisted dying legislation. I am sure that, if that legislation passes, there will be issues that the UK Parliament or the UK Government, or the officials who work for the UK Government, will wish to consider around the impact that it might have on different approaches to employment legislation across the UK and protections that are afforded to individuals.

For those reasons, I do not think that the timetable for this bill will be within this parliamentary session.

Alasdair Allan: Does the member agree that it is not only in this chamber that the concerns that

he has rightly outlined are being expressed? In the past few weeks, members have had a letter from former presidents of colleges of physicians and surgeons, who say:

> "This is an issue of huge concern. … it seems unconscionable to us that parliamentarians would be committing our profession to such a monumental change in responsibilities without complete clarity on what protection would be offered for those who, for reasons of conscience, would decline to be involved."

I take it that that is a direct reference to the section 104 order.

Michael Marra: That is certainly what I took that to mean when I received the letter. "Unconscionable" is a strong word, but in these circumstances I think that it is correct. We should not be looking at legislation in which people are not afforded those fundamental protections in their employment.

It also goes beyond those individuals. It has a fundamental impact on our health service and on our ability to provide palliative care, social care and emergency healthcare across Scotland. Given the statistics that I have set out, we have to think about what it will do to our NHS if we remove the cohort of staff who are unwilling to participate in assisted dying because they are not afforded appropriate protections.

Ross Greer: I have significant sympathy for much of the argument that Michael Marra is laying out. However, I am interested in his view on whether it is right that a Parliament that has responsibility for health and criminal justice has found itself struggling to debate the issue. This afternoon, we should be focused on the fundamental ethical issues that are at the core of the debate; instead, we are having a difficult technical debate about constitutional law because the devolved settlement has proven to be inadequate. Does he agree with that?

Michael Marra: That is worthy of reflection, and Mr Greer sets out some of the challenges. I have already set out what I think to be some of the limitations of the member's bill process in dealing with the issue. However, the fundamental ethical questions about the principle were addressed at stage 1, and, in this debate at stage 3, we have to address whether we have a practical bill that can afford people the choice that many members want but that also affords people protection. The debate is about the bill that we have in front of us—that is absolutely critical.

Michelle Thomson (Falkirk East) (SNP): I am listening intently to all the views that are being expressed, but I am not clear what specific remedies Mr Marra is suggesting.

Michael Marra: My specific remedy is not to pass the bill. That is my view. It is not the only basis on which I take that view, but, at this moment, there is a significant hole in the bill. I do not think that the issue has been properly explored and explained to Parliament, the public or—clearly, given what Dr Allan set out—the professionals who are involved. That is the principal concern. There is a significant hole at the centre of the bill in this regard.

Neil Gray: I wish to clarify the section 104 process. Mr Marra suggested earlier that it would be only for officials to negotiate and then conclude a section 104 process. That is not correct. It would still be for ministers in both Governments to agree—ministers would be involved in that negotiation process.

Michael Marra: That is a worthwhile clarification, but the process would involve secondary legislation and so would not have the full scrutiny of Parliament, which we are providing today—I see that Mr Gray acknowledges that. Given that there are significant concerns among our medical professionals about such a fundamental issue, this is a crucial discussion as to whether the bill should stand or fall.

Stephen Kerr: When I intervened on the cabinet secretary earlier, I am not sure that he was as clear as he could have been about the fact that section 104 requires secondary or subordinate legislation. That is a crucial weakness that now arises in the bill.

Michael Marra: I agree with Mr Kerr on that. As I set out to the cabinet secretary, it is a crucial point.

The process has been lengthy and we have given considered and detailed scrutiny to the bill—nobody can be faulted in that regard. However, we have come to a moment at which we think that there is a significant gap. I say to members who supported the bill at stage 1 for the first time that they have done the Parliament a service in bringing the bill to a stage at which we can explore the potential and the limitations of the devolution settlement in the area. In a future session, Parliament might wish to consider the issue in the round, to ensure that it can deal with it on a Government-to-Government basis or in a more considered way. We have previously had similar bills in the Parliament, but such issues were not discussed in relation to those previous bills precisely because they did not reach stage 2 or 3. There is a huge hole in the bill, and medical professionals are significantly concerned about it.

I shall finish soon, Presiding Officer—I appreciate your forbearance, given the amount of interest that there is in the issue. I am sure that others will touch on it, too.

It should give colleagues serious cause for concern that the Parliament faces passing a bill that would not make provision for conscientious objection. The consequence of considering amendment 148 is to see that the bill has too many holes in crucial places.

Paul O'Kane's amendment 232 would make provision for conscientious objection by organisations, thereby providing clear statutory protection for care homes and hospices. I put on record that I have heard powerful testimony from many in the care and hospice sector, particularly in faith-based care spaces, about their desire for a statutory opt-out. Those in the Catholic church are particularly fearful that the passing of the bill could spell the end for care homes that are run by and through that church. Those facilities provide exemplary and compassionate end-of-life care, and their loss would be felt keenly by the communities that they serve and who find solace in them, and by wider society. Losing key capacity in a sector that is under significant strain should concern us all.

Although I believe that the intention behind Daniel Johnson's amendments in the group is to provide a form of opt-out, I do not think that they would achieve that, because staff and organisations would still be required to refer patients and facilitate their assisted death. It is unclear how the opt-out would be achieved. As I said, I am anxious that such amendments would force faith-based spaces to close because they are unable to take any part in assisted dying. We should all be mindful that the faith-based sector is underprovisioned.

Although I believe that Pauline McNeill's and Jeremy Balfour's amendments in the group will be out of scope, they clearly remind us of the breadth of the group of health professionals who might be drawn indirectly into facilitating assisted dying in some way. Therefore, it is very worthwhile to look at the issues that are raised by those amendments this afternoon.

Thank you for your forbearance, Deputy Presiding Officer.

Jackie Baillie: I have five amendments in the group, so I hope that colleagues bear with me. I will first speak to amendments 7, 8 and 20, on behalf of the Royal College of Psychiatrists in Scotland.

The amendments would replace the existing reference to a "specialism" in section 7 with a clear requirement for assessments under section 7(2)(b) to be carried out by psychiatrists drawn from a formal regulated register, which would be established by Scottish ministers and set out transparently in regulations. That would be a necessary and proportionate safeguard, because it would respond directly to concerns that were raised by the Royal College of Psychiatrists in Scotland and other clinical experts, who have stressed the importance of ensuring that only appropriately qualified and experienced psychiatrists undertake capacity assessments in the context of assisted dying. The royal college notes that Scotland already successfully operates a national psychiatric register under the Mental Welfare Commission, which demonstrates that the model is familiar, workable and effective.

The new section that I propose in amendment 8 would oblige ministers to create such a register and set out the essential elements that must be included: clear eligibility criteria, the body that is responsible for maintaining the register, and a transparent process for applications for entry to and removal from the register.

Let me be absolutely clear about why that matters. First, amendment 8 would ensure consistency and quality. The assessment of capacity in this highly sensitive and ethically complex area must be undertaken only by clinicians who have the appropriate specialist training and experience. The amendment would make it explicit that only psychiatrists on the specialist register of the General Medical Council, or those who hold equivalent qualifications or have experience in the assessment of capacity, would be considered eligible.

Secondly, amendment 8 would strengthen oversight and governance. Expert bodies have warned of the risks that can arise internationally when a small number of clinicians undertake large volumes of assessments without adequate oversight. A formal register would provide a mechanism to ensure that minimum standards are upheld and that Scotland avoids those pitfalls.

Thirdly, a register would improve fairness and transparency. It would help to ensure that second opinions are allocated equitably and would prevent the possibility of what is sometimes described as doctor shopping. That would protect the individual seeking assessment and the integrity of the process.

Fourthly, it would support robust data collection and evaluation, which will be essential for the annual and five-year reviews that are required by the bill. Without amendment 8, gathering consistent, high-quality national data on psychiatric assessments could be extremely difficult—or even impossible.

Amendment 7, which is consequential to amendment 8, would replace the general reference to psychiatry with a reference to the new register of psychiatrists.

The amendments would not alter the principle behind the bill or place any barrier in the way of a person who meets the necessary criteria for assistance. They would ensure that the Parliament embeds in law a safeguard that clinicians themselves have told us is important for patient safety, public confidence and the integrity of psychiatric practice in Scotland.

Let me address what I suspect are the concerns of the Scottish Government and some members. First, on competence, we already successfully operate a register under the Mental Welfare Commission. We would not be changing how the GMC operates its register, because doing so would be constitutionally inappropriate. I do not believe that there are competence issues, because the proposal is to maintain a register, which we already do. In her earlier interventions, Clare Haughey outlined exactly why such an approach would be competent.

Secondly, because the Mental Welfare Commission for Scotland already operates a register successfully, there are therefore no issues with deliverability, in my view. If the Parliament intends to legislate for assisted dying, we must legislate responsibly, with appropriate checks, safeguards and oversight. The amendments in my name provide exactly that, and I therefore urge members to support amendments 7 and 8, as well as amendment 20, which is consequential to amendment 8 and provides that the relevant regulations will be subject to the affirmative procedure.

17:30

I will now move on to amendments 229 and 308, which I have lodged on behalf of Children's Hospices Across Scotland—CHAS. The amendments recognise that institutions, as well as individuals, may have legitimate ethical grounds for not participating in assisted dying. That protection is needed because it ensures that the bill respects conscientious objection at an organisational level while still protecting individuals' access to other legalised assisted dying services.

Amendments 229 and 308 would give care services and independent healthcare providers, including hospices, the opportunity to opt out of providing assisted dying where there are reasonable grounds, including where staff exercise conscientious objection.

Scotland has more than 10,000 registered independent care services, and not all of them will be suitable or appropriate settings for assisted dying. Those services already determine which healthcare interventions they provide, and they are required, through regulation, to set that out clearly within their organisational aims and objectives, to ensure that there is transparency for patients, families and professionals.

Amendments 220 and 308 would mean that those care services and independent healthcare providers would not be penalised for choosing not to provide assisted dying or for not allowing it to take place on their premises. They would also guarantee that patients and families using those services could still access assisted dying through an alternative provider, ensuring no loss of choice for the individual. They would protect the ethical integrity of care services and independent healthcare providers, including hospices and specialist providers such as CHAS. They would also maintain a rights-based balance through respecting organisational values while ensuring individual access. I therefore also urge members to support amendments 229 and 308.

Pauline McNeill (Glasgow) (Lab): Amendment 226 strengthens the conscientious objection provisions in section 18, which are essential if the Parliament is to legislate responsibly in such a sensitive area. Specifically, the amendment, which is to section 18, on page 12 at line 28, leaves out subsection (1) and inserts:

"No individual, in any role or capacity, including—

(a) medical practitioners,

(b) nurses,

(c) allied health professionals,

(d) pharmacists,

(e) administrative staff,

(f) receptionists,

(g) delivery personnel,

(h) students,

(i) trainees".

The arguments here are similar to those made by Michael Marra and Jackie Baillie. This is probably the single biggest issue about the operation of the bill, so it requires intense scrutiny. It seems to me that, given the significance of an assisted dying bill and the fact that people will have conscientious objections to it, these provisions are the most important thing to get right.

As the bill stands, it says:

"An individual is not under any duty … to participate directly in anything authorised by this Act."

Amendment 226 adds the words "directly or indirectly" and makes clear the range of roles that could fall within the scope of the bill. When we talk about conscientious objection, we must be honest about what participation could look like in practice. It is not only doctors and nurses who may find themselves involved; it could also be pharmacists

who are asked to dispense substances, a delivery driver, a receptionist arranging appointments or administrative staff. For belt-and-braces purposes, it is important to include those members of staff who may be involved in a process, should the bill pass.

For some people, any involvement in the ending of life, however indirect, raises profound moral, ethical and religious concerns. If we are serious about protecting the conscience of those individuals who may wish to step back from the process, we must cover everyone. Amendment 226 would close a loophole in relation to that. Some have argued that such amendments might risk making the bill harder to implement, but it seems to me that there must be a cast-iron right of clinical staff and non-clinical staff not to participate.

It is of serious concern that we are at stage 3 yet are arguing over whether this is competent. Perhaps lessons have to be learned about the operation of devolved and reserved matters. This is a significant bill, and it gives me cause for concern that that has not yet been resolved. As the member in charge of the bill has suggested, it could be dealt with at a later stage under a section 104 order, but that is not satisfactory. It is important to put it in the bill, and I think that it is competent. There is a good argument that it is, particularly when we are talking about non-clinical staff. We are not talking about regulations here; we are talking about the operation of our NHS.

I am not comfortable with the suggestion that there would be a gap between royal assent and the legislation coming into force. Where would that leave those who wish to object? It is crazy that we would consider there being a gap of any sort. When we pass legislation in the Parliament and it reaches the royal assent stage, unless there are specific provisions in certain sections of a bill that will not come into force, it all comes into force. It is a serious flaw in the bill. I have said on record that I will not be voting for it, but we always have to consider that it might pass, so we want legislation to be the best that it can be.

For those reasons, I will support the other related amendments. I urge any member who believes that this is an important aspect of the bill to vote to put it in the bill. I believe that it is competent. In that way, the Parliament's intention would be crystal clear that we want a cast-iron guarantee for clinical and non-clinical staff to exist from the minute of royal assent and that we do not want them to have to wait. I hope that amendment 226 is agreed to on that basis.

Jeremy Balfour: We are clearly at a slight disadvantage in debating these amendments, because we do not know how the Scottish Government will respond and what advice the cabinet secretary will give.

My amendment 227 would make the conscientious objection section clearer. Like other amendments, it seeks to close potential loopholes by which staff will be asked to indirectly participate in the process of assisted dying provision. The amendment would add to section 18(1A) examples of such types of participation—for example, the requirement to refer, direct or signpost a person to another individual or organisation to facilitate assisted dying—to ensure that that cannot be the case.

I hope that everyone in the chamber agrees that we need to work with the principle that conscientious objection is built into any future system of assisted dying. It is not an optional add-on or top-up, and it might cause some inconvenience, but we need to protect individuals in that regard. The bill simply will not work without it, because it will not have the confidence of the people of Scotland. We cannot have a situation in which, for example, because of inconvenience, a person not fulfilling a request could result in a junior healthcare staff member having to facilitate an action that would lead to someone having an assisted death. Nurses and doctors who have just qualified from university could be asked to do so in one of their first jobs in their careers, even if it was against their conscience, and that cannot be acceptable.

I am deeply concerned about the process that we are involved in this afternoon with regard to this whole group of amendments. Other members have explained them well, but my understanding—perhaps the cabinet secretary can clarify this when he speaks—is that, although both ministers and both Governments will be involved in the process of producing things, it will not come back to this Parliament.

Neil Gray: I can confirm that the section 104 process does not set out a role for the Parliament. However, I would be happy to keep the Parliament updated, should the bill pass and should the section 104 process be required, to allow colleagues to consider and scrutinise the section 104 process, whether it involves me or any future ministers.

Jeremy Balfour: The cabinet secretary has just confirmed that, if we pass the bill and it becomes an act, it will go away to both Governments to be discussed and that we can be consulted and look at that but will have no veto. That means that we could end up in a situation where people or institutions have to do things that we, as a Parliament, do not want, because we have been told by the UK and Scottish Governments that they have to do them.

Bob Doris: I have listened carefully to Mr Balfour's argument, much of which is very powerful. Has he considered how a future Scottish, or UK, Government would know the will of this Parliament on the protections that are outlined in the amendments before us here today if we do not take a view on them and vote on them? Is this not an opportunity for Parliament to come together on the protections that we think should be in place? For the Parliament, which is passing primary legislation, to stay silent on those protections by voting them down could mean that the Scottish and UK Governments would be unable to take an informed view on the will of the Parliament.

Jeremy Balfour: If I understood Mr Doris correctly, I have a worry. For example, if, in a moment, the cabinet secretary tells me that amendment 227 is incompetent, but Parliament then votes for and passes it, that would make the act incompetent and it would have to go to the Supreme Court. That does not seem to me to be a particularly good way of dealing with the issue.

Stuart McMillan (Greenock and Inverclyde) (SNP): Will the member accept an intervention?

Jeremy Balfour: I will let Mr McMillan in in a moment.

There are time pressures because this session of Parliament comes to an end in two and a half weeks' time. The issue should have been sorted out by both Governments before now, so that we knew exactly what we were voting for. That could have been the way forward because, at that point, whether I agreed with the section 104 order or not, I would know exactly what protections other people were getting. I will not have that assurance, whether I am re-elected or not.

Stuart McMillan: The section 104 process has regularly been discussed by the Delegated Powers and Law Reform Committee, and I am sure that Mr Balfour would agree that we have consistently been told that the process would start only at the end, after stage 3 has been completed, and that it would not begin before stage 3 has been completed. However, the cabinet secretary's letter of 5 March tells us that the section 104 process has already started. Does that not indicate either that the process has been changed or that it has been expedited for some other reason?

Jeremy Balfour: I absolutely agree with Mr McMillan. Perhaps, when he speaks, the cabinet secretary can tell us why that has happened so quickly. Like Mr McMillan, I spent a number of years on the DPLR Committee and I know that it is unusual for that to happen. If there had been the will, I think it would have been possible for both Governments to have drawn something up, not necessarily to tie everything up but to give us the general principles. I do not know whether the UK Government wants to give the opt-outs. We have had no indication of that in any correspondence and are being asked to take a massive leap in the dark.

Ross Greer: Regarding the exchange between Mr McMillan and Mr Balfour about the section 104 order, I share their frustrations about the level of uncertainty that we face today. There was nothing to stop the UK Government producing a draft section 104 order. Mr McMillan is correct in saying that the order could not have been made until Parliament had passed the bill, but there was nothing stopping the UK Government producing a draft or at least offering this Parliament some clarity, but it did not do that.

Mr Balfour said that we lack a veto, but the commencement regulations are our veto, particularly if amendment 133 is passed. If Parliament passes the bill, no system of assisted dying could begin until we had agreed through the commencement regulations that, for example, conscientious objection, no detriment, training requirements and so on had all been covered. Do we not have that veto through the commencement regulations?

17:45

Jeremy Balfour: I absolutely agree with Mr Greer on his initial point that the UK Government could have given us something in draft. I suppose that my point is that we are where we are. We are in the reality of politics. We do not have that, and we are not going to get it unless the UK Government comes up with it in the next week, which I do not think it will.

John Mason (Glasgow Shettleston) (Ind): Will the member take an intervention?

Stuart McMillan: Will the member take an intervention?

Jeremy Balfour: We have to consider where we are in reality. Again, it is a matter of timing. We are being asked to make decisions without having the information before us.

I give way to Mr Mason.

The Deputy Presiding Officer: Please be brief, Mr McMillan. Mr Balfour has been very generous with his time, but he will need to conclude shortly.

Stuart McMillan: On the point about—

Jeremy Balfour: Sorry—I said that I would give way to Mr Mason.

Stuart McMillan: Oh, sorry. I thought the Presiding Officer called me.

The Deputy Presiding Officer: I am sorry. I thought—

John Mason: The member did say “Mr Mason”, Presiding Officer.

The Deputy Presiding Officer: I am terribly sorry. I did not hear that and I saw Mr McMillan rise. I call Mr Mason.

John Mason: Thank you, Presiding Officer.

To answer Mr Balfour’s question about why this is happening, I do not know whether he will agree with me, but I think that it is happening because Westminster wants to keep us in our place. As it did on gender recognition, it wants to keep a veto over anything that we do.

Jeremy Balfour: Funnily enough, I do not agree with Mr Mason. I agree with him on lots of what he believes in, but I do not want to make this—and I do not think that we should make it—a constitutional argument. We should be asking what the best thing is for the people of Scotland.

Without having the information before us, unless the cabinet secretary can say that all the amendments are competent and we can vote for them, I do not believe that we should leave it to both Governments to make choices that we will ultimately have no say in.

The Deputy Presiding Officer: I call Douglas Ross to speak to amendment 228, in the name of Fergus Ewing, and other amendments in the group.

Douglas Ross: I will speak to amendments 228 and 230 on behalf of Fergus Ewing, who cannot be in Parliament today. Those amendments are vital because they seek to strengthen section 18 to protect the right of conscientious objection for medical staff and others who are involved in healthcare. They make it explicit that no one may be coerced, pressured or threatened into participating in assisted dying, whether through employment consequences, contractual threats or undue influence from colleagues, supervisors or external bodies.

It is deeply concerning that the sponsor of the bill, Liam McArthur, seeks to remove section 18 entirely, which would, in effect, strip away any critical safeguard. Worse still, he proposes that the rules on conscientious objection be determined not by this Parliament but by United Kingdom civil servants without any scrutiny from the Scottish Parliament. That is more than just a technical matter of employment rights; it is a fundamental attack on the authority of the Scottish Parliament that would shift power from elected representatives into the hands of officials who are not directly accountable.

I remind members that I am speaking on behalf of Fergus Ewing, who would want me to reiterate this point: for anyone who believes in the principle of Scottish self-government and anyone who supports Scottish independence, that should be unacceptable. [*Applause*.]

That will be the only time that I get applause from members on the benches in the middle, I am sure. [*Laughter*.]

Seriously, however, we have seen from correspondence and engagement with medical professionals that clarity and certainty on conscientious objections are not optional but essential. Staff must have absolute confidence that they can refuse to participate in assisted dying without fear of reprisal or coercion, and amendments 228 and 230 would make that crystal clear. This Parliament must send a strong message that it will not allow any staff member, volunteer or practitioner to be coerced into participating in a process that they conscientiously object to. To do otherwise would undermine both individual rights and the democratic authority of the Parliament.

Amendments 228 and 230 are not about theoretical protections; they are about protecting people, preserving accountability and defending the sovereignty of the Scottish Parliament. Disagreeing to them would be a step backwards for the Scottish Parliament, Scottish democracy and the ethical treatment of our healthcare staff. That is why I am happy to speak to amendments 228 and 230, in the name of Fergus Ewing.

Liam McArthur: The Scottish Government set out its view in a memorandum to the Health, Social Care and Sport Committee in September 2024, that provisions within the bill may be outside the legislative competence of the Scottish Parliament. That includes the provisions in section 18, which the Government has indicated may relate to the H1 employment reservation of the Scotland Act 1998.

As members are aware, section 18, as amended at stage 2, provides in essence that

“An individual is not under any duty … to participate directly in anything authorised by this Act.”

It includes a series of provisions that are aimed at ensuring that an individual, or organisation, must not be subject to any detriment for not participating or, as the case may be, for participating, in anything that is authorised by the act. However, because of the legislative competence issues to which I have referred, amendment 107 would remove section 18 from the bill, to ensure that all aspects of the bill are within the competence of the Scottish Parliament when it comes to the final vote.

I am aware of the concerns over that removal, which have been articulated this evening. I fully agree that the protection of health professionals and others who have objections to being directly involved in the assisted dying process, for

whatever reason, is of the upmost importance. So, too, are the employment protections for those professionals, as was set out at stage 2.

Equally, I wish to ensure that all provisions in the bill are within the legislative competence of this Parliament; otherwise, they cannot have the legal effect that the Parliament intends. The safest route is a constitutionally precautionary one.

Both the Scottish and UK Governments have agreed that the best way to achieve the protections that are currently provided though section 18 is through an order at Westminster under section 104 of the Scotland Act 1998. I refer to correspondence from the Cabinet Secretary for Health and Social Care to the convener of the Health, Social Care and Sport Committee, and from the Parliamentary Under-Secretary of State for Scotland to the chair of the Scottish Affairs Committee, which confirms that.

Pauline McNeill: Will Liam McArthur take an intervention?

Liam McArthur: I will, in a second.

I will quote from the letter from the cabinet secretary. In relation to section 18:

"We wrote to the UK Government on 10 February 2026, requesting an in-principle commitment to a Section 104 Order, and received a response on 3 March 2026. This response indicated that the UK Government is content, in principle, to take forward a section 104 Order."

In relation to the training, qualifications and experience provisions, Mr Gray stated:

"Having given this careful consideration, our view is that the route of seeking to make provision in a section 104 Order, perhaps to give Scottish Ministers power to make directions about such matters, is the appropriate one here also."

I quote those comments simply in response to the intervention from the First Minister about the UK Government's response. The process is an illustration of the way in which the Scottish and UK Governments, working together, can work for the betterment of the Parliament.

Pauline McNeill: I am trying to understand how Liam McArthur sees this working. He will forgive me, but I am sure that he is familiar with the commencement provisions in section 32, which says,

"This section and sections 14A, 14B, 22A, 28, 29, 31 and 33 come into force on the day after Royal Assent"

and

"The other provisions of this Act come into force on such day as the Scottish Ministers may by regulations appoint."

Was section 32 designed and written in that way so that it would work in tandem with the section 104 order that Neil Gray was talking about? It would be helpful to know how it pieces together. I do not think that that is the normal way in which the commencement of an act would be written. Am I right in saying that?

Liam McArthur: In response to that, I say that there are commencement provisions in the bill as it stands, as Ross Greer indicated when he intervened on Jeremy Balfour earlier in the debate on this grouping. My amendment 133 in the group would ensure that any commencement of the provisions of the act could not take place unless and until the section 104 order had been passed.

The section 104 order that I am talking about—which would embed the no duty, no detriment approach, and the training, qualifications and experience requirements—is entirely in keeping with standard practice in medicine. We are not looking for anything that deviates from that.

The expectation that either the UK Government or the Scottish Government, which have operated in good faith throughout the process, would somehow divert to a different course of action after the Parliament has decided to support the bill is not backed by any evidence.

Martin Whitfield: Amendment 133 is more specific than that, in that, if the section 104 order does not deal with the question of conscientious objection and opting out, the bill cannot come into force.

I will reiterate the question that I put to Michael Marra. This bill will potentially be passed by this Parliament. If it is, does Liam McArthur have any understanding of how long it would be before it came into force? That question is also being asked outside the Parliament.

Liam McArthur: The question about the implementation of the act relates not only to these provisions, as important as they certainly are. Other aspects of the bill will also need to be taken forward through secondary legislation and guidance. Unless and until those aspects are in place, medics would rightly have a lack of confidence in what is being implemented. A range of factors—systems, processes, training and so on—will need to be in place before such a process can be implemented in practice. That is what the public, patients and medical professionals would expect.

As Stuart McMillan alluded to, section 104 orders are regularly used to make consequential modifications to reserved law in relation to acts of this Parliament. A recent example would be the right of celebrants not to participate in ceremonies under the Marriage and Civil Partnership (Scotland) Act 2014, which was passed unanimously by this Parliament.

Stuart McMillan: I will refer to the Delegated Powers and Law Reform Committee once again.

Earlier in the session, two Scottish Law Commission bills came through the Parliament and section 104 orders were required. Those are now the Moveable Transactions (Scotland) Act 2023 and the Trusts and Succession (Scotland) Act 2024.

The point that was consistently put to our committee was that it would take 18 months for a section 104 order to go through the full process in Westminster before anything would come out at the end. As a follow-up to Martin Whitfield's question about the length of time for implementation, does Liam McArthur consider that we would be looking at 18 months for this bill, or does he imagine that the process would be expedited?

Liam McArthur: That is not necessarily a question that I feel equipped to answer, other than to point to the way in which the Scottish and UK Governments have approached the issue, recognising the neutrality of both.

There was no opportunity to take forward discussions on section 30 and section 104 orders until the Scottish Parliament had stated its will on the principles of the bill. As soon as we did that in May last year, both Governments have worked at pace to put in place arrangements that allow the reserved elements of the bill to be dealt with appropriately and fittingly.

Jamie Hepburn: Will the member take an intervention?

Liam McArthur: I will take an intervention in a second.

I cannot judge where we go from here. However, if we look at other jurisdictions, we see that 18 months to two years is not unusual for the implementation process. Some jurisdictions have taken longer; very few have taken less time. I think that the public would expect the bill to be expedited in an appropriate fashion. Given the track record of both Governments over the past six months or so in taking forward these provisions, there is cause for optimism that that would continue.

Jamie Hepburn: Liam McArthur is strictly correct that this is not an unusual process in terms of the implementation of acts of this place, and he cited examples. However, given the substantial nature of what we are legislating for, he must at least recognise and understand that, because there is no clarity, this puts many of us into a position of great unease. I do not doubt that there has been good faith interaction between the Administrations, but the simple matter of fact is that we do not know what will be contained in that section 104 order. That is a very frustrating place for us to be as a Parliament.

Liam McArthur: I acknowledge the frustration, and to some extent I share it, but there are enough sensitivities around the issue of assisted dying without using it to stretch the parameters of the constitutional settlement. I have always taken the view—

Alasdair Allan: Will the member take an intervention?

18:00

Liam McArthur: In a second.

I have always been clear that, in taking forward my bill, I would seek to maintain it within the competence of this Parliament, and that was the Presiding Officer's judgment in allowing the bill to be introduced in the first instance.

As I said, once the Scottish Parliament took a view on the general principles of the bill, the elements that fell outwith legislative competence—which I was told at the start of the process would take 18 months to resolve, as Stuart McMillan just alluded to—have been expedited in short order. Arrangements have been put in place to ensure that the will of this Parliament is reflected and taken forward in a section 104 order.

We are talking about the elements of no duty and no detriment, and the training, experience and qualification provisions, as reflected in the way in which other legislation relating to health and care professions currently operates. The content that needs to be in the section 104 order is very clear. I have no doubt whatsoever that the health secretary and the Scottish Government after the next election will be committed to taking forward that process in the same way in which it has been taken forward to date.

I understand the frustrations, but—as I said—that is the process for the will of Parliament to be reflected. The bill, if it is passed, will come under legal challenge—there is no doubt about that.

Jeremy Balfour: Will the member take an intervention?

Liam McArthur: Opponents are already fundraising and organising to challenge the legislation that has already been passed in the Isle of Man and in Jersey, and I think that it is safe to assume that the same will happen should this Parliament pass the bill. We need to ensure, therefore, that what we put in place is robustly safeguarded but also defensible in the light of any legal challenge.

I will take a brief intervention from Jeremy Balfour.

Jeremy Balfour: I wonder whether I could bring the member back to a particular point in my

amendment 227. I lodged a similar amendment at stage 2, to allow secretaries and other people also involved in the process to opt out, but he and the committee said no to that amendment, and it was rejected. Is the member now of the view that anyone who has an objection, whether they are a secretary or another person such as a pharmacist, should be allowed to opt out, or is he still of the view that that option should apply only to doctors and nurses?

Liam McArthur: I still believe that it ought to be those who are directly involved in the process. I also believe that it should be an individual conscientious objection, rather than an institutional one; I will touch on that in a second—[*Interruption*.] I want to make a little more progress, if I may.

In this case, the intention is that both Governments would supplement my bill in order to make the provision that is considered necessary within the identified reservations. I note the strong commitments that have been given by both the UK and Scottish Governments that such protections as are set out in my bill as amended at stage 2 will be reinstated through the order process under the Scotland Act 1998.

I recognise that we are in territory in which recent experience may colour the perspective of colleagues, depending on where they sit in the chamber. However, I point to the fact that both the Scottish and UK Governments have—as I said—already shown a commitment to respecting the will of the Parliament and to making any act workable and defensible to legal challenge on legislative competence grounds. They have worked at pace and promoted a section 30 order, which has been passed here and at Westminster, to transfer competence to specify substances and devices for the purposes of lawful assistance. Similarly, they have agreed a way forward through the section 104 order process to address issues relating to training, qualifications and the regulation of professional bodies.

I have confidence in that mechanism, which is used routinely, and I am not aware of any instance in which an order that has been agreed by both Governments has not subsequently been taken forward by the UK Government. That is why I have decided to make way for the process to take place through the removal of the provisions that will then be taken forward through the section 104 order route. I therefore urge members to vote for these amendments, and similar amendments, in my name so that the necessary protections that members wish to see in place for health professionals can be provided.

I also refer members to amendment 133 in this group. It was suggested by the BMA, and it would ensure that the bill, if passed, could not be substantively commenced unless and until appropriate protections for medical professionals are guaranteed.

It is worth noting that the substantive provisions of my bill are commenced by regulations, as I think Pauline McNeill was alluding to. As such, the Scottish ministers will already be required to be satisfied that all necessary arrangements are in place before commencement. However, in light of concerns about the protections being reinstated only after my bill is passed—concerns that I fully appreciate—I wanted to go further. Amendment 133 should provide further reassurance to members of this Parliament, as well as to practitioners and their representatives, that they will not be left without protection.

Martin Whitfield: I rise to give reassurance to those who are concerned about the extent of your amendment 133: the term “individual” includes health professionals, so it is potentially broader than was indicated in the debate this afternoon.

Liam McArthur: I am grateful to Mr Whitfield for that very welcome point.

I strongly urge members to vote for the amendments in my name, without which, as mentioned, the Scotland Act 1988 order process cannot take place.

On that basis, I cannot support, and urge members not to support, Pauline McNeill’s amendment 226; Jeremy Balfour’s amendment 227; Fergus Ewing’s amendment 228, which seeks to amend section 18; or Daniel Johnson’s amendment 17, which seeks to establish an opt-out for organisations, to which I remain firmly opposed for the reasons that I set out at stage 2. This bill is about choice—for individual patients, as well as for medical professionals—and that choice cannot be reflected in an organisational or institutional opt-out.

For the same reason, I cannot support John Mason’s amendment 231 and Paul O’Kane’s amendment 232 on the same issue, or Jackie Baillie’s amendment 229, which also addresses that issue as well as other reasons by which a person may not participate. Likewise, for these and other reasons, I do not support Fergus Ewing’s amendment 230.

Amendment 142, in the name of Miles Briggs, would add a new section to require the Scottish ministers to establish and maintain a register of health professionals who can carry out the functions under the bill. The professionals would be included in the register only if they have opted in to assist eligible terminally ill adults to end their own life, have obtained any qualifications and experience that is required under the bill and are willing to carry out the role.

For reasons that I have outlined previously in connection with the removal of section 18, along with the forthcoming debate on training-related amendments—I expect that issue to be covered in the section 104 order—I cannot support the amendment and urge members not to do so. Such matters should be left to the section 104 order process, and amending the bill in the proposed way risks legal challenge, should it be passed.

That said, I hope that Miles Briggs can be reassured that, once the section 104 order is made and in light of the commitments that both the Scottish and UK Governments have given, the Scottish Government would, ahead of commencement, engage with the health sector on matters such as the best way to ensure effective protection for medical professionals. It is likely that that would include consideration of registers such as the one proposed in this amendment and other amendments that were lodged at stage 3. Perhaps the cabinet secretary will refer to that when he comments.

Those comments also apply to Jackie Baillie's amendments 7, 8 and 20, which deal with the provision, by regulations, for a register of psychiatrists who are eligible to undertake assessments for the purposes of section 7(2)(b). I am aware that she has worked closely with the Royal College of Psychiatrists in Scotland on the amendments. Indeed, in my discussions with the royal college, I acknowledged the potential benefits of such a register.

However, as well as the legislative competence issues, I note that the Scottish Government, in its commentary, flagged issues to do with potential misalignment with existing professional regulatory frameworks. That said, it may well be that any such issues could be ironed out prior to commencement; that might also be the case with issues arising in the context of Miles Briggs's amendment.

For now, however, I cannot support amendments 7, 8 and 20 in Jackie Baillie's name or amendment 142 in the name of Miles Briggs.

Michael Marra's amendment 148 is concerned with section 4A on the duty to direct registered medical practitioners who are unable or unwilling to act. It seeks to enable doctors not to signpost. That position is out of step with current practice in other areas of medicine. I fully support the right of any registered medical practitioner not to participate, for whatever reason. However, that right should not create an absolute barrier to access to assistance and support for the terminally ill adult, which would be the effect of the amendment.

Enabling the dying person to continue to seek legal assistance under this legislation, by referring, directing or signposting them to another practitioner who may be willing, or by directing them to information about assisted dying, appropriately and effectively balances and protects the rights of all those involved.

Michael Marra: Does the member recognise that, if my amendment is not agreed, fewer people will be working in our palliative care sector?

Liam McArthur: I do not accept that at all. It is not something that we have seen in any other jurisdiction where concerns were raised in advance of the legislation being passed. The expression of the strength of that feeling, I understand, is measured in the threats to leave the sector. I find it difficult to see a situation in which practitioners, who have been committed to a sector and to the delivery of palliative care all their lives, will walk away from a profession on the basis of the availability of a choice in which they do not need to actively participate.

Ruth Maguire: Will the member take an intervention?

Liam McArthur: No.

I also note the Scottish Government's concerns on legislative competence. For all those reasons, I ask Mr Marra not to move amendment 148 and, if he does, I urge Parliament not to agree to it.

Daniel Johnson: We are dealing with profound moral issues that are issues of conscience. Therefore, individual opt-outs and, indeed, organisational opt-outs are absolutely fundamental. I am not going to repeat many of the arguments on individual opt-outs that we have heard so far in this grouping, but organisational opt-outs are equally important. I do not think that there is as hard a distinction as is being set out by Liam McArthur. In particular, when we think about hospices, we are not talking about large, impersonal institutions. By their very nature, they are small, intimate and personal. It is up to each hospice—as an organisation—to think about how including assisted dying might impact on its practice and influence the people who work in that organisation and, indeed, the patients in the hospice. I acknowledge that not all hospice patients stay there, but many do.

Ruth Maguire: Will Mr Johnson accept the point that, although folk who work in hospices have dedicated themselves to a career, this proposition is quite a different thing for them? That needs to be acknowledged. Not for everybody, but for many people who work in palliative care, this is almost the opposite of what they are doing at the moment.

Daniel Johnson: Ruth Maguire makes the point excellently. Many people will be able to incorporate assisted dying into their practice. It would be wrong to say that it is a binary issue, but many people will

be deeply troubled by it. What is more, many people working in a small environment with a small number of patients and colleagues would be troubled. Those organisations need to reflect that.

I lodged a similar amendment at stage 2, but amendment 17 is different. The considerations for organisations differ from those of individuals. It is deeply problematic to obligate individuals to do anything, including signposting, and I agree with Michael Marra's amendments in that regard. For some of the reasons that Liam McArthur alluded to, if we are going to provide an opt-out for organisations, it is important that we provide some ability for individuals to be signposted to other organisations or services that might be able to help them if they choose to avail themselves of the provisions in this bill.

Patrick Harvie: Will the member take an intervention?

Daniel Johnson: I will give way in a moment, if I can first complete the point.

People might find themselves in hospice, having not contemplated using the provisions of the legislation, and then they might change their mind. I believe that organisations have a right to opt out because of the wider implications, and there is an inner obligation to provide them with the ability to opt out. However, it would not be fair to exclude individuals from using the provisions of the legislation simply because of the hospice that they chose—or found themselves in—due to particular circumstances, when those circumstances have changed.

I am happy to give way now.

Patrick Harvie: I wonder whether Daniel Johnson would reflect on one of the other objections to the idea of an organisational opt-out. He said that it should really be about the patients. If the Parliament decides that we should pass legislation that allows a degree of choice to access assisted dying in those circumstances, the implication of an organisational opt-out is that somebody reaching the final stages of a terminal illness, often with highly complex care, would effectively be told that they would have to move to another location in very difficult circumstances in order to exercise the choice that the Parliament decided they have a right to exercise. Surely that is the unintended consequence of an organisational opt-out.

18:15

Daniel Johnson: I do accept that there are some very finely balanced judgments to be made here. I acknowledge the points that have been made in that regard, but I do not necessarily think that what I am proposing will prevent an organisation from providing access.

The more important point is that there is a flipside to the situation that Mr Harvie has set out. If we oblige organisations to take part in this, we are essentially putting professionals and other patients in a context in which they might be confronted with a practice to which they have fundamental moral objections. That might result in those people avoiding those institutions and, in turn, result in those organisations finding it difficult to operate in a way that they are comfortable with. Some organisations, especially those with a religious foundation, might feel that they cannot continue to operate at all. We have to acknowledge that a great number of hospices have a religious foundation. For some, that might be in the past, but for others, it is very much in the present.

Kate Forbes: I wonder whether the member will agree that one core element of choice is, of course, a well-resourced, well-provisioned service with staff. I know that Liam McArthur has suggested that nobody will leave, but a survey by the Association for Palliative Medicine found that 40 per cent of palliative care doctors would leave on account of that fundamental shift in the service. Of course, choice is strengthened by hospices being available. Have any hospices told the member that they will indeed close if they are forced to provide the service?

Daniel Johnson: I have to say that I have not heard that from hospices, but I have certainly heard from practitioners who have indicated as much.

In conclusion, my amendment 17 seeks to strike a balance by enabling those organisations to opt out, and to carry on, in a way, but to uphold a degree of responsibility to those in their care who might choose to use the possibilities that the bill seeks to enact. I think, therefore, that it strikes a balance in comparison with the other organisational opt-outs, which are more categorical and do not strike the same balance. I believe that the considerations for an organisation are different from those of an individual in that regard.

I will leave my remarks there.

The Presiding Officer (Alison Johnstone): I call John Mason to speak to amendment 231 and other amendments in the group.

John Mason: I will concentrate on my own amendment, but I will also touch on some of the others in this group.

Clearly, quite a few amendments have been lodged on the whole area of opting out, conscience and all the rest of it, and my own amendment, like

Daniel Johnson's, purely focuses on organisations. It seeks to introduce a new section to the bill for the purpose of an organisational constitutional objection. Surely it is completely wrong that organisations should be compelled to participate in the bill's provisions when they provide a service for a very different reason—I am thinking of, for example, care homes.

Every organisation has values and, for faith-based organisations, those values are potentially incompatible with the introduction of assisted dying. We cannot find ourselves in a situation in which, should the bill be passed, organisations are forced to participate by the state in the ending of life against their principles and wishes. Presumably, their only other option, as has been mentioned, would be to close down, and we are not at this time in a position where we can lose hospices—or care homes, for that matter. Both sectors need to be expanded.

If we were to pass the bill without this amendment, the state could actively force participation in assisted dying by organisations that have no desire to have anything to do with it. Are we going to force the likes of the Salvation Army, for example, whose poverty alleviation work is so widely appreciated, to take part in assisted dying against its wishes and conscience?

I am conscious that a similar amendment was rejected previously, because it was felt that—

Ross Greer: I am grateful to Mr Mason for taking my intervention. When this debate started, I was broadly in favour of an organisational opt-out. However, the more I have thought about what it would mean in practice, the more I have realised that it would result in people ending their lives in the most undignified way in the car parks of hospices that they might have gone into, with no intention of seeking an assisted death, but having changed their mind once they got there. On balance, I would prefer that the individual had that right.

Mr Mason's argument is that the organisation would be compelled to participate. Given the protections that we have discussed to ensure that individual practitioners are never forced to participate, the question, then, is whether the organisation should have to facilitate that and allow outside medics in.

The parallel that I think of, on that basis, involves a faith-based organisation that runs a hospice but is sincerely of the view that blood transfusions are unacceptable. I do not think that it would be acceptable for that organisation to deny paramedics access to give someone a blood transfusion. Surely this argument is about access, not about compelling an organisation to participate. It is about allowing access to medical professionals, so that the individual patient has the right to make that choice.

John Mason: That is a pretty extreme case. I am not aware of any medical facility in this country that does not allow access for blood transfusions or similar. There is a fundamental difference there.

Daniel Johnson made the same argument. It is all very well saying that such organisations, including hospices and care homes, should be able to refer people to others when they will not provide the service, but that itself goes against the ethos of those care homes and hospices. If their aim is to protect life as much as they can, albeit not necessarily to extend life indefinitely, even encouraging or allowing somebody to come in and talk about, and perhaps to encourage, assisted dying is fundamentally against their ethos.

Mr Johnson said that he is striking a balance, but I do not think that he has done that. There is something fundamental here. If the ethos of an organisation is to protect life, encouraging or allowing people in to do the opposite brings a real problem.

Miles Briggs: Everyone is talking about hospices, but this point does not just concern hospices. Most people concerned are at home. That is where the vast majority of people want to die; they are telling us that that is their wish.

Under Mr Mason's amendment 231, would he not expect people to be supported at home by the same organisations? Would that just be within the hospice boundaries? If that is the case, the capacity that would be removed to care for people at home would be vast. I am not quite sure what Mr Mason is trying to achieve through his amendment.

John Mason: If a religiously based hospice is providing a service, including within its own premises—I think that most of them provide a greater service outside—the two very much go together. I cannot imagine people who are opposed to assisted dying in a hospice then going out and helping people to take part outside the hospice.

Lorna Slater: I object very strongly to the member using the word "encourage". There is no encouraging here; there is allowing people to understand their options, so that they can make an informed choice. I ask the member not to use that word, please.

John Mason: That is a fundamental point—it is quite a good one. I do not know if the member has seen the Japanese film "Plan 75", but it was extremely good and raised some of these issues.

This goes back to the question of drift. When we allow something to start with, shortly afterwards it

becomes a matter of encouraging it. The two do go together, and that is one of my fundamental objections to the bill: that it will lead to encouragement by whoever.

To sum up, I hope that colleagues will vote for my amendment 231, or at least for one of the other amendments that cover similar ground.

Paul O'Kane (West Scotland) (Lab): My amendments in this group are in the vein of other amendments on organisational opt-out. I accord with much of what has already been said about individual opt-out for medical professionals, not least doctors—which we have covered and will cover further—and about organisational opt-out, which is particularly important for organisations that hold a certain ethos, which is usually based on faith.

I followed the debate on this aspect at stage 2, when Stuart McMillan lodged amendments that were co-designed with the Salvation Army, which has been referred to again this evening. Exchanges in the stage 2 debate on this aspect and on the services that the Salvation Army runs are perhaps not the best examples for trying to understand what we are talking about here—the need for an organisational opt-out. That is not to do a disservice to the Salvation Army's excellent work, though.

Instead, it would be really useful—both this evening and throughout our remaining consideration of the bill—to deal with clear examples of where there would be significant challenges and problems, rather than deal in broad concepts that lead to comments such as those Mr Greer made about people being left to die in car parks. I really do not think that that is helpful. We need to focus on what actually happens in practice just now and on where the potential pitfalls might be.

We can consider a clear example in the religious orders of the Roman Catholic Church that deliver social care, which they have done for centuries. To use the example of the Little Sisters of the Poor, such provision has happened in Scotland in various ways for well over 160 years. The Little Sisters of the Poor order has care homes in Greenock, in my region, and it has a presence in the city of Glasgow. It also had a presence in places such as Dundee and Edinburgh from about 1863 until recently.

The religious order provides such care within its charism, which means that the entire delivery of that care is in line with the vows that its religious sisters have taken. We cannot decouple the two things. The administration and running of the care homes are done by religious sisters—for example, the registered manager of Holy Rosary care home in Greenock is a religious sister—so it is not as though those two things are entirely separate and set apart; they are interwoven and interlinked.

Needing to offer assisted dying through health and social care frameworks, or to advertise or undertake any of the discussions that might be required through the health and social care partnership, would therefore be in direct conflict with the charism and the ethos of such an organisation and the vows to which the sisters have committed themselves. In such a situation, an opt-out for that organisation would clearly be required.

We need to ensure that, at the outset of someone choosing a care home or a hospice facility, they know what the ethos, direction and view on assisted dying in that facility will be. It rather misses the point to say that someone would need to leave that facility and find another in a short space of time; that would not be true if it were clear who was opting out and who was opting in.

Liam McArthur: I have been listening to Paul O'Kane's points with interest and some sympathy. However, the point was made earlier that an individual's view on whether they would seek to access the option of assisted dying might change over time. There are people who might find themselves entirely willing to sign up to whatever the restrictions are in the home or the hospice that they are going into, but, in due course, there would not be the flexibility to respect a change in that position. Nor would there be the flexibility to manage such situations in circumstances in which a variety of views are held among a wider hospice community.

Paul O'Kane: I recognise that that can be the case. It would not be unusual for there to be a considered and compassionate approach to such circumstances and to ensure that appropriate alternative provision can be considered.

Michael Marra: Will the member take an intervention?

Paul O'Kane: I will finish this point and then give way to Mr Marra. Principally, when somebody inquires about assisted dying in the kind of setting that I am talking about—for example, the care homes of the Little Sisters of the Poor—the sisters will be placed in the position of needing to decide what is right by the law and what is right in order to give that person the best support possible, when they cannot, in good conscience, refer them to or reflect their wishes on assisted dying.

Michael Marra: Does Mr O'Kane recognise that what Mr McArthur and Mr Greer said is a fallacy, because such institutions would not exist in those circumstances? They would close, because the Catholic Church would not operate care homes in such circumstances without an institutional opt-

out. As a result, it would close and remove the facilities that are currently available to communities across Scotland.

Paul O'Kane: Mr Marra is helpfully moving me on to that point, which I will move to now in the interest of time. There is serious concern in the Catholic Church in Scotland that those organisations would cease to exist. As I said in my opening remarks, the Little Sisters of the Poor have cared for people in this country since 1863. More than 160 years of work in this country may be at risk because of the way in which the legislation has been drafted.

The funding of such organisations is also largely dependent on the provision of social care through acts of this Parliament, which gives them the funding that is required to do so. Removing that funding would make them financially unviable, even if they were to choose to continue in some form. Members have referred to other examples of places in which legislation on assisted dying has been passed, after which religious groups have found it hard to operate.

18:30

Bob Doris: I have some sympathy for Paul O'Kane's amendment 232 and would distinguish it from Mr Marra's and Mr Balfour's amendments with a similar policy intent, which are both very clear that organisations would not have to signpost people to others. I have issues with that position. Mr O'Kane, your amendment is silent on that. If, in line with your amendment, an organisation did not involve itself in assisted dying, would it somehow compassionately signpost vulnerable people, or at least make them aware of where they could seek assisted dying?

The Presiding Officer: I remind members always to speak through the chair.

Paul O'Kane: I accept that my amendment 232 is drafted more broadly than others, and that it is not specific in the ways that Mr Doris outlines. My sense of the ethos and charism of those organisations tells me that they would compassionately signpost people, but whether we can legislate for that is an issue for wider debate than the one on the competing amendments that we are having today. That is my view, knowing the organisations as I do.

I am conscious of time. Rather than debating the issues either in a broad, academic context or in a vacuum, we must look at where there has been delivery of services for older people, those with disabilities, and those who are at the end of life or are particularly vulnerable. Those services have existed in Scotland for many years and the legislation would have an impact on them. It would affect the practical application of services and whether such organisations would be able to continue delivering them and, as many members have pointed out, it might also affect whether they would be able to exist at all. It would be to the detriment of this country if we did not have that rich variety of care that allows people to choose a setting that is right for them, in line with their beliefs and with the ways in which they want to live the latter stages of their life and to have their death.

Ross Greer: I will speak in support of amendments 107 and 133 from Liam McArthur. In particular, I will speak to amendment 133 because I have amendments to that amendment, although those will debated in a later group. It is not that I lack support for the substance and intended outcome of other amendments in the group, but there are concerns about the legislative competence of many of them—I will come back to that.

We have heard the view of the member in charge and the Scottish Government that we need to remove the protections for those who do not participate and then rely on a section 104 order, or the like, to reinsert those protections. I support the approach taken in amendment 133, which makes the commencement of the bill effectively conditional on the UK Government reinserting the protections, and I welcome the fact that amendment 133 would mean that there was no duty to participate and no detriment. For anyone who is watching at home and is concerned, that effectively means that the bill cannot come into force and that the system cannot begin without those protections being put in place. I was working on a similar amendment and am grateful to Liam McArthur for engaging with me and reflecting my feedback in his drafting, particularly given the direct feedback that I have received from many GPs in my region.

That position would set the bill within the confines of the Scotland Act 1998, but I still do not think that we are in a satisfactory situation, because we are debating a bill that effectively has a gap in it and are being asked to trust that that gap will be filled by the UK Government. I do not intend to bring our usual constitutional politics into this, but it seems obvious to me that, if this Parliament and Government are making arrangements for, and deciding whether to introduce, a system for assisted dying, it should be for this Parliament and Government to decide the specifics of those arrangements.

Kate Forbes: I agree with what Ross Greer says about the democratic deficit. As Daniel Johnson said, we are dealing with profound moral issues. We will be passing a bill but then leaving it to our workforce—to our doctors and nurses—to actually implement it and have challenging conversations with patients. There is a deficit

between us passing the bill and someone else being responsible for bringing in protections for the workforce. Does Mr Greer feel that big chasm between those responsibilities?

Ross Greer: I am grateful for the intervention because I am acutely aware of that gap, although I think that we can bridge it to an extent because of the way that amendments 133, 133A and 133B interact. I will come on to that.

I want to talk briefly about how we reached this point. In his letter to the Health, Social Care and Sport Committee last Thursday, the cabinet secretary said that the Scottish Government had received an

"in-principle commitment to a Section 104 Order"

from the UK Government on 3 March, which was after the deadline for lodging amendments at stage 3, and that a letter from the UK Government confirming that would go to Westminster's Scottish Affairs Committee "in the coming days".

Last night, I wrote to the cabinet secretary, to Liam McArthur and to the non-Government bills unit to say that although I was not calling into question the information that the cabinet secretary provided, the Parliament cannot be expected to make an informed decision on such a fundamental issue based on second-hand information. At that point, the UK Government had still not sent the letter to the Scottish Affairs Committee.

The letter was published this morning and has been quoted several times in the debate. I will read one line of it. It says:

"This in-principle agreement is in relation to employment protections and professional qualifications and experience."

The details of that are to be confirmed later.

On the duty to participate, the letter from the UK Government at least provides reassurance that no-duty and no-detriment provisions will be in place for those who opt out. However, I am frustrated that even though the competence issues in relation to poison control and conscientious objection were aired well ahead of time—certainly well ahead of the stage 3 lodging deadline—the apparent need to remove all training, qualification and experience requirements emerged at the very last minute. It was too late for many members to alter their amendments in this group so that they were compatible with the new reality.

I ask the cabinet secretary to provide clarity in response to the points that Miles Briggs and Jackie Baillie made in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003. I do not claim that my research is perfect, but my understanding is that that act required a section 104 order, but not for the register that is being used as the precedent in this case. That suggests that the UK Government has previously agreed that the Parliament has the power to set up equivalent professional registers. I am keen to hear from the Scottish Government—or whether it can relay from the UK Government—why that is not within devolved competency.

We will come to the wider questions about training, qualifications and experience when we reach group 5, but I want to briefly cover how amendments 107 and 133 in this group interact with my amendments 133A and 133B in group 5. As I said to the cabinet secretary at the start of the debate, the UK Government's letter refers to "qualifications and experience" and "training, qualifications and experience" interchangeably. I ask the cabinet secretary to clarify, when we reach group 5, why the Scottish Government believes that training is outwith competence, given the mismatch in the wording that is used.

I support amendment 107 without enthusiasm, because it is necessary. Our final decision on the bill should be based on the ethical questions concerned, not on questions of legislative competence, but it is a hard balance to strike. The more that we take out of the bill in order to ensure legislative competence, the more detail about the operation of the system and its safeguards we put beyond the bill and leave unanswered—for now. There are some mitigations against that. As I said, I worked with Liam McArthur to ensure that amendment 133 specifies in advance that the section 104 order covers the option not to participate and the no-detriment provision, if they are appropriate. I ask members who are concerned about what amendment 107 would remove to support it on the basis that amendment 133 and—once we get to them—amendments 133A or 133B provide alternative options.

Agreeing to amendment 133 will ensure that the bill is legislatively competent. No assisted dying system will commence without professionals having the option to opt out and being protected from any detriment if they do opt out. Critically, should amendment 133 and either amendment 133A or amendment 133B be agreed to, the provisions in the bill will not be commenced until training, qualification and experience requirements are set out for professionals who choose to be involved. If that combination of amendments is not agreed to, I will reflect carefully before the final vote. I ask members to support amendments 107 and 133.

Martin Whitfield: I agree in large part with Ross Greer's thesis about the amendments. I pose this question to him, and to others. How long does he envisage that it will take for the bill, if it passes, to come into force so that people see its results? There is a disjoint between the expectation of what

might happen when the bill is voted on next Tuesday and when its provisions will come in.

Ross Greer: That is a fair question, but I do not know the answer to it—in truth, I do not think that anyone in the Parliament does. What gives me comfort is that, before the system can commence, the Parliament will have to approve commencement regulations. If we agree to amendments 107, 133 and either 133A or 133B, the system cannot commence without all these protections: the no-detriment protection, the no-duty-to-participate provision and minimum standards for training, qualifications and experience.

I cannot say when that will happen, and it is completely unsatisfactory that the current devolved settlement leaves us in this situation. I do not know whether it will happen in the first year of the next session of Parliament, or the last year, or even in a session of Parliament beyond that. All I know is that, regardless, Parliament will, at that point, have the final say and the power of veto through the commencement regulations.

Neil Gray: The Scottish Government has some significant concerns about amendments in this group in so far as they relate to reserved matters or novel issues in our legal system. I will come to those, but I start with Mr McArthur's amendment 107, which seeks to remove section 18 from the bill.

I very much understand the sensitivities around this amendment and I, too, have received correspondence and representation from medical professionals who are deeply concerned about what the removal of this section would mean for their ability to object to participation in an assisted death. I make it clear to members and to those who have raised concerns that the removal of these provisions does not mean that the matter cannot or will not be addressed.

As we have said before, it is the Scottish Government's view that section 18 of the bill may relate to the H1 employment reservation and, as such, the section should be removed from the bill because it may, in our view, be outwith the legislative competence of this Parliament. The Scottish Government has been engaging constructively with the UK Government on the matter, and it is our intent to seek to resolve these matters, should the bill pass, via a section 104 order.

The UK Government has given in-principle agreement to take forward a section 104 order to make consequential provision for individuals and practitioners to opt out of participating in assisted dying and to provide appropriate employment protections. Should the bill pass, the Scottish Government will continue to engage closely with the UK Government on the form that the section 104 order will take.

I appreciate that many members and medical stakeholders would have had a strong preference for these matters to have been addressed ahead of the final vote on the bill, just as the matters relating to approved substances and medical devices for use in assisted death have been enabled by a section 30 order. Mr Hepburn and others have, understandably, made that point.

The Scottish Government discussed with the UK Government whether all the issues that were identified could have been addressed in the section 30 order. However, the UK Government took the view that, in order to respect the distinction between reserved and devolved matters, anything that could be dealt with by a section 104 order should be dealt with in that way, with changes to legislative competence—that is, the use of a section 30 order—being kept to a minimum.

Jamie Hepburn: I will not make the same point again about the section 30 process. However, can the cabinet secretary set out, or has the UK Government set out, how any divergence of opinion between the Scottish Government, in seeking to implement the will of this Parliament, and the UK Government, in its interpretation of matters, would be resolved?

Neil Gray: That is a fair question from Mr Hepburn. There may well be differences of opinion, but that would be subject to negotiation. I give the commitment that I gave earlier, which is that if I were the health secretary or the responsible minister at that time, I would seek to keep Parliament as informed as I could.

Stuart McMillan: Will the cabinet secretary take an intervention?

Jeremy Balfour: Will the cabinet secretary give way?

Clare Haughey: Will the cabinet secretary take an intervention?

Neil Gray: I give way to Mr McMillan first.

Stuart McMillan: Can the cabinet secretary provide some information with regard to why the process for this bill is different from the process for previous bills that the Delegated Powers and Law Reform Committee has considered? Those bills were non-contentious and very technical, and we were informed that it would take up to 18 months for them to go through the process, whereas this bill appears to have short-circuited the process.

Neil Gray: If I understand Mr McMillan's question correctly, he is asking how the section 30 order has been able to be resolved more quickly than other processes. That is down to the good-

faith negotiations, to which Mr McArthur rightly referred, and our ability to get to an agreed position.

I will give way next to Ms Haughey and then to Mr Balfour.

Clare Haughey: I thank the cabinet secretary for letting me intervene, and I refer members to my entry in the register of members' interests, which I did not put on record earlier.

Cabinet secretary, can you understand, given that we are being asked to vote on a bill without legislative protection for health staff, how nervous a lot of staff and the representatives would be about what the situation will be if the bill should pass?

18:45

Neil Gray: Yes, of course I do. I share that concern, and I understand it completely. We are in a position where, should the Parliament's will be to pass the proposed legislation, we will need to seek to provide the necessary protections. However, given the Government's neutral position and our obligation to protect the statute book, I am also compelled to inform Parliament of any areas of legislative incompetence or legal deficiency and other technical issues. I recognise the challenges that there will be. I pass no comment on those, except to say that, should we not agree to amendment 107, for instance, or should we accept some of the amendments that I will come to, we will potentially fall foul of the Supreme Court in this matter.

Audrey Nicoll (Aberdeen South and North Kincardine) (SNP): Will the member give way?

Neil Gray: I will give way to Mr Balfour and then to Ms Nicoll, and then I will need to make progress.

Jeremy Balfour: I wonder whether the cabinet secretary could help me out. There is obviously a clear difference among some members in regard to how far we should go. Should religious institutions be allowed to opt out? Should people who are not medical professionals, such as secretaries, be allowed to opt out, as my amendment 227 would provide for? My understanding is that we will not vote on these amendments, because, if we agreed to them, they would make the bill incompetent. How, then, will the cabinet secretary, or his successor after the election, know what the Parliament wants regarding opt-outs? We are not being allowed to make a decision that would enable us to tell you how we want you to act. I am worried that you or your successor will be left in a difficult place because of that.

The Presiding Officer: Always speak through the chair.

Neil Gray: I will come to that point in a second, and I note that Mr Doris made a similar point. I will give way to Ms Nicoll, and then I will make progress to cover the amendments.

Audrey Nicoll: I am sure that the cabinet secretary is aware of a joint statement that was signed by seven medical groups in Scotland, including some of the royal colleges, which says:

"A Section 104 Order, by its nature, receives limited parliamentary scrutiny".

We have been discussing that point this afternoon. It also says:

"Matters central to professional regulation, employment protections, and the rights of staff should not be left to a later process in which detailed debate ... and accountability are significantly constrained."

Does the cabinet secretary recognise that the proposed solution of a section 104 order is causing real anxiety to medical organisations?

Neil Gray: I absolutely recognise the perspective that Ms Nicoll has put on the record. I cannot make any comment on that, as the Government is neutral on the bill. All I can do is set out where there are issues of legislative competence or where there are technical issues or further ramifications that I and the Government feel that the Parliament should be aware of while it is coming to a determination.

I will now turn to the amendments that I wish to comment on. Amendments 226, 227 and 228 in this group seek to amend section 18. As I have already outlined, section 18 should be removed from the bill entirely. I heard the point that Mr Doris and Mr Balfour made about Parliament expressing a view, but, if amendments that are potentially outside this Parliament's competence are accepted, there is a risk that the bill will be referred to the Supreme Court.

Bob Doris: Will the cabinet secretary take an intervention?

Neil Gray: I am sorry, but I have to make progress. I have tried to be as generous with interventions as I can.

The legislative competence of the bill, as introduced, was first raised by me in a memorandum in September 2024, following the stage 1 vote. As I have said, the Scottish Government has sought to remedy that issue. However, there are amendments in this group and in other, later groups that would bring the bill further outwith legislative competence. As I have said, although it is not a requirement that amendments to bills must be within legislative

competence, the Parliament has a responsibility to consider such issues when considering legislation.

The Scottish Government's view is that amendments 7, 8 and 20 might raise issues of legislative competence in view of the G2 reservation regarding regulation of the health professions.

Jackie Baillie: Will the cabinet secretary give way?

Neil Gray: Very briefly, Ms Baillie.

Jackie Baillie: I genuinely say to you that there is no problem with competence, because, when the legislation that created the register of psychiatrists that is operated by the Mental Welfare Commission went through this Parliament, there was no need for a section 104 order, and amendments 7 and 8 are entirely in keeping with that approach.

The Presiding Officer: Always speak through the chair, colleagues.

Neil Gray: Mr Greer asked for a clarification of that point, as did Mr Briggs. I will come to it shortly, because, as well as our own considerations, that point has been discussed with UK colleagues.

On amendments 7, 8 and 20, it is not clear how establishing a statutory register of psychiatrists for the purposes of assisted dying assessments might align with the existing professional regulatory frameworks. There are also potential deliverability challenges in establishing and maintaining what would appear to be intended to operate as an opt-in register for psychiatrists.

Similarly, the Scottish Government's view is that amendment 142 may raise issues of legislative competence in view of the G2 reservation. Again, I heard Mr Briggs's and Mr Greer's points about the mental health legislation from 2003, and Ms Baillie has just put that on the record, too. I can clarify that we have engaged with the UK Government and reached our position following those discussions. We have considered other examples of legislation as part of that process, as well as amendments lodged at stage 3. We are clear that those issues must be considered on their own merits and terms. That is as much clarity as I can provide on how the Government has arrived at the position that we have.

Liam McArthur: On the issue of legislative competence, and following on from the contribution that Ross Greer made in articulating the importance of amendment 133 in giving this—or a future—Parliament a say over anything before it is implemented, can the cabinet secretary confirm that the Scottish Government's view is that amendment 133 is certainly within competence?

Neil Gray: I confirm to Mr McArthur that, as he will hear in the remainder of my contribution on this group, I have no comment to make on amendment 133, and that should help colleagues recognise that we do not have a concern about legislative competence or otherwise around amendment 133.

Amendment 148 would provide that a registered medical professional has no duty to participate in or facilitate the provision of assistance and should not suffer any adverse employment consequences as a result.

Amendment 230 would provide that any individual or organisation must not be subject to direct or indirect pressure to participate, including threats to employment. It is the Government's view that those amendments may raise issues of legislative competence relating to the H1 reservation of employment.

Amendments 231 and 232 seek to provide for some form of institutional conscientious objection. It is not clear how an institution might demonstrate what its conscience position is, given that conscientious objection concerns the personal beliefs of individuals. Such a provision would be novel in our legal system.

Finally, I turn to amendment 229, which the Scottish Government considers may raise issues of legislative competence relating to the H1 reservation of employment. From a technical perspective, the person referred to in subsection (3) is not linked to the persons mentioned in subsection (2). That means that, unlike in subsection (1), subsection (3) does not say

"A person mentioned in subsection (2)"

or words to that effect. That means that the subsection would appear to have wider application, including to natural persons, which could encompass employees and the protections that apply to them.

The Scottish Government has no comment on the remaining amendments in the group.

The Presiding Officer: I call on Miles Briggs to wind up and to press or withdraw amendment 142.

Miles Briggs: This debate has demonstrated the heart of what many of us are balancing up. It is not just about those individuals who want access to an assisted death but about those who work in the field. During the time when I was consulting on my bill on a right to palliative care, one of the best parts of that job was meeting those who work in our palliative care sector and seeing both the passion that they bring to the job and their delicacy around the families.

Fundamentally, the bill aims to ensure that the wishes of the person who is dying are fulfilled. However, many individuals have expressed to

me—and to every member in the chamber—that, if the bill passes, they will not want to be involved in some of that work. Like other members who have lodged similar amendments, I want to make sure that the bill includes that voice, because, fundamentally, it must.

With that in mind, I press amendment 142.

The Presiding Officer: The question is, that amendment 142 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Ind)
Dowey, Sharon (South Scotland) (Con)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Findlay, Russell (West Scotland) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Johnson, Daniel (Edinburgh Southern) (Lab)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
McCall, Roz (Mid Scotland and Fife) (Con)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Mundell, Oliver (Dumfriesshire) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
White, Tess (North East Scotland) (Con)
Whitfield, Martin (South Scotland) (Lab)
Whittle, Brian (South Scotland) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Balfour, Jeremy (Lothian) (Ind)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Bibby, Neil (West Scotland) (Lab)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carlaw, Jackson (Eastwood) (Con)
Chapman, Maggie (North East Scotland) (Green)
Clark, Katy (West Scotland) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Golden, Maurice (North East Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
O'Kane, Paul (West Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ross, Douglas (Highlands and Islands) (Con)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Wells, Annie (Glasgow) (Con)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Greene, Jamie (West Scotland) (LD)

Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Mountain, Edward (Highlands and Islands) (Con)

The Presiding Officer: The result of the division is: For 37, Against 79, Abstentions 5.

Amendment 142 disagreed to.

Section 4—Request for assistance: first declaration

Amendment 143 not moved.

The Presiding Officer: At this point, I will suspend the meeting for a comfort break of some 20 minutes. I ask colleagues to be back in the chamber just after 7.15 pm. Thank you.

18:56

Meeting suspended.

19:16

On resuming—

The Deputy Presiding Officer (Annabelle Ewing): We turn to group 4, which is on coercion, pressure and undue influence of terminally ill adults. Amendment 144, in the name of Michael Marra, is grouped with amendments 151, 24, 152, 25, 27, 158, 160, 33, 172, 174, 175, 35, 177, 178, 36, 180 to 182, 187, 93, 189, 209, 41, 50, 51, 305, 76, 315, 77, 319, 320, 80, 321, 82 and 84. I draw members' attention to the procedural information relating to those amendments that is set out in the groupings.

Michael Marra: The amendments in group 4 are aimed principally at the prevention of circumstances in which vulnerable individuals are coerced into giving up their own lives. I believe that that has become a growing concern among members, which has been backed by testimony and evidence from external sources during the passage of the bill, and I believe that that vulnerability is inherent in the opening up of state-facilitated death.

That area of risk has led me, as someone who entered the Parliament in 2021 undecided on the issue, to oppose the bill. I have come to the conclusion that, in a society as unequal, discriminatory and sexist as ours, coercion is a risk that is beyond effective mitigation. A Scot can be persuaded that they are a burden by one individual in their own home, or by all 5.5 million of us across the country. The feeling of being a burden financially, practically and emotionally on those whom they love or the community in which they live may bring people to the lonely conclusion that their best choice is to end their life. Clearly, those pressures fall more heavily on the poor, the disabled and the vulnerable.

The amendments in this group seek to give protections against something that can be so insidious that it is extremely difficult to detect or prove. I fear that, were some of the amendments to be agreed to, parliamentarians and the wider public would have a false sense of security that the words in the legislation would fail to provide in any real sense.

John Mason: If somebody had been coerced, however subtly, into saying that they wanted to finish their own life, would they not also make a statement declaring that their declaration was voluntary?

Michael Marra: That is a distinct possibility. I will come to my amendment 144 directly. In short, I am less convinced of it than I was when I lodged it. I feel that John Mason's contention is consistent with ever more of the evidence that I have heard and seen.

Defining coercion and internal pressure is difficult enough; proving it is another matter entirely. However, by no means does that suggest that it does not exist. Just last week, I hosted Dr Anni Donaldson in the Parliament. She is an expert in domestic abuse and coercive control, who has decades of experience in Scotland. Dr Donaldson has caused me to reconsider my view of the possibility of improving the bill, including through my amendment 144. The self-declaration for which my amendment 144 provides would, in her view, be practically redundant as a safeguard, for the reason that John Mason set out. A person—normally, a woman—who experiences coercive control will very rarely perceive it as such, so they would make such a declaration. Even if they perceived it, they might not feel empowered or able to decline to make such a declaration.

The dynamics to which I refer are overwhelmingly between abusive men and vulnerable women. We know about the scale of that abuse: in the past two years, instances of domestic abuse in Scotland have increased by 44 per cent.

On 2 March, Lee Milne of Dundee was found guilty of killing Kimberly Milne through systematic continued abuse. She jumped to her death. His hand did not push her, but he was her killer. Daily, I pass the purple ribbons left on the bridge in Dundee by those who mourn for her and share some of the pain that she felt.

Last week, Dr Donaldson told MSPs about her sure conclusion that assisted dying could open a new route to manipulative, misogynistic and abusive men ending the lives of the women they abuse. Dr Donaldson sees no means by which that can be mitigated. Victims do not disclose abuse readily; it takes time, with trained and experienced

professionals, to identify it. Even then, very often, it is not escaped.

Bob Doris's amendments appear to be aimed at highlighting internal coercion. I believe that the evidence that I have seen renders those amendments functionally redundant, unfortunately, as internal coercion and indirect pressures are virtually impossible to identify, much less prove. I will support amendment 27, as it would insert a further protection by requiring the medical practitioner who carries out the initial assessment at least to raise the issue of indirect pressures with the person who has made a first declaration.

Similarly, I recognise that Brian Whittle's amendments are aimed at strengthening protections against coercion, but the chances of an independent assessor being able to accurately assess whether or not a person is being coerced are incredibly slim. I fear that those amendments risk making the bill look safer while making no real difference to protections from abuse or coercion.

I believe that Paul O'Kane's amendments are also very well intentioned but, given the difficulties in detecting and proving, and training professionals to detect, coercion, I will not support them, with the exception of amendment 319, which seeks to strengthen safeguards by ensuring that the registered medical practitioner's statement covers the full set of safeguards that are listed in section 7.

Jeremy Balfour's amendments would require a registered medical practitioner to record in writing that the person's request to end their life comes solely as a result of a terminal illness and not as a result of disability, mental distress, financial pressure and so on. Although that is a noble attempt to increase transparency and accountability, I am concerned that it will not provide an effective safeguard for vulnerable individuals.

I will listen carefully to Ruth Maguire's justification of her amendment 93. I welcome the intent behind it, given the suggested process to determine that the decision is taken free from coercion. However, I remain sceptical that any medical professional could ever confidently make such an assessment. Members will get the gist of my views in those areas.

I am deeply concerned by Liam McArthur's amendment 50, which seeks to reduce the custodial sentence for coercing or pressuring someone into assisted dying from two years to 12 months. I cannot think of what possible justification there is for that, although I will listen to whatever justification is given and will reflect on it in closing. Surely we cannot countenance sending a signal to abusers that coercing or pressuring someone into assisted dying is not an incredibly serious crime, for which people will face grave consequences.

Liam McArthur's amendment 51 seeks to increase the fine that can be levied for coercion. It is unclear how amendments 50 and 51 are meant to interact. Would the Parliament not be sending a clear signal to the legal profession that a fine was the more appropriate punishment for such a terrible crime? If so, that is entirely the wrong message to send. I will listen to the justification and the debate with interest.

I move amendment 144.

The Deputy Presiding Officer: I call Paul O'Kane to speak to amendment 151 and other amendments in the group.

Paul O'Kane: I will reflect on much of what my colleague Michael Marra has outlined about the challenge in the bill around coercion and the need to try to deal with coercion at this late stage in the process. For many colleagues across the chamber, it is a significant hole in the bill that coercion and the potential for coercion have not been appropriately addressed throughout the process.

My amendments in the group seek to strengthen the safeguards to ensure that declarations under the legislation will be genuinely voluntary. The amendments would require that practitioners are satisfied that a declaration has been made without coercion or undue influence. The bill does not specify how coercion should be identified, nor would it ensure that practitioners have training or are able to access relevant expertise on coercion, which I will come to when we debate amendments in the next group.

My amendment 172 would require practitioners to take

"all reasonable steps to identify whether the person has been subject to coercion, pressure or undue influence",

including through private assessment, consideration of social and caregiving circumstances and, where appropriate, consultation with safeguarding experts.

My amendment 156 would require that practitioners receive training on

"the identification of … coercion, undue influence and coercive control",

including in contexts of

"dependency arising from illness, disability, age, social care needs or caring arrangements."

I have sought to construct reasonable amendments that can command support. However, I recognise what my colleague Michael Marra said about how difficult it will be to identify coercion and how pressurising it could be for GPs

to have to take that forward. For much of my life before I became an MSP I worked with people who have a learning disability, and I recognise many of the things that Mr Marra said about women's experiences of coercive control. The people I worked with were often vulnerable and did not have a strong family network, and many of them had lived much of their lives in institutional settings before this Parliament sought to move people into the community and tried to give them a life with choice and control. Many of those people had become vulnerable through the institutionalising of the way in which they lived their lives. Many of them were vulnerable and would not be able to identify it to somebody if they were being coerced into doing something.

For me, that sits at the heart of the bill. It is about whether we can provide adequate safeguards for the most vulnerable people in our community and society and whether we can at least equip the medical professionals who will carry out assessments and deal with the issues to be able to do that in the most direct way possible. That would be in private and in a one-to-one setting, and they must be adequately trained to do that.

I put on the record that I have had interaction with the social work profession on many of the issues that are raised in amendments in the group, and I declare an interest as I am married to a registered social worker. It is clear that the social work profession is rejecting the bill not because of the issue at hand, on which it has a neutral position because social workers take different views on whether to support assisted dying, but fundamentally because, as it has pointed out, it is concerned that we appear to be forgetting about the important role that social work processes play in identifying coercion, coercive control, abuse and all the other issues that I have outlined.

I have met both Social Work Scotland and the Scottish Association of Social Work, and they are clear that they are very concerned about the lack of regard that is given in the bill to existing adult support and protection processes and to the creation of new processes. I acknowledge the amendments that Brian Whittle and others have lodged to try to sustain those social work processes and provide for them to be followed.

We need to take clear cognisance of the fact that the bill might not be able to square the circle on coercion by creating robust enough safeguards to protect the most vulnerable in society. Social work professionals, who are often tasked with the most difficult decisions in our society about children and young people, older people and people who have a disability are experts in their field. They are trained, they know their communities and they know all the risks that exist in that space and how to identify them. If they are saying that they do not have confidence in the bill, we have to sit up and take notice of that.

Audrey Nicoll: I completely agree with the member's observations regarding existing legislation, which includes the Adult Support and Protection (Scotland) Act 2007 and the Adults with Incapacity (Scotland) Act 2000. Has he had a chance to think about how those pieces of legislation interact and how the professionals who work under their provisions would work together? How would they be able to collaborate and work on a cross-sectoral basis with regard to what we are discussing?

19:30

Paul O'Kane: Ms Nicoll makes an important and good point. She recognises the multidisciplinary nature of how we approach such things in Scotland at the moment. Adult protection investigations and child protection investigations are governed by a multidisciplinary approach that involves social work, health, the police, education and those who have a relevant interest in the person. In the discussions that I have had with the social work representative bodies, it was clear that the same process is not envisaged in the bill for people who are engaging in an assisted death, particularly those people who would be vulnerable at the end of life.

Liam McArthur: Will Paul O'Kane recognise that the amendments that were agreed to at stage 2 will now ensure that co-ordinating medical professionals and independent medical professionals would be able to consult social work, social care and other relevant professionals to seek an input where appropriate? However, mandating that in each and every instance would seem to be disproportionate and completely out of step with the approaches that we take in similar pieces of legislation related to social work.

Paul O'Kane: I recognise what Mr McArthur said about how the bill was amended at stage 2. However, that does not get away from the fact that the social work representative bodies are still making the point that they cannot support the bill at this stage because they are concerned that it does not do enough with regard to the automatic triggers for someone who is particularly vulnerable, who might already be subject to adult protection processes, and concerned about what it would mean to have a further layer of multidisciplinary investigation around them.

Having had those conversations with the social work representative bodies, I know that there remains a clear concern that those aspects have not been addressed in the bill. That could call into question long-standing professional procedures

for social workers and also their professional integrity.

The danger of saying to GPs that they can request such input and advice is that it could lead to a role for independent social workers. Many people in the social work profession want to avoid going down that road and instead want to keep the role within existing systems, as Ms Nicoll raised in her intervention.

I appreciate that there will be further speeches on these issues and that there are amendments in the name of Fulton MacGregor that would deal with much of what we are discussing. However, it is important to put these points on the record as we begin the stage 3 debate on the amendments this evening. It is also important to ensure that, if we cannot answer the questions that have been posed to us by professionals in social work—

Ross Greer: Will the member take an intervention?

Paul O'Kane: I was just about to sum up, but I will take Mr Greer's amendment.

Ross Greer: I have a lot of sympathy with Paul O'Kane amendment 151 and the amendments that are consequential to it. I want to briefly ask him about paragraph (a) in amendment 172, which is the provision to conduct

"at least one assessment meeting with the person alone and in private".

How would Paul O'Kane envisage that taking place in practice when people have particular communication needs—for example, British Sign Language users? I understand the intention behind the provision, but I am trying to understand how such a meeting could practically take place when there are some individuals for whom it is hard to envisage there being any circumstance in which they would not require another individual to be with them to advocate on their behalf or to communicate for or with them.

Paul O'Kane: Mr Greer raises a fair point. My intention in lodging the amendment was that the provisions would follow the processes that are already in place to deal with those issues in the healthcare space. People can access interpretation, advocacy and support as is appropriate and as they are comfortable with in relation to the discussions that they will be having. In such contexts, the people who provide those services are usually independent.

My other response goes back to the point about social work, which is that a multidisciplinary team will act in the interests of the individual to ensure that their rights are upheld and that, when they go to see their GP or whoever it is in whatever context, they have independent support if they require it.

Mr Greer's point goes back to the issue that I was highlighting in my peroration. If we cannot square the circle and work out how to verify that someone has not been coerced and that they have made independent decisions, it becomes difficult to understand how the bill can progress and be supported without those valuable safeguards

I am conscious that I have taken up quite a bit of time—I am grateful, Presiding Officer.

The Deputy Presiding Officer: I call Bob Doris to speak to amendment 24 and other amendments in the group.

Bob Doris: I have many amendments in this group, but I want to focus on amendments 27, 160 and 33, because I do not wish to see those amendments lost in amongst the various other amendments in my name, which I will come to later.

Amendment 27 seeks to require an assessing doctor to inquire about and take account of indirect pressures and whether such pressures are unduly limiting someone's ability to choose freely. Surely that is fundamental when it comes to striking a balance in assisted dying legislation, notwithstanding the challenges in doing so that Mr Marra outlined in his contribution.

We know that all sorts of factors might affect a person's ability to decide freely to seek an assisted death. For example, they might feel a burden; there might be financial pressures; or there might be a major failure of service, be it in housing, social care or palliative care or, indeed, in other ways. All of those things can exert indirect pressures.

Palliative care practitioners in Scotland regularly support people expressing a wish to die due to indirect pressures, and those people often go on to enjoy valuable time when those pressures are explored, understood and addressed. Indeed, they will often say later that they are glad that they did not end their lives.

Currently, the bill does not suggest, or require, that the assessing doctor identify or consider such indirect pressures; instead, it focuses exclusively on coercion as something done by another person. I think that that is a weakness. I should also point out at this stage that I, like others, will not be supporting this bill at the end of the stage 3 process; however, I do think that I have a responsibility to strengthen the bill and make it as robust as possible, and my amendments have been cast in that light.

I suspect that many of us know from experience, whether from personal experience of family and friends or through our constituency casework, the impact of financial distress, the challenges that inadequate care packages place on a person or their family—I think that Pam Duncan-Glancy

referred to that earlier—and the profound impact that lack of access to appropriate symptom management or palliative care can have on a person's lived experience and the perception of their quality of life. I very much hope that MSPs will agree that it is reasonable for the registered medical practitioner to inquire into and take account of such indirect pressures. If they do, I ask them to please support amendment 27.

Ross Greer: I have a lot of sympathy for amendment 27 and what Bob Doris is laying out. My only slight concern is the meaning of the phrase "indirect pressures". In a society, we all come under pressure from one other all the time and in all sorts of different ways. Does he agree that what he is proposing would work particularly well in combination with what Paul O'Kane has proposed in amendment 151, which uses the phrase "undue influence" before talking about such pressures? In particular, the use of the word "undue" suggests influence that is somehow insidious or negative in nature, and not just the pressure that we all feel through our interactions with the rest of society on a daily basis.

Bob Doris: I thank Ross Greer for that very helpful intervention, which gives absolute clarity to the policy intent here. I hope my other amendments in this group, which I am about to speak to, will reinforce some of that.

Amendment 160 simply gives some examples of relevant indirect pressures, including

"a person's beliefs about themselves, society's expectations, the significant absence of health or social care services to meet the person's needs,"

while amendment 33 seeks to require a registered medical professional to

"have regard to any relevant professional guidance on decision making, including the impact of indirect pressures and other factors affecting free choice."

Together, amendments 27, 160 and 33—

Lorna Slater: Would "indirect pressures" include the pressure not to seek an assisted death? What if a patient were asking for an assisted death, but their family members were pressuring them strongly not to do it? All the assumptions are that doctors and family members are somehow pressing their loved ones to end their lives—"encouraging" was the word that Mr Mason used. What if the pressure is in the other direction?

Bob Doris: I should point out that indirect pressures, direct pressures, societal pressures and pressures from family members happen in all and any circumstances, but the proposal in front of us fundamentally changes the law, and it is right to build in these kinds of protections. I very much hope that Lorna Slater agrees with that and will support my amendments 27, 160 and 33, given the passionate comments that she has made about such protections.

Rona Mackay (Strathkelvin and Bearsden) (SNP): How does Bob Doris respond to the fact that international evidence from other jurisdictions shows that there is no evidence of coercion—absolutely none? Lorna Slater's point is absolutely correct: the evidence is often the other way around, in that it shows that people try to talk people out of assisted dying.

A clinician in California has written to us, saying:

"I've never, in the many hundreds of cases that I have been part of, seen anything resembling family or friends attempting to coerce a dying person into receiving an assisted death."

You seem so certain that there is coercion, but there is no international evidence of it. I wonder how you would respond to that.

The Deputy Presiding Officer : Always speak through the chair, please.

Bob Doris: I am certain that, when we make such a substantive change to legislation, we should build in safeguards, in case there might be coercion. I cannot imagine, in the world that we live in, that we should simply assume that there will not be coercion or indirect pressures, and therefore not ascertain whether they exist.

That is why amendments 27, 160 and 33 are important for the operability of the bill and for ensuring that there are safeguards in place.

Finlay Carson (Galloway and West Dumfries) (Con): I had no intention of speaking in this debate. However, the idea that coercion does not exist is very naive. I will give an example. I will remember, to the day that I die, sitting along with my mother and a consultant, as she was waiting to get her treatment for cancer. The consultant said, very flippantly, "I presume that it will be DNR", in a way that suggested to my mother that, as he was an expert, he was recommending that she sign up for a "Do not resuscitate" order. That was the first that she heard of it, and that was coercion, because he gave her the sense that it was his opinion and suggestion that she should sign up for a "Do not resuscitate" order. That is why I cannot support this bill, because it will happen—and it will happen regularly.

Bob Doris: I think that the positions of both Finlay Carson and Rona Mackay can be encompassed if they support amendments 27, 160 and 33, which are the scaffolding to ensure that we put safeguards into the bill, as far as we can, in a proportionate way. If coercion does not exist, as Rona Mackay suggests, let us put in the safeguards anyway; and, if it does exist, let us make sure that we absolutely put them in. Both of

those interventions highlight the need for members to support all three amendments.

Finally, I have a swathe of amendments in the group that seek to amend references to coercion. There are repeated references in the bill to a person not being

"coerced or pressured by any other person".

However, there is concern that coercion in other forms, such as those that we have discussed—this links back to indirect pressures—might not be fully recognised using the current terminology. Amendments 24, 25, 35, 36, 41, 76, 77, 80, 82 and 84—I simply list them; I will not, the Deputy Presiding Officer will be relieved to hear, speak to them individually—therefore all simply delete the words "by any other person" each time that the bill mentions a person being "coerced or pressured", in order to reflect that not all pressures arise from other people. I believe that those amendments are worth while, but I again remind members that the key substantive amendments—

Patrick Harvie: Will the member take an intervention?

Bob Doris: I was just finishing off, Mr Harvie.

The Deputy Presiding Officer : Very briefly, Mr Harvie, and then please conclude, Mr Doris.

Patrick Harvie: It is a question on the group of amendments that remove reference to "by any other person." If we were talking about the concept of pressure, I would understand why people might feel pressure from a range of different sources or circumstances in their lives. However, the current bill talks about being "coerced or pressured", and surely the use of those words implies intentionality: if not by a person, then by whom?

Bob Doris: We discussed that in great detail, in relation to indirect pressures, in the debate on my earlier amendments. That case has been made. Removing the words "by any other person" adds something to the bill. Nothing is lost, and it is beneficial. More importantly, the core of my amendments in this group are amendments 27, 160 and 33, which are important safeguards. As deficient as they might be, as Mr Marra pointed out, it is important that we put something in to offer some form of protection.

The Deputy Presiding Officer : I call Brian Whittle to speak to amendment 174 and other amendments in the group.

Brian Whittle: I know that we are nearly five hours in, but this is my first opportunity to say to my friend and colleague Liam McArthur that I really appreciate the way in which he has taken the bill through Parliament and interacted with all colleagues and MSPs. If we all took legislation through Parliament in that light, I think that it would be a better place indeed.

I also thank my colleagues on the Health, Social Care and Sport Committee for the way in which we have managed to work together. We have advance knowledge of coercion, which we are talking about today, given that we have rehearsed that issue in committee, both in developing our report and at stage 2.

19:45

I have listened to Michael Marra and Paul O'Kane speaking on the potential for GPs to spot coercion. I think that GPs are already trained to spot coercion, as are social workers. It occurs to me that one of the things at the back of this bill is that, whatever happens, and whether it passes or not, it shines a light on many other aspects of healthcare. I will highlight one of the things that worry me with regard to coercion. Although GPs might already be trained to spot coercion, it used to be that the relationship between GP and patient was enduring and they knew each other well, but that is becoming increasingly rare. The same could be said for social work.

Lorna Slater raised a point about which way coercion goes, noting that it is not all about coercion to take part—there may also be coercion not to take part. That is where my amendments sit. My concern is that an individual who potentially has a moral or personal reason to oppose the decision of a person who has made an assisted dying declaration could use the police and court system to delay the process through a protracted investigation resulting from an allegation of coercion.

My amendments 174, 187, 189, 198 and 209 would create a mechanism for review, independent of medical professionals, for use in cases in which people who are close to the patient, be they family, named friends or carers, suspect coercion. The reason why I picked the 10-day period is that it is modelled on the similar approach to the independent assessment for organ donation.

Amendment 182 would provide that reports are referred to the medical profession or the police where appropriate, and amendment 305 would give ministers the flexible powers to bring forward the model. Those provisions would be triggered only when those close to the patient expressed that concern.

The 10-day reporting time is also an effort not to prolong the suffering of a person who wishes to access assisted dying. I have to say that I asked both the member responsible for the bill and the Scottish Government to make suggestions on how

to address my concerns in this area at stage 2, and I am yet to have those concerns alleviated.

I point out that I will be discussing advance directives in relation to my later amendments, which links in directly with how we could tackle the issue of coercion. However, I would ask that members consider supporting amendments 174, 187, 189, 198, 209, 182 and 305 in this group, as I am trying to tighten up the rules around coercion.

Jeremy Balfour: I will speak to amendments 177 and 180 in my name. At their core, those amendments seek to reinforce a principle that I believe that most members across the chamber would agree is fundamental: that any requests for existing assisted dying under the provisions of the bill must arise solely as a consequence of a person's terminal illness and not for any other reason.

The bill has consistently been presented to Parliament and to the public as legislation that is limited in its scope. We have heard today about amendments that would limit that scope further. The bill has been described as applying only to competent adults who are terminally ill and where suffering arises from that condition.

If that is indeed the intention of the bill, I believe that it is entirely reasonable for the legislation to say so, and say so explicitly. If it says it on the tin, that is what is in the tin. That is what my amendments seek to do. They would ensure that a request for assisted dying must be made solely as a result of the individual's terminal illness itself, rather than as a consequence of the pressures or circumstances that may arise at the end of their life.

The final stages of life can be extraordinarily hard for many people. Individuals who are terminally ill might experience not only physical suffering but a range of emotional, social and practical pressures. They might fear becoming a burden to those whom they love. They might worry about the emotional strain placed on family members. They might feel isolated or dependent in ways that they have never experienced before. They might even feel that their continued care places demands on already-stretched services or resources.

Interestingly, about two and a half years ago, my father had terminal cancer. He had never required any practical help throughout his life. One of his biggest fears—one of the things that he kept talking about—was whether he was a burden to the carers and whether he had been a burden to my late mother. Such feelings are profoundly human. They deserve compassion, care and support, but they should never become a reason why someone feels that their life ought to end sooner. If the Parliament chooses to legislate in an area as grave as assisted dying, we have a duty to ensure that the safeguards are not only well intentioned but robust and beyond doubt.

On the idea that there is no problem with coercion and that no one is going to be forced or pressured, I note that the amendments can lie dormant; they can just be there as protection. My concern is that, without the clarification that my amendments would provide, the legislation risks leaving people and the motivations behind a request for assisted dying unclear. In a matter of such profound consequence, we cannot be unclear—we must say it directly.

The amendments seek to ensure that eligibility under the bill is tied directly and especially to the experience of terminal illness. They would reinforce the boundary that supporters of the bill have said exists; they simply say what the member in charge of the bill has said over and over, as have others.

The decision on the bill that we have been asked to consider is one of the most serious that any Parliament can take. It is the most serious decision that I have made in my 10 years in the chamber. It concerns matters of life, death and protection. Members from across the chamber will have come to their own conclusions on the broader question of assisted dying. I respect, even if I disagree with, colleagues who have come to a different view from mine. However, regardless of where we stand on the principle of the bill, we should have a shared, common and committed understanding that any legislation that we pass is as tightly drawn as possible. Amendments 177 and 180 would do that. The wording is important, so I encourage members to support the amendments in my name.

The Deputy Presiding Officer: We are nearing the agreed time limit for debate, so, under rule 9.8.4A(c), I consider it necessary to allow the debate on the group to continue beyond the limit in order to avoid debate being unreasonably curtailed.

I call Ruth Maguire to speak to amendment 93 and other amendments in the group.

Ruth Maguire: Consent, choice, free will and autonomy are principles that should exist in all our lives, but they are not experienced equally by all. They are not something that the estimated one in three Scottish women who live with domestic abuse and coercive control are likely to recognise in their lives.

The amendments in the group see that reality and take seriously the real danger of coercion. My amendment 93 is an attempt to strengthen safeguarding at the point of the second declaration. It recognises that coercion can be

direct, indirect or internal, and requires each to be actively considered.

I want to acknowledge what Michael Marra said and to be honest with members: I am not entirely convinced that we can legislate to protect people against coercion, but, like everyone with an amendment in the group, I have attempted it.

The first point that I wish to make is about safeguarding. Hearing something described as containing robust safeguards can go a long way to providing reassurance, but when the stakes are as high as they are in the bill, it warrants further interrogation.

Any so-called safeguards are statements about what should happen in an ideal world to protect people from harm, but I think that we would all acknowledge the real-world stresses and pressures of clinical practice that our medics face. Members will understand the impact of a terminal illness diagnosis and will know that the family dynamics around that are not always ideal. The Parliament introduced groundbreaking domestic abuse legislation and is well versed in the complexities around coercion and the patterns of behaviour that make it so. Given that, everyone in the chamber should understand three things very clearly: just how far from operating in an ideal world a woman being coercively controlled by her partner is; the challenge in gathering evidence of coercion, even for experts; and therefore how limited any safeguards that are put in place can be for those women.

We know that women who are abused by their partners are at serious risk of being killed and of dying by suicide as a result of domestic abuse. Michael Marra mentioned Kimberly Milne from Dundee. We also know that domestic abuse does not end with a diagnosis of illness, with disability or with older age. Those who intend to vote for the bill should be clear about what level of risk they are willing to accept to meet the aim of legislating to allow some people to end their life early. I am not confident that we can prevent coercion even if all the amendments in the group are agreed to.

That is not about putting the issue in the too-difficult pile—we should never put anything in that pile—but some things should be in the too-dangerous pile. I strongly agree with experts Dr Anni Donaldson and Isabelle Kerr. The truth is that, for some women, the danger that the bill becomes another lethal tool to be wielded by an abusive partner is real. The deadly consequences for those women would be final, and that is not a risk that I am willing to take.

Liam McArthur: Michael Marra's amendment 144 seems, in the first paragraph, to broadly replicate what is already set out in schedule 1 to the bill, as introduced by section 4, regarding first declarations.

The second paragraph in the amendment relates to a person indicating that making the declaration

"is not influenced by unmet palliative care, social care, housing, financial or caregiving needs".

I am not convinced that that would add anything meaningful to the process that the bill will already require. That a person's decision to seek assistance is voluntary and free from coercion will have to be ascertained by the assessing doctors through detailed conversations in the assessment stages. The assessing doctors will not be able to grant eligibility to continue the application under the bill unless they are satisfied of those factors. Making a statement to that effect in the first declaration is not necessary and would add no benefit of safety.

Understanding the issues requires detailed conversation and exploration with a trained professional, for which the bill and regulations will provide through the assessing doctors and, where appropriate, other medical and relevant professionals. Requiring a statement detailing what might be influencing a person's decision would also not be useful and would risk policing later open and honest conversations between doctor and patient. As I have said in the debates on previous groups, people's motivations and choices at the end of life are complex and multifaceted. A list of concerns that a person is apparently not allowed to have might dissuade them from honestly sharing and addressing their concerns, if they feel that there is a risk that that might make them ineligible for an assisted death.

Brian Whittle: Does Liam McArthur accept that, over the past few decades, the doctor-patient relationship has changed significantly? That relationship has evolved over time and it is much rarer for a doctor to know a patient these days, so it will be much harder for the doctor to assess coercion.

Liam McArthur: I understand the concern that Brian Whittle raises. In the processes that are put in place in the bill, there are safeguards so that, if the understanding of the broader context of the individual patient is felt to be inadequate, that would be required to be explored further. In a sense, the process puts in place safeguards that are not there at present, which means that the individuals' vulnerabilities are not picked up.

20:00

On Michael Marra's amendment 181, stage 1 evidence brought out clearly the fact that doctors are well trained and capable of making capacity

and coercion assessments. The process already requires two doctors to make those assessments independently of each other and with reference to other relevant medical experts and professionals if and where appropriate. Only if both doctors are satisfied that all criteria are met can a person move to a second declaration. Introducing another layer in the form of a panel of experts at that stage would simply add another hurdle for the sake of it, rather than provide a safeguard to address a risk.

Michael Marra: What would Liam McArthur say to Dr Anni Donaldson, given her evidence to MSPs in the past week that an on-going relationship with an individual is required in order to best understand whether they have been the victim of coercion or abuse, and that a 20-minute conversation—which could, as the bill is drafted, perhaps even be conducted online via a Zoom call—is not a sufficient means of understanding that individual and determining whether they are facing the circumstances that have been described?

Liam McArthur: When it comes to individuals accessing particular treatments, protections are largely non-existent at the moment. The example that Michael Marra quoted shows the consequences of that. The bill puts in place a process that robustly safeguards access to other individuals beyond the co-ordinating medical professional and independent medical professional, drawing on the expertise of social work, social care, and other relevant medical experts, to fully assess the terminal nature of the illness, the capacity of the individual and whether there are any signs of pressure or coercion.

Paul O'Kane's amendments 151, 152, 158, 172, 175, 178, 315 and 320 seek to replace the assessment that is made by the assessing doctors, and relevant statements in relation to coercion and pressure, with a wider provision that would seek to confirm that the terminally ill adult had not made the declaration as a result of undue influence, whether explicit or implicit, including pressure that had arisen from dependency, family or caring responsibilities, financial circumstances, care arrangements or the perception of being a burden on others. Again, I do not believe that such amendments are necessary. As was clearly evidenced during stage 1, medical professionals have an understanding, an awareness and experience of detecting coercion. Guidance and training already exist in that area and will be updated as appropriate, should the bill be passed.

The bill provides clarity that the safeguard is intended to protect individuals from pressure and coercion. The amendments risk creating uncertainty by replacing the word "coercion" with "explicit or implicit" "undue influence", which is hard to define and to apply consistently.

As was debated at length at stage 2, there are also risks from seeking to put in the bill ever more detail about what constitutes coercion, rather than ensuring that such assessments are always made in line with relevant, up-to-date guidance. Confusion and inconsistency will only increase risk and reduce safeguard. From my conversations with Mr O'Kane, I know that he would wish to avoid that.

On amendments 24, 25, 27, 33, 35, 36, 41, 76, 77, 80, 82, 84 and 160, which were lodged by Bob Doris, it is important that the bill provides appropriate and proportionate safeguards while allowing those who wish to have assistance to access it in a reasonable timeframe and an appropriate framework. It is fundamental that a terminally ill adult makes the choice about requesting assistance without coercion or pressure by another person. The bill is expressly premised on the act's being voluntary for the person who seeks assisted dying. Both doctors and the professional who provides the substance at a later stage in the process must, among other things, be satisfied that the person is making the decision of their own free and settled will, without having been coerced or pressured—not forced, nor subjected to psychological and/or moral pressure.

The bill further contains a specific offence of coercion, for which a person can be punished. That is intentional and aligns with the bill's construction that coercion is an act that is done by one person to another, which is consistent with established principles under Scots law.

Audrey Nicoll: I flag the recent commentary by the Royal College of General Practitioners that assessing coercion is beyond the capacity of its members, and that it does not believe that that work can or should be incorporated into an already very busy and stressful professional role. Does Liam McArthur recognise that, whether or not we require training on the issue of coercion and its identification, that is not seen as feasible by some in the medical profession?

Liam McArthur: I certainly acknowledge those concerns, which the Royal College of Physicians of Edinburgh and others have expressed to me directly. The way in which assessment is rolled out, as I have said before, will look different in different parts of the country. The matter of how it is resourced will need to be taken forward by the Scottish Government on the back of the Parliament passing the bill. Accommodation to ensure that there is sufficient time to allow the assessments to be carried out and that, where appropriate, there is input from experts—whether medical experts, social workers or others—is allowed for. All those aspects are integral to making sure that the safeguards work as intended.

For those reasons, as I said at stage 2, I am wary about widening the understanding of coercion and pressure from being a form of illegitimate influence that is brought to bear by another person to one that is done by the person themselves, by societal expectations, by the health and social care system—as opposed to individuals within that system—or by the state.

Bob Doris: I thank Liam McArthur for commenting on my amendments. However, he lumped together my amendments 27, 160 and 33 with all the other amendments on coercion "by any other person". I drew a distinction between them. Amendment 27 in particular, with amendments 160 and 33 supporting it, enables the conversation between the co-ordinating medical practitioner and the individual to discuss what indirect pressures might be impacting on the individual. Surely that is a positive thing, given our exchange in Parliament this evening.

Liam McArthur: I thank Bob Doris for that intervention. I lumped those amendments together but I will break them apart later in my remarks. I acknowledge the point that he is making.

I am concerned that defining coercion and pressure in the way that I just described risks introducing new definitions of legal terms, thus creating confusion and making the detection of coercion or pressure and the prosecution of the offences under the bill more difficult. From the stage 2 debates and the conversations that Bob Doris and I have had over many months, I certainly understand the intent behind his amendments and accept that various factors may express a person's vulnerable status and situation, which would potentially make them prone to influence and could affect their decision making. However, I believe that retaining the need for coercion or pressure to be an act that is done by another person, supported by the offences in the bill and the ability for other health, social care and social work professionals to input into the assessment process, is the best way to proceed.

I am therefore not persuaded to support the amendments that would change that, but I am prepared to accept those relating to the removal of references to "by any other person", which are amendments 24, 25, 35, 36, 41, 76, 77, 80, 82 and 84. Likewise, I will accept amendment 33. Amendments 27 and 160 seem to me to go further than is necessary, helpful and desirable in terms of seeking to define "indirect pressure". It will be for Parliament to decide whether it wishes to support those. Bob Doris has set out the arguments for them very clearly.

I turn to Brian Whittle's amendments 174, 305, 182, 187, 189 and 209. As I said at stage 2, given that the assessing doctors will already be assessing for risk of coercion, I question whether a further assessment by an independent assessor is necessary. I would be concerned that that may create undue delays and prolong the suffering of the person who is seeking an assisted death, particularly given that a period of 10 working days may pass following the assessment before the report is produced. I note also the Scottish Government's view at stage 2 that introducing independent assessors may present significant deliverability challenges.

Brian Whittle: Those amendments were not just brought out of a thought. If we do not agree to them, it will be possible to scupper somebody's accessing of assisted dying simply by suggesting that there might be coercion. The police would then have to carry out an investigation, which would stop the whole assisted dying process. If we do not have a process for handling the assessment within a certain period of time, the whole thing is put in peril. Medical professionals have said before that, in the cases of people who decided not to take any more medical help or treatment towards the end of their life, if other people wanted to go against that decision, the medical professionals had to accept that. If we do not agree to these amendments, we risk the same thing happening to those who are trying to access assisted dying.

Liam McArthur: I accept Brian Whittle's argument—we had a discussion about that at stage 2 and in the intervening months since then. I do not accept that the process that is proposed in the bill does not provide a way to deal with the concerns that he has raised. As I said, I do not ignore such concerns at all, but introducing an assessor would not be a proportionate way to address them. As such, I am not inclined to support his amendments.

Kate Forbes: I am conscious that members at large have concerns about coercion, which is why there are so many different amendments in this group, and that Liam McArthur has shifted on the six-month prognosis issue because of pressure from colleagues. Is he willing to concede any ground on the question of coercion?

Liam McArthur: I have accepted a number of amendments that will tighten up the safeguards that are related to coercion as well as other interests in relation to capacity. The bill is heavily safeguarded in that respect. More can and would be done, not only through secondary legislation, but through the guidance. The point made by Ruth Maguire and Michael Marra was that the level of understanding of coercive and controlling behaviour is more recent and developing. Therefore, that would need to be reflected in training, not only in this instance but more widely in the health and judicial sectors.

With regard to Jeremy Balfour's amendments 177 and 180, the bill would already require assessing doctors to state that they are satisfied that the person seeking an assisted death is a terminally ill adult who has made their declaration voluntarily, without pressure or coercion. The bill would also provide for steps to be taken should the assessing doctor consider that the person is not terminally ill or if they have doubts about the person's capacity. Amendments 177 and 180 are therefore unnecessary.

The reasons and motivations that are set out in the amendments are subjective, numerous and varied. The bill already contains strong safeguards to ensure that a person is eligible, has capacity and is acting voluntarily. A thorough, detailed and honest conversation that is undertaken by two separate clinicians, exploring the person's concerns and motivations, would go hand in hand with a discussion of alternative care options. That would help to establish eligibility for an assisted death in a far more person-centred way than Jeremy Balfour's amendments would allow.

I similarly question the purpose of the further assessment that is proposed by Ruth Maguire's amendment 93. The co-ordinating registered medical professional and authorised health professional must be satisfied at the time that the substance is provided that the adult is requesting assistance voluntarily and has not been coerced or pressured by any other person into doing so. The amendment would introduce an overly prescriptive assessment that duplicates safeguards that are already in the bill.

Ruth Maguire: Rona Mackay mentioned that no coercion had been detected anywhere else in the world. Why does Liam McArthur think that that is the case? Are women safe everywhere, or is something perhaps lacking in doctors' training when it comes to spotting coercion? How would he address that issue?

Liam McArthur: I would reflect that what Rona Mackay said is certainly true. The evidence that we see—in all the reporting and in all the jurisdictions that I am aware of—is that the issue of coercion has not been raised. Our understanding of coercive control and behaviour might mean that the way that medical professionals engage with the process, and the interactions that they have with patients, would develop over time, and that will provide far more of a safeguard than what is in place at the moment, given that such conversations simply are not happening. It is not that I do not accept that there is a risk—the prevalence of coercion is potentially more extensive than we understand it to be—but the process that is proposed in the bill would introduce protections that do not exist at the moment.

Amendment 93 also contains subjective concepts, such as indirect coercion and dependency, which risk creating uncertainty for healthcare professionals and are difficult to apply consistently.

Paul O'Kane: If Liam McArthur is not willing to accept that GPs struggle to spot coercion, does he accept my point about social workers being highly trained professionals who identify patterns of coercion and systematic abuse? Does he understand how serious it is when the Scottish Association of Social Work and Social Work Scotland say

"Scotland's most vulnerable people cannot be an afterthought in a Bill designed to serve them"?

20:15

Liam McArthur: I certainly accept the point, as I indicated in my intervention on Mr O'Kane, which is why the bill was amended at stage 2 to ensure that social work and social care were far better and more clearly reflected in the referral pathways that were set out in the bill. An indication of the journey that I have been on with this bill is that that is reflected in the bill in a way that it was not at the outset. I think that what Mr O'Kane refers to is very clearly the case in relation to not just coercion but capacity. Social work professionals also make a fairly legitimate case that the understanding of the range of options that are available to an individual, to ensure that the choice that they are making is an informed one, is likely to come from the expertise that social work professionals have. However, I still do not believe that having a mandated referral to social work in each and every instance is a proportionate way of addressing the risk that I absolutely accept exists. Safeguards should remain robust but should allow clinicians to exercise clinical judgment rather than prescribing highly detailed assessment processes in legislation.

Finally, my amendments 50 and 51 in this group are intended to ensure consistency with the general approach to summary penalties and to reflect standard drafting practice. Section 21(2)(a) sets out the penalties that are applicable on summary conviction for offences under that section. Amendment 50 substitutes a reference to 2 years with 12 months, and amendment 51 substitutes a reference to

"level 5 on the standard scale"

with "the statutory maximum", updating the description of the maximum fine that may be imposed on summary conviction. To be clear, and in response to Mr Marra's earlier point, these amendments are intended to ensure consistency with the Scottish Sentencing Council's guidelines and approach to maximum and minimum

sentencing for summary offences. I also note that the provisions on indictment remain the same, carrying a sentence of up to 14 years in prison and an unlimited fine.

Pam Duncan-Glancy: The National Council on Disability reported that social and family pressure has influenced some disabled people to consider assisted death, and that such pressure is often rooted in their perceptions of being a burden.

The bill states that the person seeking assistance must declare that they have not been coerced. Changes at stage 2 required inquiries on that issue from professionals, as we have just heard from my colleague Liam McArthur. However, I worry that those changes, and many others proposed in amendments that we are considering, are not and will not be enough. I associate myself with the comments on that aspect made so far, and in particular with those of Ruth Maguire.

As we have heard from various members, social workers—and others who regularly make determinations on people's lives—have raised concerns about the societal and institutional pressures, including pervasive narratives about being a burden, the cost of care, or the emotional and financial toll on families, and how those can shape a person's decision in ways that are profound and deeply difficult to detect.

Paul O'Kane: Pam Duncan-Glancy referenced the stage 2 amendments and the role of social workers, which, along with colleagues, I have been commenting on. Does she recognise that Social Work Scotland and the Scottish Association of Social Work have said that the provisions that were agreed to at stage 2 are not sufficient and will not go to where they need to be on the issue of coercion?

Pam Duncan-Glancy: I was about to say that social workers have contacted us ahead of today's debate to say that they are deeply worried about the bill as it stands, including, specifically, the amendments that were agreed to at stage 2.

I and colleagues around the chamber—including, I am sure, my colleague Paul O'Kane—believe that we must listen to social workers. They are often asked to protect people. To do so against the background of legally ending someone's life would be a big ask, and we should listen to them when they raise concerns.

Despite being a group of people who have contact with the state more often than many others, disabled people, and especially disabled women, are still more likely to experience domestic violence and abuse than others. In fact, they are twice as likely as non-disabled women to experience abuse. They are also more likely than non-disabled people to experience abuse from an adult family member. One in 10 domestic violence abuse cases is perpetrated by someone with a caring responsibility.

I am talking about some of the most regulated people in society. I say this not flippantly, but as an example: it is difficult for a disabled person to even get on a train without having to give their full name and phone number for staff to check whether they have booked assistance. This is a group of people who have a lot of contact with a lot of professionals in their lives, yet abuse and coercion towards them still go undetected. That goes to the heart of what members across the chamber, and in particular my colleague Paul O'Kane, have spoken of in relation to social workers' concerns about the bill.

There is another angle of risk to highlight. When structural inequalities and dependency are present, as they often are for people at the end of their lives—or, for some, throughout their lives—no safeguards can fight the tide of internalised coercion or ableism. Such coercion is subtle, but it is deeply internalised and extremely difficult to detect.

There are many amendments on coercion, financial abuse, encouragement to choose assisted suicide et cetera that seek to remove the possibility of improper motives influencing the process. The reality is that disabled people's experience is so deeply oppressed that seeking to remove those things simply by amending one bill is unrealistic. It would take sweeping change across all areas of public policy and all areas of life to protect disabled people from the internalised everyday ableism that they experience.

The subtle pressure faced by disabled people and those who live with dependency or live differently from others stems from cultural attitudes. We know that when it comes to people experiencing ill health, disabled people or people who have lost function in some way, those attitudes are not yet what we would all hope them to be.

I see these things every day. It is hard to believe that your way of life is acceptable when so many people tell you that it is not; that changes to make something accessible to you are too expensive; that there are not enough care funds to go around, so you should have lower expectations of the life that you want to live; or that surely a woman in your condition will not want a family. Those are the very real beliefs that many disabled people face every single day.

We saw that at its extreme during the Covid pandemic, when the lives of many groups of people were considered to be of less value and "Do not resuscitate" orders were placed on them without their consent. At that time, my husband

and I were so scared of the value that society placed on our lives that we wrote to each other to say that we wanted to be resuscitated.

These fears are real. As I have said, even in a highly regulated environment, disabled people's experience of coercion and abuse goes undetected. We cannot detect it now, and we would be unlikely to detect it afterwards if the bill were to pass. If you are told every day that your life is of less value, you learn to believe it. When everything in this world says that you do not belong, you learn to believe it. You internalise it, just as many people internalise the negative attitudes that people have towards them.

For many reasons, people mask such feelings—the feelings of inadequacy and shame that they have come to believe. They can be impossible to detect, and people often do not tell you about them. Some people do not even detect such feelings in themselves until they see others living well.

Many people in Scotland have no choice or autonomy in their own lives. Some disabled people do not get to choose who enters their home to care for them, who helps them to put their clothes on and take them off, or what they have for their dinner. The absence of choice in all other aspects of life could make assisted dying attractive; indeed, it could be the only choice that some people have.

The everyday ableism, and the constant barriers that accumulate and can make life intolerable, can encourage—and, indeed, coerce—people to end their lives. We have seen it happen in other jurisdictions, and we have to protect against it. However, simply asking someone to say that they are exercising choice and autonomy is not protecting against it, and neither is asking a professional to make that judgment. Not only is that difficult, as we have heard members across the chamber say, but many people do not have the skills, or the time, to do it. It would also be asking a lot for health professionals to have the necessary understanding of the deep-seated inequality that every single disabled person faces, and the everyday ableism that they experience, to the extent necessary for those professionals to be assured that the person is acting with autonomy, within the terms of a bill such as this, and in making such a decision.

Taken together, the amendments in the group reflect a genuine effort to strengthen safeguards against coercion. I recognise that. However, they cannot resolve the deeper challenge that, when societal pressures, unmet care needs and personal vulnerability intersect, it becomes extremely difficult to be certain that a decision has been made entirely free from influence. For that reason, I remain deeply concerned that no set of procedural safeguards could fully eliminate the risk of coercion under legislation of this kind.

Edward Mountain (Highlands and Islands) (Con): This is the first of the few times that I will speak to the bill at stage 3. I start by saying how much I think that our debates on the amendments have shown the Parliament in a good light, in that we have all been able to talk across the issues. I thank the member in charge of the bill for making that possible.

My concern about coercion is one of the fundamental reasons why I struggle with the bill. How do we identify coercion, and how do we prevent it? Brian Whittle was entirely right in what he said earlier. How do we identify coercion when we no longer have the relationships between doctors and patients that we used to have, where a doctor knew so much about what was going on in their patients' families?

How do we prevent coercion? I do not know. As we heard so powerfully from Michael Marra and Ruth Maguire, coercion can be subtle and it is often undetectable. It goes on, often by suggestion and repetition, without anyone really knowing what is happening, apart from the person who is inflicting it on somebody else.

In addition, there is the coercion that people put on themselves. We should be under no illusion about that. If someone gets an unfavourable diagnosis, one thing that they will think about is whether it might be easier to end their life than to put their family through everything that they might go through. Some people have supportive families who can break through those shackles and prevent them from coercing themselves into doing something that they might regret, but not everyone has such a family around them.

I have heard of people across the Highlands who are coerced by the fact that there is a lack of palliative care in the area where they live. The other day, I heard of somebody who, if the bill passes, would contemplate ending their life rather than going to Inverness, two and a half hours away from their family, where they might get the palliative care that they cannot get locally, because they could not bear to be separated from their family. To my mind, it is that lack of palliative care, coupled with the approach in the bill, that makes the issue of coercion so difficult.

We know that, in Scotland, 14,000 people a year are probably not getting the palliative care that they need. Why is that? It is because there is not enough palliative care provision and there is a huge lack of funding. If they cannot get palliative care through the state, many people consider funding such care themselves, but not everyone has the ability to do that. People often ask why they should do so if they know where they are

going, and they ask whether it would not be better to give what little resources they have left to their children and their partner.

I am not sure that any of the amendments in this group that were lodged by Paul O'Kane, Michael Marra, Bob Doris, Brian Whittle, Jeremy Balfour and Ruth Maguire make me any less concerned about coercion. I fear that they do not. However, I wish those members success, because I absolutely believe that Parliament should do anything that it can to ensure that there is no coercion in such cases. In particular, I believe that we should consider amendments 177 and 180 and ensure that they are agreed to.

I do not want to make a big thing of this, but amendment 50 gives me a huge amount of concern because it proposes reducing the penalty for a summary conviction for coercion. How can that be right, given that many of us fear that the potential for coercion is one of the main problems with the bill?

Christine Grahame: I put my cards on the table: I support the bill, but I want it to be as robust as possible. I fully accept that there are members who will not support the bill no matter what we do to it, and I respect that, whether it is for religious reasons, reasons to do with disabilities or whatever.

I will address the issues of coercion and undue influence, which belong in a trio of issues along with capacity. As I said when speaking about capacity, those concepts and values are well established in Scots law, and many examples of what they constitute have come before the courts. When we are making legislation, we must make it clear that the terms we are using have a background and foundation in case law, should that be required.

20:30

I am going to refer to the places in the bill where I think it addresses the issues of undue influence and coercion. I will not be supporting amendment 144, but I am sympathetic to Bob Doris's amendments 25, 27 and 33 and broadly support them because they deal with the practitioner making inquiries or having regard to guidance as to whether they might be looking at someone who is suffering from undue influence or coercion. Professional training is important there.

Section 4 deals with the "first declaration" made by a terminally ill adult. Subsection (2)(a) states that that first declaration must be

"in the form set out in schedule 1"

and if we go to schedule 1 we see the wording:

"I make this declaration voluntarily and, in particular, I have not been coerced or pressured by any other person into making it."

That would not be enough on its own, but we can look at the other sections of the bill. Section 6 is titled "Medical practitioners' assessments" and states that

"The coordinating registered medical practitioner must"—

so that is mandatory—

"as soon as reasonably practicable"

do several things, one of which is that

"If, having carried out that assessment, the coordinating registered medical practitioner is satisfied as to the matters mentioned"

in another section, which I will come to,

"that practitioner must refer the person to another registered medical practitioner (the 'independent registered medical practitioner') for that other practitioner to carry out the assessment mentioned".

Below that, subsection (4)(c) states that the person must have "made the declaration voluntarily" and that they have not been

"coerced or pressured by any other person into making it."

That wording is not just in that provision; it is in section 8, which is titled "Medical practitioners' statements". Section 8(1)(c) states that the person must have "made the declaration voluntarily" and that they have not been

"coerced or pressured by any other person into making it",

and 8(2)(c) also refers to someone who has

"made the declaration voluntarily and has not been coerced or pressured by any other person into making it."

Without labouring the point too much, I note that if we go on to the schedules we will find schedule 1, which I have already referred to, and schedule 2, where the medical practitioner must agree to the statement that

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

Overleaf, at paragraph 2 of the independent registered medical practitioner's statement, we find the words:

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

I will finish with one final bit, from the second declaration to be made by the person seeking assisted dying:

"I make this declaration voluntarily and, in particular, I have not been coerced or pressured by any other person into making it."

There are a whole lot of hurdles.

Bob Doris: I do not want to incur the wrath of Christine Grahame and must be nice to her because I have some amendments in this group. However, the matters that she has put on the record are not additional layers of protection; they are simply a repetition of something that recurs throughout the bill because we have to keep repeating what is in the bill from start to finish.

Basically, there are two assessments and two declarations, and then the person is signed off. That is it. That might be sufficient for some members, but is not sufficient for me. I know that Christine Grahame would not want to inadvertently mislead Parliament that the bill contains layer upon layer of protections, because it does not. She is reading out repetition.

Christine Grahame: Those are not simply repetitions. They are undertakings by medical practitioners and by the applicant that, to the best of their knowledge, they have acted voluntarily. Two medical practitioners, independent of each other, will make those statements.

I think that Bob Doris's particular amendments are useful, and I will certainly consider voting for them because they require guidance and training for practitioners. However, in the Parliament, we sometimes do a great disservice to medical practitioners, who we somehow think will just go through the process willy-nilly when somebody comes in front of them. I am sure that most GPs have knowledge about coercion. If they had a concern, they would hesitate and test it, and they may well make an inquiry about the case that is in front of them. We are asking a lot of GPs, and if a medical practitioner were to go about it in some casual, superficial manner, he or she would be up before the BMA, let alone anything else.

The provisions seem pretty rigorous to me, but I understand that they will not persuade people in the Parliament who have been against the bill from the beginning, which is fine. However, if you are wavering because you feel that the bill will somehow make vulnerable people more vulnerable, I assure you that I would not vote for it if I thought that it would do so.

I am voting for the bill because I think that, to the best of my testing of the legislation and the amendments so far—there may be others—the bill is fairly robust. We are talking about robust stuff, and the bill would lay the onus on the practitioner to get it right.

The Presiding Officer (Alison Johnstone): Always speak through the chair, colleagues.

Michael Matheson (Falkirk West) (SNP): I am grateful to the members who have lodged amendments in this group on coercion, which is one of the key risks that are associated with the bill. During the stage 1 debate, when we were debating coercion, it was asserted—as we have heard tonight—that there is no evidence that coercion takes place in other international jurisdictions in which legislation of this nature has been introduced. I respect members who hold that view, but I simply do not believe that to be the case. Coercion is a wider societal issue and it has been for a long time.

Given that coercion is one of the most significant risks that are associated with the bill, it is wrong and dangerous to give the impression that, because there is no evidence from other international jurisdictions, coercion does not take place in areas such as assisted suicide. I know from the discussion that I had with Dr Anni Donaldson, who is an expert in this field, that anyone who asserts that coercion does not take place must be subject to some level of scrutiny with regard to the quality of the evidence base that has been evaluated in order to make that assertion.

I want to give some reasons as to why I am not convinced that that impression is the case. When we were framing the Domestic Abuse (Scotland) Bill and making provision to address coercive and controlling behaviour in legislation for the first time, one of the challenges was to be able to define that type of offence. In the end, we decided to define it as a course of behaviour that occurs over a period of time.

Critical to making that offence work effectively is having the right skill set and professional group to undertake the assessment that is needed to identify such a course of behaviour over a period of time. The evidence shows that the key to identifying coercive and controlling behaviour in domestic abuse is often a relationship that is built up over a period of time with specialised police officers and social workers, who work with the individual to identify the coercion that is taking place.

I am saying that because there is strong evidence that individuals who are being coerced are often not even aware at the time that they are being coerced and controlled. That is why the point that Paul O'Kane made about the importance of skill sets is critical. That is also why, when we implemented the Domestic Abuse (Scotland) Act 2018, there was an extensive training programme across a range of agencies to develop the specialist skills that were necessary to help to underpin the legislation and the new offence that we had created.

With all due respect to Christine Grahame, and with no disrespect to medical colleagues, I say that it is evident that general practitioners, who hold a range of skill sets, would not be experts in

identifying coercive and controlling behaviour in the short period involved in dealing with a declaration. That requires specialist skills and needs to be undertaken over a period of time.

Further, coercive and controlling behaviour takes place against vulnerable members of our society in our communities on a day-in, day-out basis. It materialises through adult protection cases that social work colleagues deal with on a day-in, day-out basis. In some cases, it involves physical abuse, sometimes it is coercive and controlling behaviour for financial purposes and there can be a range of other factors.

The reality is that that type of behaviour will also impact on assisted dying, should the bill be enacted. There is no way that we could suggest that that type of coercive and controlling behaviour will not happen in some way for assisted dying, in the same way as it happens now under adult protection legislation on a day-in, day-out basis for some of the most vulnerable members of our society.

Rona Mackay: I totally appreciate that coercion exists in domestic abuse and other cases but, in relation to assisted dying, I go back to your point that you do not believe the international evidence. That being the case, do you believe that there have been no prosecutions for coercion in other jurisdictions—not one?

The Presiding Officer: Always speak through the chair.

Michael Matheson: Given that coercive and controlling behaviour impacts on a range of aspects of our society, including on vulnerable individuals, I do not believe that it will not impact on vulnerable individuals when it comes to making decisions about assisted dying. I cannot speak for the academics who referred to what has happened in other jurisdictions or the evidence that they have from other jurisdictions. There will be issues around training and the knowledge of individuals. Some individuals will be dead by the time that the authorities want to do case reviews, so the evidence might no longer be present at that point. There are also issues about the definition of coercion.

There are a variety of issues, but I simply do not accept that coercion is not a potential significant risk factor when it comes to assisted dying, and I actually think that it is quite dangerous to try to create the impression that it is not.

Lorna Slater: I absolutely hear the concerns of members from across the chamber about safeguarding, particularly for very vulnerable individuals in our society. That is something that we absolutely all share. Has the member looked at the evidence from around the world that shows that most people in other jurisdictions who choose assisted dying are affluent, well educated and able bodied, and that practitioners in those jurisdictions are often reluctant to approve people who come from deprived backgrounds, who are disabled or who come from vulnerable backgrounds? That makes me worry that we are setting up a system in which only privileged people will be able to escape suffering at the end of life and that we are restricting people's ability to make choices, because we think that we know better and can make choices for them.

Michael Matheson: There are issues about potential inequalities that are associated with the bill. Inequality is created when individuals cannot access the palliative care that they would like to have, because it is not available to them—if they had the financial means, they might be able to purchase it for themselves. That happens in our society at present. There are also issues of inequality in how aspects of care services are provided. Some of that would play through in relation to the bill and in the decisions that people would make. Financial inequality would result in some people deciding that they want to end their life because they cannot access the services that they believe that they require.

Christine Grahame: Will Michael Matheson take an intervention?

Brian Whittle: Will Michael Matheson give way?

Michael Matheson: I will take Christine Grahame's intervention, and then Brian Whittle's.

20:45

Christine Grahame: That was a substantial argument from Mr Matheson, as usual. I agree with everything that he said about coercion, especially in regard to domestic abuse cases. He has a long track record in the Parliament on justice issues.

If we went down the road of having training—it would be only in a certain number of cases; it would not be in every case, but that does not make it good—and guidance for the medical profession, would that assist in persuading Mr Matheson that medical practitioners would have sufficient nous and awareness of the subtleties of coercion to allow this to proceed?

Michael Matheson: I will take Brian Whittle's intervention, and I will try to deal with both interventions at once.

Brian Whittle: I am listening to the debate and, given that those of us on the Health, Social Care and Sport Committee had the benefit of taking evidence from witnesses from around the world, I am concerned that some members are being selective in the evidence that they have gathered.

There was certainly no suggestion from any of the evidence that we took, as far as I can see, that there is any coercion in this area whatsoever. I am a wee bit concerned that we are looking at things from our own perspective, rather than at all the evidence and facts.

Michael Matheson: I am grateful for Mr Whittle's intervention, given that he has been a member of the Health, Social Care and Sport Committee and considered the issues.

On Christine Grahame's point, training is one aspect, but I do not believe that the way in which the declaration phase is framed in the bill provides sufficient time and opportunity to deal with the issues thoroughly. It is unreasonable to expect two independent general practitioners who have undergone a period of training to be able to substantiate sufficiently that no coercive and controlling behaviour has influenced the individual they are considering. As I mentioned, we framed the 2018 act in such a way that a pattern of behaviour has to be demonstrated and established, and that takes time and effort.

Russell Findlay (West Scotland) (Con): Brian Whittle talked about the international evidence on coercion, or lack thereof, which is what the debate is about.

Let us look closer to home, because, in my past life as a journalist, I did not need to look too far to see examples of trusted legal professionals targeting and exploiting elderly vulnerable clients. Those ugly cases were frequent. I looked up a few just now. In 1999, there was a solicitor who took £100,000 from elderly clients. There was a case in 2021 of a solicitor stealing cash from another elderly client in Edinburgh. There was another who was struck off for overcharging elderly clients in Aberdeen, and yet another, in 2023, who targeted someone with dementia and made off with their money.

Those are real examples of crimes in which elderly people were targeted by trusted professionals in later life—the most vulnerable time. The point that I am trying to make—I wonder whether Michael Matheson agrees with me—is that there is a chance that, if the bill is passed, we will see similar crimes to those but in relation to the bill.

Michael Matheson: Russell Findlay makes a valid point. We cannot overestimate the scope of coercive and controlling behaviour in different parts of our society. As I said, it happens on a day-in, day-out basis, with social work staff dealing with it through adult protection legislation.

My final point is about the changes to penalties that would be made by Liam McArthur's amendments. I note his point about changing the two-year custodial sentence to one year and increasing the fine to a higher rate in order to be consistent with Scottish Sentencing Council guidelines. I point out that the SSC issues guidelines; it is for the sheriff or judge in an individual case to determine what they consider as appropriate when handing down a sentence. The guidelines could change in a couple of years' time.

The problem is that Liam McArthur has lodged amendments that will put those guidelines in the bill. If, at some point, the Scottish Sentencing Council chose to increase the sentences, the bill would have to be amended. That is why I do not think that the provisions should be amended. The guidelines can be applied without anything being put into the bill. That is what the Scottish Sentencing Council was established to do.

Liam McArthur: I commend Michael Matheson on the way in which he has set out his argument. I may disagree with him, but that is another matter. He has set out very well the case on coercion.

When it comes to sentencing guidance, my amendments were brought forward in consultation with the Scottish Government, which identified what it felt were anomalies in the bill. I take Michael Matheson's point about guidance being updated. As is the case with other aspects of the bill, that will need to be kept in line with the rest of the statute book. However, as I said, the amendments were brought forward in consultation with the Scottish Government, to ensure that anomalies in the bill were addressed.

Michael Matheson: I am grateful for that clarity. The Government does not always get it right, of course—I can say that, these days, from the back benches. I do not think that we should lower the threshold, because that would send out the wrong signal. The sentencing guidelines can be used by the bench when determining a case, and we should allow our sheriffs and judges to do so without the need to revert to amending the legislation.

Murdo Fraser (Mid Scotland and Fife) (Con): Will Michael Matheson give way?

Michael Matheson: I will give way briefly to Murdo Fraser.

Murdo Fraser: On the sentencing point, will the member reflect that, first, there is a presumption against sentences of a year or less; and, secondly, even if someone were sentenced to a year, they would serve, under the current automatic early release arrangements, only 15 weeks in prison? Does he agree that that is little deterrent against coercion?

Michael Matheson: I should declare the fact that I was the justice secretary who introduced the presumption against sentences of less than a year.

However, I think that we should leave the sentencing guidelines to stand as they are without necessarily putting them in the bill, for the reasons that I set out.

I believe that one of the significant risks that are associated with the bill is coercion. I respectfully say to those who have lodged amendments—for which I am grateful—that I do not believe that we can legislate to prevent coercion. We can legislate to help to identify it, then seek to convict people for it, as we did through the Domestic Abuse (Scotland) Bill, but the reality is that coercion will take place, and we need to ensure that we have robust law to deal with it as and when it is identified.

Neil Gray: As with previous groups, I can make no comment on the merits or otherwise of the case that has been made in setting out some of the amendments in this group, which, it is clear, are rooted in deep conviction. All that I can do is set out the technical, legislative competence or deliverability concerns of the Government. It will then be for colleagues to decide how they choose to vote.

Amendments 24, 25, 35, 36, 41, 76, 77, 80, 82 and 84 could potentially introduce greater subjectivity and inconsistency into assessments, as, from a technical perspective, the removal of references to pressure "by any other person" would risk widening the concept of coercion in a way that might reduce legal clarity, making it more difficult for practitioners to determine the threshold at which indirect pressures amounted to a lack of voluntariness.

Amendments 27 and 33 would place new and explicit duties on registered medical practitioners and on the Scottish ministers to identify, consider and provide guidance on indirect pressures. Although professional guidance already supports clinicians to assess capacity and voluntariness, as Christine Grahame pointed out, embedding those requirements in statute could increase the complexity and length of assessments, which could have potential implications for training, consistency of practice and practitioner confidence.

The careful development of guidance would also be required, to avoid creating an expectation that all forms of indirect pressure could be identified or mitigated uniformly.

Bob Doris: [*Made a request to intervene*.]

Neil Gray: I happily give way to Bob Doris.

Bob Doris: I thank the cabinet secretary for giving way. Would my amendments require the careful development of guidance? Absolutely—of course they should, and that is why amendment 27 should be agreed to. That is absolutely clear.

As for amendment 27 leading to a lack of consistency in practice, I remind the chamber that the amendment seeks to encourage a conversation between the medical practitioner and the person applying for an assisted death about the possibility of indirect pressures. That is what amendment 27 would do. If such conversations do not take place, we will have absolute consistency, won't we? If we do not ask for those conversations to take place, we will consistently not have them. Of course we must ask for that to happen. Perhaps the cabinet secretary should reflect on that.

Neil Gray: I say again to Mr Doris, as I said to all colleagues at the start of my remarks on this group, that I can only set out the issues or concerns that the Government has with certain amendments. I am not in any way passing comment on the merits of the arguments that have been made by colleagues in setting out their amendments. I understand them and, in Mr Doris's case, I understand that they come from a deep-rooted conviction. All that I am saying is that what has to be weighed up is the case that colleagues have made in speaking to their amendments and some of the considerations that the Government wishes to put on the record with regard to deliverability and technical and legislative competence issues.

Amendments 50 and 51 would ensure consistency with the general approach to summary penalties. Mr McArthur has already set out that we have co-operated on those amendments.

Amendment 93—

Jeremy Balfour: Will the cabinet secretary give way?

Neil Gray: I will.

Jeremy Balfour: I wonder whether the cabinet secretary can give me a wee bit more information on this. Mr McArthur has said that he has done this on the Government's understanding, but we had a fairly clear statement just a few moments ago that that should not be linked to the bill. Can the Government at least give us some idea of why it feels that the statutory time limit should be reduced and why that should be included in the bill?

Neil Gray: I thank Mr Balfour for his intervention. As I have said, it would ensure consistency with the general approach to summary penalties. It is about the requirement for legal consistency.

Amendment 93 would significantly expand the requirements that would be placed on the co-ordinating registered medical practitioner at the point at which a second declaration is made by directing, in detail, the nature of the assessment to be carried out; the specific forms of coercion to be considered; the steps to be taken where concerns

are identified; and the matters that must be recorded in the adult's medical records. Although the bill already requires the practitioner to be satisfied that declarations are made voluntarily, the amendment goes further in seeking to set out a structured and highly specified assessment framework in primary legislation. That might reduce flexibility for professional judgment and could have implications for deliverability, including the increased time and resource demands that would be associated with assessment, record keeping and training.

In relation to amendments 151, 152, 158, 175, 178, 315 and 320, the extent to which the amended provisions are linked to the offence of coercion or pressure in section 21 of the bill is not clear.

Amendment 172 would introduce significantly more prescriptive requirements in relation to assessment, training and procedure, which could have practical implications for delivery, including a substantial increase in the time required to carry out assessments and, ultimately, an increased financial burden.

On amendment 174, it is not clear who an "independent assessor" might be, but it is noted that amendment 182 seeks to insert a provision into section 8 of the bill, on medical practitioners' statements. On that basis, if it is a duty of the Scottish ministers to make regulations setting out qualifications and experience in relation to medical practitioners, that might raise issues of legislative competence in a similar way to other provisions of that nature in the bill that we have already debated.

More broadly, amendment 174 and related amendments 182, 187, 189, 193, 209 and 305 also raise deliverability challenges. Introducing a new statutory role of an independent assessor might require the establishment of qualification standards, regulatory oversight and sufficient workforce capacity, which could be challenging to implement consistently across Scotland.

According to concerns expressed by third parties, the trigger for referral lacks a clear threshold and could add delay and uncertainty to the process. There are also questions about how an independent assessor's conclusions would interact with existing clinical judgments and safeguarding duties, and about the proportionality of mandatory referral to Police Scotland. Taken together, those amendments could add procedural complexity and delay.

21:00

The effect of amendments 177 and 180 would be that the assistance under section 15 could be provided only where the co-ordinating registered medical practitioner and the independent registered medical practitioner were both satisfied that the adult was seeking the assistance solely due to their terminal illness and for no other reason. While I fully appreciate the intent behind those amendments, it is possible that including such provision in the bill could have the effect of people feeling that they could not be open or honest about their reasons for seeking an assisted death for fear that doing so could lead to their request being denied. That may prevent open conversations from taking place about the alternatives and the support that is available to the person to help them with any other issues that may factor in their decision. It could also have implications for the ability of the assessing registered medical practitioner to determine whether the person is acting voluntarily.

On amendment 181, setting up a panel or multiple panels would be likely to have major financial implications. With regard to the remaining amendments in the group, the Scottish Government has no comments.

The Deputy Presiding Officer: I call Michael Marra to wind up and say whether he wishes to press or withdraw amendment 144.

Michael Marra: I thank members for their contributions to the debate. I will start my closing comments with amendment 50. To be frank, I do not think that we have heard any proper defence of the substance of the change in reducing the penalty for coercing someone to take their own life from two years to 15 weeks. We heard arguments about consistency with sentencing guidelines, but—to be frank, cabinet secretary—if those are the guidelines, they are an ass and they should not be applied in this area. There has been no substantive defence, and I hope that members will reject the amendment on that basis.

I feel that what we have heard speaks a little to the tone of some of the approach that has been taken.

Daniel Johnson: I wonder if it is, in fact, worse than Michael Marra has suggested. To suggest that the Scottish Sentencing Council somehow has primacy over this place regarding penalties is to get the precedent round the wrong way. Surely it is for Parliament to legislate for what the penalties should be; the Sentencing Council's role is merely to guide thereafter.

Michael Marra: Mr Johnson makes a very good point, which covers an issue that I was just coming to. Reverting to sentencing guidelines actually diminishes the scale of the change that we are talking about. We have to get the penalties right when we are talking about life or death, and it is absolutely right that we consider each instance on its own merits. I believe that reducing the penalty in the bill from two years to 15 weeks is

inappropriate and that the Parliament should take a strong view on that.

It speaks to my sense that there is perhaps, in the way that parts of the bill have been dealt with and discussed—including the discussion of the amendments in this group—an implication that it would not be making a profound change. It is a profound change, however, and the consequences are very significant. Paul O'Kane's point in relation to social work and his engagement with social work organisations tells the story itself. I also declare an interest, as I, too, am married to a social worker.

I am referring to the way in which that point was addressed by the member in charge of the bill. When Paul O'Kane talked about the bill's lack of coherence with the current social work framework, which is based on the idea of protecting life, Liam McArthur said that such an approach would be disproportionate. However, that gets it the wrong way round, as Daniel Johnson described. In actual fact, we have to think about what is proportionate to the scale of the change that we are proposing in the bill. It is absolutely reasonable to take on board the existing frameworks within which social workers currently operate, and we should take very seriously the objections that they have made.

Ruth Maguire: To go back a little, to the sentencing issue, does Michael Marra agree that our constituents, whether they are for or against the principles of the bill, would expect the penalty for coercion to reflect the seriousness of what is happening and the fact that someone's life is being ended against their will?

Michael Marra: I fully agree. Anybody watching these proceedings would be astonished that, while we are making such a profound change, not just the member in charge but the Government is seeking to reduce the sentence on the basis of a tidying-up exercise and coherence.

Ross Greer: I agree with Michael Marra on that point, and I will vote against amendment 50. On the point that he makes about the people watching at home, does he agree that it is important to be very clear that we are talking only about summary conviction? In this case, conviction on indictment would carry a maximum sentence of up to 14 years. It is important to reassure our constituents that that would remain the case.

Michael Marra: I agree that that is important. The member in charge, Liam McArthur, put that on the record earlier. It is welcome that Mr Greer reiterates that, although I do not think that that diminishes the core point that we are discussing.

Moving on to the need to have regard to social work status, Paul O'Kane made the case for that very well. Ruth Maguire was correct in describing the core of this debate on coercion as being about consent, choice, free will and autonomy. The real question is, who has it? We are talking about giving some rights to some people in the country—we have already discussed the eligibility limits that we would set on that—but there is a question about who is able to exercise their choice, free will and autonomy and whether they are actually able to give their consent freely. That is the core of the argument on coercion that we have been having for the past hour or so.

Paul O'Kane identified this point as the significant hole in the bill, and I would say that he is absolutely correct in that regard. Bob Doris talked about having to ensure that there was scaffolding in place to address these issues. That is a good way of putting it.

There has been growing concern among MSPs about the issue of coercion since stage 1—and before that, in fact. If the Parliament does not put in place restrictions in this area, it will be at odds with the public. I read in *The Herald* today that "twice as many" Scots agree that "MSPs should reject" any law that would increase risk, that three times as many Scots agree that safeguarding would not be able to detect domestic abuse in assisted dying, and that 68 per cent of Scots fear that

"victims of domestic abuse would feel pressured into ending their lives".

That is a snapshot of what people outside this building—people across Scotland—feel about the risks. When we balance those risks, as Ruth Maguire set out, those are the considerations that the public have.

Finlay Carson: I will take this opportunity to present a quote that sums things up for me. It is from Michael Marra's former colleague Johann Lamont. She tweeted:

"I did not always think this way but I have concluded that, if my freedom of choice at the end of my life is at the expense of those who are vulnerable to coercion, that is not a cost that I can accept. Coercion is often invisible but all the more devastating for being hidden."

Michael Marra: It is always good to hear from Johann Lamont—a wise woman, in my experience. That is a fine point that, I think, emphasises where the vast majority of the public are on this issue. They perceive risks in what we are doing, and we must do our best to guard against them.

Rona Mackay said that there was no evidence of coercion. In Victoria, Australia, the training on coercion identification amounts to about five minutes: a two-minute video and a two-minute PowerPoint presentation. Perhaps there is a minute in between. That is the level of training to identify coercion. When we say that no coercion

has been identified in those circumstances, it is little wonder. We have to look to the practices that are adopted when we draw on different evidence.

Liam McArthur: What Michael Marra has just said does not necessarily reflect the evidence that the Health, Social Care and Sport Committee heard from representatives involved in the assisted dying process in Victoria. Would Mr Marra at least accept that the protections for those who find themselves subject to coercion, whether that is coercion into unpleasant, horrible, protracted death or coercion into medical treatment that may not be appropriate, are not there and that the bill at least sets out a system—which was noted in graphic detail by Christine Grahame earlier—for putting in protections that do not currently exist? With training requirements alongside that to reflect the clearer understanding of coercive controlling behaviour, those protections would only be enhanced.

Michael Marra: I think that it is a false equivalence. Some people receive care that they feel is inappropriate and does not suit their needs. We should—and we can—address that situation through the NHS.

Liam McArthur: But we do not.

Michael Marra: Liam McArthur says that we do not. That goes to the heart of some of the problems with the bill. We do not seem to be addressing the issue of appropriate palliative care. The member said in the stage 1 debate that palliative care had to be a viable alternative to assisted dying, yet now he is saying that it is not a viable alternative because people are receiving care that is inappropriate. I will leave it there; it is perhaps a debating point.

The bill would introduce a law that would give the state the power to be involved in the taking of someone's life or to allow them to take their own life. That is the substantive difference—that is what we are dealing with. To draw an equivalence with the provision of other forms of services at different times is a fallacy; it does not tally. We have to deal with protections for the laws that are before us.

Brian Whittle's amendments are a good contrast to the situation in Victoria, Australia, and to the options that members are considering in some of the other amendments.

On the proliferation of coercion, we should also consider that the World Health Organization says that 16.6 per cent of people over the age of 60 suffer elder abuse. Clearly, people over the age of 60 would be more likely than others to avail themselves of the assisted dying option.

Overall, Liam McArthur rejected in his analysis the fact that internal coercion exists at all. Maybe that is a question of how we see society and whether we consider that class and poverty determine outcomes. For me, that is self-evident. That is how society works, whether we like it or not, and I certainly do not. On almost any other policy issue, whether it relates to health, addiction, mental health or educational outcomes, we recognise that the circumstances in which somebody is born set them on a path of outcomes. Internal coercion is absolutely part of that.

Pam Duncan-Glancy—as ever—set out powerfully how that is represented in the disabled community and how that feels on a day-to-day basis. She is a powerful advocate on those issues.

The idea that we reject systemic risk on the basis of how we perceive society—namely, that people do not feel those pressures—is not something that I recognise in how we approach almost any policy area in this Parliament.

Liam McArthur: I do not think that anyone is rejecting the concept of internal coercion—that was reflected very much in the debates that we had at stage 2 on similar amendments in this area. What was discussed at that point, and agreed to in committee, was that linking to the guidance on coercion—which certainly acknowledges internal coercion and other societal factors—is a more appropriate way of addressing the issue than dealing with it in the bill, which would take us away from legal concepts that are well understood, increase the risk of confusion and put both medics and patients at risk.

Michael Marra: That wraps up my two points quite well. The first is that it is, in part, a question of how powerfully we perceive those fractures in society and the risks that are inherent in them. We must also recognise that this would be a significant departure in the law with regard to what the state would be enabled to do and that the current structures are not appropriate. We must address the risks structurally in the bill in order to give people the protections that they require.

As I set out in my opening statement, I am mindful of colleagues' time. I do not believe that we can safeguard these issues sufficiently. I have come on some journey on that, even since lodging my amendments. It is on that basis that I seek to withdraw amendment 144.

Amendment 144, by agreement, withdrawn.

The Deputy Presiding Officer: We turn to group 5, which is on training, qualifications and experience of health professionals. Amendment 3, in the name of Daniel Johnson, is grouped with amendments 86, 4, 145, 146, 87, 147, 5, 88, 6, 156, 89, 238, 239, 120 to 123, 125, 133B and 133A. I point out that, if amendment 86 is agreed to, I cannot call amendment 4, and, if amendment 88 is agreed to, I cannot call amendment 6, due to

pre-emption. Additionally, if amendment 125 is agreed to, I cannot call amendment 301, which is to be debated in group 7—which is on assessments, including support, of terminally ill adults—also due to pre-emption.

I call Daniel Johnson to move amendment 3 and to speak to other amendments in the group.

21:15

Daniel Johnson: One of the jeopardies of any stage 2 or 3 proceedings is that we do not quite know where in a grouping our amendments will be called. I stand up somewhat self-consciously for two reasons. First, my amendments in this very important group would, in some ways, have been better covered in the previous group. In my view, they are about training with regard to coercion and capacity. Secondly, I do not believe that my amendments cover those aspects of training as effectively as other members' amendments do.

However, I will reflect on what was said previously. What Michael Matheson said is incredibly important. Coercion is an evolving concept, and we need to think carefully about it. However, the most important point with regard to his contribution is that detecting and dealing with coercion comes down to ensuring that individuals who come into contact with people who may be subject to coercion have the necessary training, expertise and ability to detect it. The bill must cover that effectively.

With regard to the broader amendments in this section, as I said in some of my earlier contributions, we all need to accept that the effect of this legislation, if it were passed, would come down to subjective judgments. Yes, those judgments would be made with a great deal of expertise, training, insight and understanding, but they would nonetheless be subjective judgments. Therefore, a number of the amendments in this group are worthy of a great deal of consideration. With regard to training on coercion and capacity, although I will move amendment 3 in order to enable the debate to proceed, I intend to withdraw it, and not to press amendment 6, should it be called. I urge members to support the amendments in Miles Briggs's name, which make a far more comprehensive effort to cover the key elements that require training.

I move amendment 3.

The Deputy Presiding Officer: I advise members that we will shortly reach the next time limit. We still have to debate two more groups of amendments. As a consequence, I am minded to accept, under rule 9.8.5A, a motion without notice to propose that the time limit be extended by 30 minutes. I invite the Minister for Parliamentary Business and Veterans to move such a motion.

Motion moved,

That, under rule 9.8.5A, the time limit for group 5 be moved by up to 30 minutes.—[*Graeme Dey*]

Motion agreed to.

Liam McArthur: I will speak first to my amendments in the group. The bill, as amended at stage 2, allows the Scottish ministers, by regulations, to set out the training, qualifications and experience required of co-ordinating registered medical practitioners, independent registered medical practitioners and authorised health professionals. As discussed, the Scottish Government considers that these provisions may relate to the reserved matter of the regulation of health professionals, under section G2 of schedule 5 of the Scotland Act 1998. As a whole, amendments 86 to 89, 101, 104, 105, 120, 121, 123 and 125 would remove those regulating powers from the bill, including consultation requirements and other procedural matters, with a view to their being taken forward under a section 104 order.

I am also conscious of the need to ensure that the public, and particularly any person who wishes to access assisted dying, can have the fullest confidence in the assisted dying process. It is therefore imperative that only health professionals with the appropriate level of professional training, qualifications and experience can participate. However, as I set out earlier, we must ensure that all the provisions of the bill as passed are within the legislative competence of this Parliament, otherwise they cannot have legal effect as Parliament intends. Taking a constitutionally precautionary approach is the only sensible thing to do in such circumstances. I refer again, as I did earlier in relation to the protections, to the strong commitments made by both Scottish and UK Governments and the constructive approach that has been adopted at pace to respect and reflect the will of this Parliament. That gives me confidence, and it should also give Parliament confidence, that these provisions—and those on protections—will be taken forward appropriately through the section 104 order route. Therefore, I urge members to vote for these amendments in my name.

I turn to Daniel Johnson's amendments 3 to 6. I fully agree that training is essential and, for that reason, I lodged related amendments at stage 2. However, as already explained, given the concerns raised that including training provisions in the bill may touch on reserved competence, I believe that the most appropriate and secure way of enacting any training requirements will be by way of a section 104 order. For that reason, I cannot support amendments 3 and 5, and my amendments 86 and 88 pre-empt amendments 4 and 6, making them redundant.

In light of my amendments, I also cannot support Jackie Baillie's amendments 145 and 146, which would require the regulations—which I am seeking to have removed—to include a certification process for medical practitioners to evidence their training, qualifications and experience. I also cannot support Paul O'Kane's amendment 136 or Miles Briggs's amendment 147, which would require the regulations to specify minimum training standards. Those are all very reasonable proposals, which I would expect to be addressed in due course, but which fall to be dealt with through the section 104 order process.

Ross Greer's amendment 238 provides that Scottish ministers may set out in regulations the training, qualifications and experience that are required in order to carry out the role of co-ordinating registered medical practitioner, independent registered medical practitioner and authorised health professional. It therefore adds to the legislative competence concerns raised by the Scottish Government. I note that regulations made under amendment 238 would require the agreement of the secretary of state, and that Mr Greer's amendment 239 provides that the secretary of state may set out in regulations the training, qualifications and experience that are required in order to carry out the role of registered medical practitioner and so on. The cabinet secretary will no doubt state his own view, but my understanding is that that would not address the competence concerns that have been raised by the Government.

I very much acknowledge the principle behind the amendments, as well as the huge amount of work that Ross Greer and his team have put in on the issue ahead of stage 3. However, I consider that, for the reasons set out, it would be better to reject those amendments and consider how to take the issue forward in the context of the amendments that I will turn to now—namely, Ross Greer's amendments 133A and 133B, which are amendments to my earlier amendment 133.

Amendment 133A includes conditions, in addition to those made by amendment 133, which must be satisfied before ministers can make regulations to commence the bill as enacted and bring it into effect. The additional precondition that must be satisfied—through a section 104 order or otherwise—is that provision has been made for the training, qualifications and experience of participating health professionals. Amendment 133B is also an amendment to amendment 133. It provides that the precondition prescribed by amendment 133A be satisfied only through the conferral of power on Scottish ministers to specify the training, qualifications and experience that must be held by participating health professionals. It also requires that the Scottish ministers have exercised the power to make such provision.

As the cabinet secretary set out in his letter to the Health, Social Care and Sport Committee on 5 March, the expected route for making provision for the training, qualifications and experience of participating health professionals would be via a section 104 order. I understand that that route could not be used for conferring regulation-making powers, as is required as a precondition in amendment 133B.

As I highlighted earlier, and consistently throughout stage 2, I consider it of the utmost importance that participating medical professionals receive the right level of professional training and have the level of qualifications and experience deemed necessary to ensure confidence in the delivery of assisted dying services. I have also spoken of the importance of ensuring that all provisions in the bill are within legislative competence, and of the agreement of both the Scottish Government and the UK Government that the best way to achieve requirements in relation to those factors is through a section 104 order. The content of such an order is a matter for the Westminster Parliament. We are not in a position to set out what that order may contain, albeit that it will be through agreement between the Scottish and UK Governments and relate to the commencement provision in amendment 133.

As I explained, I am sympathetic to the principle at the heart of amendments 133A and 133B. However, Parliament should be clear about the effect of imposing further brakes on commencement, and must ensure that the legislation is not framed in a way that could prevent Parliament's intention from being realised. On that basis, I encourage Parliament to back Ross Greer's amendment 133A, which gives effect to the substance of the issues that were debated earlier, but to reject amendment 133B, which would apply a brake in a way that Parliament may find difficult to release in due course. Again, I thank Ross Greer for lodging those amendments.

Jackie Baillie: I will speak to amendments 145 and 146, in my name, which I was asked to lodge by Children's Hospices Across Scotland. The amendments seek to ensure that, if Scotland legislates for assisted dying, the legislation explicitly recognises the unique complexities that are faced by young people who are under the age of 25 and living with prognostic uncertainty and fluctuating conditions.

Although the bill applies to adults, the Parliament has already acknowledged that many young adults—particularly those with serious or life-limiting conditions—continue to receive care in

paediatric or transitional environments, including the service that is provided by CHAS. Those young people often have cognitive, social and clinical development that is different to that of older adults. Without tailored safeguards, there is a risk that assessments could be inconsistent or unsafe.

We know that such protections are needed because evidence that was submitted throughout stages 1 and 2 made it clear that assessing capacity in young adults with complex conditions is highly specialised and requires advanced clinical knowledge. Coercion can be more difficult to detect where communication relies heavily on family or carers, and diagnoses in that age group often fluctuate, making terminal illness harder to determine with confidence. Those are not routine clinical judgments; they carry significant ethical weight and irreversible consequences, which require a robust, nationally consistent framework.

Amendment 145 would require the Scottish Government to set specific rules about the "training, qualifications and experience" that doctors need when assessing young adults who are under 25 and living with prognostic uncertainty or fluctuating conditions. It would ensure that such regulations provide equivalent safety to existing national frameworks that recognise reduced cognitive maturity in people under 25, such as is the case with the Scottish sentencing guidelines. Justice sentencing acknowledges that young people who are under 25 are more vulnerable, more susceptible to influence, less able to weigh complex risks and more likely to enter harmful relationships.

That directly mirrors CHAS's concern that young people may be more vulnerable to coercion or self-duress when they face life-limiting illness, especially during such a difficult time in their life as when they transition from child to adult services and when much of the support that they rely on falls away.

Amendment 146 seeks to strengthen the clinical framework. It states that regulations must include a method such as certification for doctors to verify that they have the appropriate training and experience to carry out the roles that are specified by the bill. It should not just be assumed that a doctor is qualified; there needs to be a formal system to show that they meet the required standard to ensure patient and workforce safety.

I also support amendment 147, in the name of Miles Briggs, which would strengthen assessments, safeguarding and support in the bill for young people who are under 25.

All that said, the central difficulty with the amendments is that the Scottish Government believes that many of them are not legislatively competent. However, those are the amendments that would provide reassurance. When he comes to speak, will the cabinet secretary give an on-the-record commitment from the Scottish Government that the provisions in the amendments will all be included in the section 104 agreement? If he cannot do that, what assurances do we actually have?

Neil Gray: *[Made a request to intervene.]*

The Deputy Presiding Officer: Is Ms Baillie finished?

Jackie Baillie: I am finished, but I am happy to stand again and take an intervention if that clears things up.

The Deputy Presiding Officer: We will pretend that you had not finished.

Neil Gray: As I have already set out, the contents of a section 104 order will be for negotiation. I must correct some of what Ms Baillie has said. It is not just our assertion that some of the amendments that we are talking about are outwith legislative competence; as I have previously put on the record, that decision has also been arrived at through consultation with UK ministers.

Jackie Baillie: I welcome the intervention, but I am sure that the cabinet secretary realises that people are trying to build safeguards into the legislation. Taking those safeguards away while providing no reassurance that they will return as part of a section 104 agreement is incredibly worrying for those who want to ensure that the legislation—if the Parliament passes it—is the best that it can be.

21:30

Miles Briggs: To pick up where Jackie Baillie left off, the regulation of training for authorised health professionals is a devolved issue. I will support all the amendments in group 5, which do exactly what we want: they ensure that training opportunities are put in place.

Like Jackie Baillie, I have been working with CHAS, and my amendment 147 would ensure that, if Scotland legalises assisted dying, any professionals who are involved in eligibility assessments, information provision or application support have the specialist training that is required to work safely with adults aged under 25. Young adults often receive paediatric or transitional care, including from CHAS, and present with unique clinical, developmental and social needs.

Why is such protection needed? Evidence that was given at earlier stages of the bill process shows that assessing capacity in young adults with complex conditions is challenging and demands specialist expertise. Coercion might be harder to

identify due to reliance on family and carers for communication and support. Uncertainty is also greater among young adults, which makes terminal illness harder to determine. Such decisions carry irreversible consequences and require consistently high clinical standards.

Amendment 147 would establish mandatory minimum national training standards that would include: assessing capacity in young adults with complex or fluctuating conditions; identifying subtle or relational coercion that is often experienced by young disabled adults; understanding the prognostic uncertainty that is associated with rare or unfamiliar conditions in people under 25; communicating sensitively with families during emotionally complex decisions; and signposting palliative, hospice and home-based care options across Scotland. Those standards would ensure that assessments are safe, informed and nationally consistent. Jackie Baillie touched on why that matters. Young adults' illnesses and trajectories are often unpredictable and do not match adult timeframes. Many experience fluctuating capacity, communication differences or different periods of stabilisation in their conditions. That makes eligibility assessments particularly difficult and increases risks of misinterpretation and safeguarding issues.

Amendment 147 would ensure that training standards are developed through expert consultation that is led by the chief medical officer. They would be reviewed every three years to reflect new clinical evidence and supported by guidance to be published when regulations commence. If the Parliament legalises assisted dying, the safeguards would ensure that young adults' assessments are safer and more ethical and consistent.

Paul O'Kane: I do not intend to say too much about my amendment 156, because my points have been largely covered in colleagues' amendments. A number of amendments in the group seek to do the same thing: mandate that regulations are laid on the training to be offered to medical professionals to identify

"coercion, undue influence and coercive control"

and

"situations of dependency arising from illness, disability, age, social care needs or caring arrangements."

Those are the words of my amendment.

In the debate on the previous group, in the wider debate that we had on coercion and coercive control and in the debate on this group, we have identified that medical practitioners do not always have the specialist training that is required to recognise the complex and often conflicting issues that arise in cases of abuse and in the patterns of behaviour that are associated with coercive control. Such patterns have to be monitored over a longer time. Colleagues have highlighted the challenges that arise from the fact that a patient's relationship with their general practitioner is not what it was many years ago, when patients were more likely to see the same practitioner consistently. That issue has to be looked at more broadly.

That is why I have raised the need for wider multidisciplinary input, including from social workers and other professionals, which will help to identify coercive control much more easily.

Looking at the evidence that has been provided on other jurisdictions, I note that the Jersey review panel's recent examination of assisted dying safeguards concluded that assessments should draw on as broad a range of professional expertise as possible. It acknowledges that medical training alone cannot provide what is required to identify coercion or coercive control. I say that to back up my previous point about social work, but also to make it clear that training is important and it is going to be required. It will allow us to deal with some of the issues that have been raised about the capacity of medical professionals to identify these pernicious issues.

As I said, I do not intend to labour points that have already been made. I am grateful for the time that I have had to add to the debate.

Ross Greer: My contribution to the debate on this group directly follows on from what I said in the debate on group 3 on conscientious objection and no detriment, because the way that we resolve these issues is intertwined, as Liam McArthur laid out. Specifically, my amendments 133A and 133B are amendments to Liam McArthur's group 3 amendment 133, which ties commencement to resolution of the issues on the right of professionals not to participate and to be protected from any detriment if they do not.

My amendments 238 and 239 were in essence a way to reach the same outcome by replicating the structure of the cabinet secretary's amendments 110 and 111 in a Scotland Act 1998-compliant way of creating regulation-making powers on the issue of training, qualification and experience. Amendments 238 and 239 are my least preferred options and I do not plan to move them. I lodged them simply because I wanted to give the Parliament the option and there were only a few hours between the cabinet secretary lodging his amendment and the deadline for members to lodge ours. I thought that it was prudent to lodge a structural equivalent to his amendments on poison control in relation to this area. I do not think that my amendments 238 and 239 are now necessary, as we have come to a solution elsewhere, in

amendments 133A and 133B. I am grateful for the support of the British Medical Association and the Royal College of Nursing on the drafting of those amendments, and also for the support of Dignity in Dying and the Queen's Nursing Institute Scotland.

I think that we would all agree that it would not be acceptable to have a system of assisted dying without setting out the training, qualification and experience requirements for those who would deliver the system. As Liam McArthur said, we would not want to proceed in such a manner. Without the amendments, though, we could have such a bill. The bill proposes a dispersed rather than a specialist service, so it is not automatically the case that those who would be involved would have specific training and qualifications. This Parliament needs to decide that that is necessary. At stage 2, the committee decided that that was necessary by supporting my amendments to include such provisions, but they are in the section that is now being removed for the sake of legislative competence. I recognise the necessity for that, and my amendments 133A and 133B seek to resolve the situation. They seek to make commencement of the bill conditional on the gap being closed by the UK Government in the same manner as we have just addressed the issue of no-duty and no-detriment provisions through Liam McArthur's amendment 133.

Amendment 133A would simply require that the UK Government finds a solution to provide for the training, qualification and experience requirements, but it may do so in a way that it sees fit. That could mean it making the arrangements or devolving regulation-making powers to Scottish ministers.

Amendment 133B would require the specific solution that the UK Government must confer the training, qualification and experience regulation-making powers on the Scottish ministers. That is not a constitutional wedge issue; it is a fundamental point of safeguarding. This Parliament is trying to make arrangements for an assisted dying scheme, so it should be this Parliament that makes those decisions. If, under amendment 133A, the UK Government is to set those standards itself, I hope that it will listen to what Scottish ministers and stakeholders have to say, but there is no guarantee of that. We could have training standards that this Parliament does not support, which would leave us with the nuclear option on what to do with the commencement regulations.

That is why amendment 133B was my preferred approach. However, I am going to ask members not to support amendment 133B but to support 133A, much as I think it is not ideal, because 133B would effectively give the UK Government the choice of either granting a section 30 order—which is something that it clearly does not wish to do, for whatever reason—amending the Scotland Act 1998, or effectively blocking an assisted dying bill that this Parliament has voted for. I do not think that that would be an acceptable outcome. That is a roundabout way of explaining why, with all those options on the table, I am asking members to support amendment 133A.

In closing, I have a question for the cabinet secretary. His letter to the Health, Social Care and Sport Committee said:

> "our view is that the route of seeking to make provision in a section 104 Order, perhaps to give Scottish Ministers power to make directions about such matters, is the appropriate one".

The UK Government's letter on the section 104 order is silent on the approach that it would take in that regard, so I would be grateful if the cabinet secretary could clarify whether, in those discussions, the UK Government expressed any preference for how it would go about the section 104 order. Would the UK Government do that itself or would it give Scottish ministers direction-making powers? I bring up the point about direction-making powers because it was in the cabinet secretary's letter and because those powers would not require the approval of this Parliament. Scottish ministers have the ability to direct the national health service without going via the Parliament. The Parliament would have the final say via the backstop of the commencement regulations, but it would be far better if the Government were to engage with the Parliament up front.

With that, I will not move amendments 238, 239 or 133B, but I urge members to back amendment 133A, and I would also be keen to hear from the cabinet secretary.

Neil Gray: I can confirm to Mr Greer that the UK Government has not expressed a preference for how that issue should be resolved.

Ross Greer: I am grateful to the cabinet secretary for that clarification, disappointing though it is. I do not want to rehearse a lot of the arguments that we have already had about how much this has turned into a debate about the limits of the devolution settlement, rather than one about the issue at hand. I hope, given the strength of feeling that the cabinet secretary has seen from members across Parliament, that there will, at least from this Government, be consistent engagement with the Parliament and that, if Scottish ministers are given direction-making powers, they will ensure that the Parliament is engaged before they issue any directions, even if that does not have to go via the Parliament.

I will conclude on that point.

Alasdair Allan: Liam McArthur's amendments would remove ministers' powers to set regulations defining the training, qualifications and experience of the co-ordinating registered medical practitioner. As members understand, that is because such powers would be out of scope for this Parliament.

Therefore, should the bill ultimately pass, we face two options. Either Parliament agrees to Liam McArthur's amendments, effectively outsourcing such important decisions to unelected UK officials, or Parliament does not agree to the amendments, which would mean that the legislation would be all but certain to end up in the Supreme Court.

To avoid any misunderstanding, I accept that the areas in question here are pro tempore indisputably reserved to Westminster. However, I also believe that it is not good lawmaking to draft laws to end up in the courts while issues of competence are settled. I therefore understand the motivations of those seeking to make many of the amendments and do not intend to stand in their way, but it is difficult to endorse those moves with much enthusiasm.

My concern is that we are being asked to pass legislation here without having any real idea of what the UK Parliament has in mind or how it intends to plug the holes in our own law. I have already mentioned a letter that was sent to members by former presidents of the royal colleges of physicians and surgeons to make clear their concerns about that. We cannot interrogate any of what might be in a future section 104 order, because it has yet to appear. In any case, such an order, by its very nature, receives limited parliamentary scrutiny.

I mention those things to point to the dilemma that has been created. In previous debates, as well as in this one, members have pointed to the fact that debate is central to discussion that we are having. This is not a constitutional debate, although it certainly engages issues around the constitution; it is a question about whether this Parliament should get to see complete legislation and the full implications of that legislation before it makes a decision.

21:45

Neil Gray: The Scottish Government has worked with Liam McArthur on amendments 86 to 89, 120, 121, 123 and 125, as well as amendments 101, 104 and 105, which are in group 8. Collectively, they would remove the sections of the bill that would require the Scottish ministers to specify, by regulations, the training, qualifications and experience of co-ordinating registered medical practitioners, independent registered medical practitioners and authorised health professionals. The amendments would also make other changes consequential on that removal.

As I have outlined previously, the Scottish Government's view is that the provisions in the bill might raise issues of legislative competence, as they might relate to the G2 reservation in schedule 5 to the Scotland Act 1998, which relates to the regulation of the health professions.

I have already set out our intention to address issues of legislative competence and our discussions with the UK Government, which has given an in-principle agreement to take forward a section 104 order and to consider and make appropriate provision to specify the training, qualifications and experience that are required for participating healthcare professionals.

Should the bill be passed, the Scottish Government will continue to engage closely with the UK Government on the form that that section 104 order will take. To respond to Mr Greer's direct question, I give my commitment that, should I continue to hold my current responsibility after the election, I will seek to keep Parliament informed.

As I turn to other amendments in the group, I remind members of my previous comments on the Parliament's responsibility to consider matters of legislative competence in passing legislation. On amendments 3 to 6, 145 to 147 and 156, the Scottish Government's view is that sections 4(5)(a), 6(6)(a) and 15(8), to which the amendments variously relate, might raise issues of legislative competence and should therefore be removed from the bill, with any necessary provision made instead through an order under section 104 of the Scotland Act 1998, should the bill be passed.

Amendment 133B, from a practical perspective, suggests using a section 104 order to confer a regulation-making power. It is considered that such an order cannot be used to confer regulation-making powers. Another vehicle would therefore be required to fulfil the requirements of amendment 133B, such as provision in an act of the UK Parliament. As I said in response to Mr McArthur's previous intervention, we do not have legal or competence concerns with amendments 133 and 133A.

On amendment 238, the Scottish Government's position is that it might raise issues of legislative competence as it would provide a power to set out the required training, qualifications and experience of health professionals. Amendment 239, which seeks to give power to the secretary of state, would be outwith the legislative competence of the Scottish Parliament, as the substance of the power is beyond competence. A specific power to confer such a regulation-making power on the secretary of state would need to be identified, such as by

way of a section 30 order, as has been done in connection with provisions to do with substances and devices.

The Scottish Government has no comment on the remaining amendments in the group.

The Deputy Presiding Officer: Members will note that, despite extending the previous time limit by 30 minutes, we will shortly reach the next time limit, and we still have a further group to debate. As a consequence, I am minded to accept a motion without notice to propose that the last sentence of rule 9.8.5A be suspended. I invite the Minister for Parliamentary Business and Veterans to move such a motion.

Motion moved,

That the last sentence of rule 9.8.5A be suspended.—[*Graeme Dey*]

Motion agreed to.

The Deputy Presiding Officer: Under rule 9.8.5A, I am minded to accept a motion without notice to propose that the time limit be extended by 30 minutes.

Motion moved,

That, under rule 9.8.5A, the time limit be extended by up to 30 minutes.—[*Graeme Dey*]

The Deputy Presiding Officer: The question is, that the time limit for debate on amendments be extended by 30 minutes. Are we agreed?

Kenneth Gibson (Cunninghame North) (SNP): No.

The Deputy Presiding Officer: We are not agreed.

Kenneth Gibson: I was in a committee meeting from 8.30 this morning, and I am exhausted, as are many other people. We have to pace ourselves over the next couple of days. We have had endless speeches, and we have not even had votes for a number of hours—it just goes on and on. Frankly, I think that it is unacceptable that the debate seems to keep being extended by 30 minutes, and I think that we should have a vote on it.

The Deputy Presiding Officer: I thank Mr Gibson for his intervention. I point out that I do not seek to extend proceedings by 30 minutes beyond 10 pm. What I need to do is extend the timeline, which is what the process has been.

Kenneth Gibson: Apologies; that was not clear.

The Deputy Presiding Officer: I could not hear that, Mr Gibson, but I assume that you are accepting my position as I have just stated it, which is all good.

Motion agreed to.

That, under rule 9.8.5A, the time limit be extended by up to 30 minutes.

The Deputy Presiding Officer: With that, I call Daniel Johnson to wind up and press or withdraw amendment 3.

Daniel Johnson: In the interests of Kenny Gibson's good humour, I have nothing further to add. I seek to withdraw amendment 3.

Amendment 3, by agreement, withdrawn.

The Deputy Presiding Officer: I remind members that, if amendment 86 is agreed to, I cannot call amendment 4 due to pre-emption.

Amendment 86 moved—[Liam McArthur].

The Deputy Presiding Officer: The question is, that amendment 86 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division. Members should cast their votes now.

The Presiding Officer (Alison Johnstone): The vote is closed.

Jackie Baillie: On a point of order, Presiding Officer. I apologise; I could not connect on the app. I would have voted yes.

The Presiding Officer: Thank you, Ms Baillie. We will ensure that that is recorded.

Craig Hoy (South Scotland) (Con): On a point of order, Presiding Officer. I apologise; I think that my app is as tired as Kenny Gibson. I would have voted no.

The Presiding Officer: Thank you, Mr Hoy. We will record your vote.

For

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Maggie (North East Scotland) (Green)
Clark, Katy (West Scotland) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dowey, Sharon (South Scotland) (Con)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Findlay, Russell (West Scotland) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)

Gallacher, Meghan (Central Scotland) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Golden, Maurice (North East Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McCall, Roz (Mid Scotland and Fife) (Con)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Sarwar, Anas (Glasgow) (Lab)
Slater, Lorna (Lothian) (Green)
Smith, Liz (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Whitfield, Martin (South Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Wishart, Beatrice (Shetland Islands) (LD)

Against

Adamson, Clare (Motherwell and Wishaw) (SNP)
Baker, Claire (Mid Scotland and Fife) (Lab)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Choudhury, Foysol (Lothian) (Ind)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gulhane, Sandesh (Glasgow) (Con)
Hoy, Craig (South Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Leonard, Richard (Central Scotland) (Lab)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
O'Kane, Paul (West Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Ross, Douglas (Highlands and Islands) (Con)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Villalba, Mercedes (North East Scotland) (Lab)
White, Tess (North East Scotland) (Con)
Whittle, Brian (South Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Balfour, Jeremy (Lothian) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Mountain, Edward (Highlands and Islands) (Con)

The Presiding Officer: The result of the division is: For 82, Against 29, Abstentions 5.

Amendment 86 agreed to.

The Presiding Officer: Amendment 145, in the name of Jackie Baillie, has already been debated with amendment 3. I call Jackie Baillie to move or not move amendment 145.

Jackie Baillie: Amendment 4 is first.

The Presiding Officer: For clarity, amendment 4 has been pre-empted, which is why I have moved on to amendment 145.

Amendment 145 moved—[Jackie Baillie].

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

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Choudhury, Foysol (Lothian) (Ind)
Clark, Katy (West Scotland) (Lab)
Ewing, Annabelle (Cowdenbeath) (SNP)
Gallacher, Meghan (Central Scotland) (Con)
Griffin, Mark (Central Scotland) (Lab)
Johnson, Daniel (Edinburgh Southern) (Lab)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mundell, Oliver (Dumfriesshire) (Con)
Regan, Ash (Edinburgh Eastern) (Ind)
Roddick, Emma (Highlands and Islands) (SNP)
Ross, Douglas (Highlands and Islands) (Con)
Sweeney, Paul (Glasgow) (Lab)
White, Tess (North East Scotland) (Con)

Whitfield, Martin (South Scotland) (Lab)
Whittle, Brian (South Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Balfour, Jeremy (Lothian) (Ind)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Bibby, Neil (West Scotland) (Lab)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Maggie (North East Scotland) (Green)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dowey, Sharon (South Scotland) (Con)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Duncan-Glancy, Pam (Glasgow) (Ind)
Eagle, Tim (Highlands and Islands) (Con)
Findlay, Russell (West Scotland) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Gulhane, Sandesh (Glasgow) (Con)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hoy, Craig (South Scotland) (Con)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Martin, Gillian (Aberdeenshire East) (SNP)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McCall, Roz (Mid Scotland and Fife) (Con)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
O'Kane, Paul (West Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Slater, Lorna (Lothian) (Green)
Smith, Liz (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Wishart, Beatrice (Shetland Islands) (LD)

Abstentions

Fraser, Murdo (Mid Scotland and Fife) (Con)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Mountain, Edward (Highlands and Islands) (Con)

The Presiding Officer: The result of the division is: For 21, Against 94, Abstentions 3.

Amendment 145 disagreed to.

Amendment 146 not moved.

Amendment 87 moved—[Liam McArthur].

The Presiding Officer: The question is, that amendment 87 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Chapman, Maggie (North East Scotland) (Green)
Clark, Katy (West Scotland) (Lab)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)

Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dowey, Sharon (South Scotland) (Con)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Eagle, Tim (Highlands and Islands) (Con)
Findlay, Russell (West Scotland) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Gallacher, Meghan (Central Scotland) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Golden, Maurice (North East Scotland) (Con)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Neil (Airdrie and Shotts) (SNP)
Greene, Jamie (West Scotland) (LD)
Greer, Ross (West Scotland) (Green)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hoy, Craig (South Scotland) (Con)
Hyslop, Fiona (Linlithgow) (SNP)
Johnson, Daniel (Edinburgh Southern) (Lab)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McCall, Roz (Mid Scotland and Fife) (Con)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
O'Kane, Paul (West Scotland) (Lab)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Sarwar, Anas (Glasgow) (Lab)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Villalba, Mercedes (North East Scotland) (Lab)
Whitfield, Martin (South Scotland) (Lab)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Wishart, Beatrice (Shetland Islands) (LD)

Against

Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Ind)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Choudhury, Foysol (Lothian) (Ind)
Duncan-Glancy, Pam (Glasgow) (Ind)
Ewing, Annabelle (Cowdenbeath) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Leonard, Richard (Central Scotland) (Lab)
Marra, Michael (North East Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
McNeill, Pauline (Glasgow) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
Regan, Ash (Edinburgh Eastern) (Ind)
Ross, Douglas (Highlands and Islands) (Con)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Wells, Annie (Glasgow) (Con)
Whittle, Brian (South Scotland) (Con)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Carson, Finlay (Galloway and West Dumfries) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gosal, Pam (West Scotland) (Con)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Kerr, Stephen (Central Scotland) (Con)
Mountain, Edward (Highlands and Islands) (Con)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
White, Tess (North East Scotland) (Con)

The Presiding Officer: The result of the division is: For 86, Against 25, Abstentions 10.

Amendment 87 agreed to.

After section 4

Amendment 147 moved—[Miles Briggs].

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

Members: No.

The Presiding Officer: There will be a division.

For

Adamson, Clare (Motherwell and Wishaw) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Ind)
Clark, Katy (West Scotland) (Lab)
Dowey, Sharon (South Scotland) (Con)
Eagle, Tim (Highlands and Islands) (Con)
Ewing, Annabelle (Cowdenbeath) (SNP)
Gallacher, Meghan (Central Scotland) (Con)

Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Hoy, Craig (South Scotland) (Con)
Johnson, Daniel (Edinburgh Southern) (Lab)
Kerr, Stephen (Central Scotland) (Con)
Leonard, Richard (Central Scotland) (Lab)
Mason, John (Glasgow Shettleston) (Ind)
McCall, Roz (Mid Scotland and Fife) (Con)
McNeill, Pauline (Glasgow) (Lab)
Mundell, Oliver (Dumfriesshire) (Con)
O'Kane, Paul (West Scotland) (Lab)
Regan, Ash (Edinburgh Eastern) (Ind)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Russell, Davy (Hamilton, Larkhall and Stonehouse) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Sweeney, Paul (Glasgow) (Lab)
Villalba, Mercedes (North East Scotland) (Lab)
Whitfield, Martin (South Scotland) (Lab)
Whittle, Brian (South Scotland) (Con)
Wishart, Beatrice (Shetland Islands) (LD)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Balfour, Jeremy (Lothian) (Ind)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Burnett, Alexander (Aberdeenshire West) (Con)
Chapman, Maggie (North East Scotland) (Green)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Duncan-Glancy, Pam (Glasgow) (Ind)
Findlay, Russell (West Scotland) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greer, Ross (West Scotland) (Green)
Gulhane, Sandesh (Glasgow) (Con)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kerr, Liam (North East Scotland) (Con)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lennon, Monica (Central Scotland) (Lab)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Marra, Michael (North East Scotland) (Lab)
Martin, Gillian (Aberdeenshire East) (SNP)
McAllan, Màiri (Clydesdale) (SNP)
McArthur, Liam (Orkney Islands) (LD)
McKee, Ivan (Glasgow Provan) (SNP)
McLennan, Paul (East Lothian) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Mochan, Carol (South Scotland) (Lab)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
Rennie, Willie (North East Fife) (LD)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Collette (East Kilbride) (SNP)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Greene, Jamie (West Scotland) (LD)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
Mountain, Edward (Highlands and Islands) (Con)
White, Tess (North East Scotland) (Con)

The Presiding Officer: The result of the division is: For 41, Against 70, Abstentions 8.

Amendment 147 disagreed to.

Section 4A—Registered medical practitioner unable or unwilling to act: duty to direct

Amendment 148 not moved.

The Presiding Officer: That concludes proceedings on amendments for this evening. Members will be aware that the Parliament is beyond the timetable that was agreed by motion earlier today. The Parliamentary Bureau will require to consider how business is rescheduled, as current progress suggests that we cannot meet the unanimously agreed timetable. The bureau will meet tomorrow.

Committee Announcement (Standards, Procedures and Public Appointments Committee)

21:58

The Presiding Officer (Alison Johnstone): The next item of business is a committee announcement. I call Ruth Maguire, deputy convener of the Standards, Procedures and Public Appointments Committee, to make an announcement on pastoral support for MSPs.

Ruth Maguire (Cunninghame South) (SNP): The Standards, Procedures and Public Appointments Committee wishes to draw members' attention to a matter relating to when an MSP is subject to a complaint.

As MSPs, we are office-holders rather than employees of the Parliament. However, there might be times when it would be appropriate for MSPs to have access to the pastoral support that any organisation should provide for its workers. Depending on the terms of a complaint, it might not be appropriate for a member to share information about a complaint or to seek support from those to whom they would ordinarily turn, such as individual colleagues, or from party structures. We understand that, when they are subject to a complaint, they might not find support from those usual structures.

The committee has advised the Scottish Parliamentary Corporate Body that the current telephone support line is wholly inadequate for the circumstances in which a member might find themselves when subject to a complaint. The Ethical Standards Commissioner's evidence to the committee last week was both powerful and unambiguous: members navigating a complaints process require robust, professional and trauma-informed support, and the present arrangements fall substantially short of that standard. Crucially, the commissioner confirmed that he raised those concerns directly with the SPCB earlier in this parliamentary session. The failure to respond meaningfully to those warnings represents a clear and troubling gap in the Parliament's duty of care to its own members.

As a committee, we wish to draw the attention of members to the fact that the SPCB is considering the issue. We hope that positive progress will be reported soon.

Decision Time

22:00

The Presiding Officer: As there are no questions to be put at decision time, I close the meeting.

Meeting closed at 22:00.

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