The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 17 November 2015

Session 4

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HEALTH AND SPORT COMMITTEE
31st Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr James Cant (British Heart Foundation Scotland)
Jim Hume (South Scotland) (LD)
Jordan Linden (Scottish Youth Parliament)
Anne McTaggart (Glasgow) (Lab)
Lindsay Paterson (Royal College of Physicians of Edinburgh)
Dr Sue Robertson (BMA Scotland)
Maureen Watt (Minister for Public Health)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 17 November 2015

[The Convener opened the meeting at 09:30]

Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill: Stage 2

The Convener (Duncan McNeil): Good morning and welcome to the 31st meeting in 2015 of the Health and Sport Committee. As I normally do at this point, I ask everyone to switch off mobile phones because they can interfere with the sound system, and to note that officials and members are using tablet devices instead of hard copies of the papers.

The first item on the agenda is stage 2 of the Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill. I welcome Jim Hume MSP, who is the member in charge of the bill, and his officials: Stephen Fricker, an assistant clerk in the non-Government bills unit; and Louise Miller, a solicitor in the office of the solicitor to the Scottish Parliament. I also welcome Maureen Watt, who is the Minister for Public Health, and her officials: Siobhan Mackay, policy executive, and Claire McDermott, bill team manager, both from the Scottish Government tobacco control team; David Wilson, a Scottish Government solicitor; and Meryl Skene, a parliamentary counsel in the Scottish Government.

Everyone should have with them a copy of the bill as introduced, the marshalled list of amendments, which was published on Friday, and the groupings of amendments, which sets out the amendments in the order in which they will be considered.

There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment, and to speak to all the other amendments in the group. Members who have not lodged amendments in the group but who wish to speak should catch my attention in the usual way.

If they have not already spoken to the group of amendments, I will invite the minister and then the member in charge of the bill, Jim Hume, to contribute to the debate before we move to the winding-up speech. The debate on the group will be concluded by my inviting the member who moved the first amendment in the group to wind up.

I take it that most people know the amendment procedure, so I will not go through it all.

Section 1—Offence of smoking in a motor vehicle with children

The Convener: Amendment 10, in the name of Malcolm Chisholm, is grouped with amendments 11 to 15. I draw members' attention to the pre-emption information that is shown with the groupings.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): Amendment 10 is the central amendment in the group, although it should be grouped specifically with amendment 15, which defines "driver", which is, of course, the central word in amendment 10.

As I am a loyal committee member, my starting point is the recommendation in paragraph 65 of the committee's report on the bill, of which I will quote a bit. It states:

> "the Committee is persuaded on balance that making the driver and the smoker liable for the offence is the sensible approach. This would bring this Bill into line with other duties on drivers (e.g. seatbelt legislation), be consistent with the approach south of the border, and provide added incentives to protect children from the harm of second-hand smoking in private vehicles."

As the committee did, I took the view that making the driver as well as the smoker liable would strengthen the bill and its central purpose, which is to protect children from second-hand smoke. Amendment 10 sets out the main thrust of all the amendments in the group.

Amendment 11 deals with the exception subsection, which is subsection (2) of section 1. Obviously, proposed new subsection (1A) includes the same exception. Amendment 14 would extend the proposed new subsection (1A) offence to section 1(5), which is the fine. Amendment 12 would extend the proposed new offence to section 1(4), which is to do with believing that the persons in the car are all adults.

I understand that the cabinet secretary will try to remove section 1(4). That complicates the debate, but I lodged amendment 12 to make sure that the new offence would apply to section 1(4).

I have also added a new defence in amendment 13. Paragraph 67 of the committee's report says:

> "ASH Scotland and the Scottish Coalition on Tobacco considered there should be a defence if the driver was unable to prevent another individual from smoking and the driver 'made all reasonable efforts' to prevent the offence. They also noted this would bring Scotland into line with similar provisions in Wales, England and Northern Ireland."

The committee will see the words "all reasonable precautions" in amendment 13. Although the central thrust of the amendments in the group is to make the driver liable in the same way as the smoker will be, amendment 13 also provides a specific defence for the driver, which seems to be only fair and reasonable.

The amendments in the group all hang together. I will listen with interest to the views of the minister and members of the committee before I decide whether to press them.

I move amendment 10.

The Convener: Thank you. As no other members want to take part in the debate, I call the minister.

The Minister for Public Health (Maureen Watt): Thank you convener. I will speak to amendment 10 and the other amendments in the group. I welcome the opportunity to set out the Scottish Government's position on amendments 10, 11, 12, 13, 14 and 15, which are in Malcolm Chisholm's name.

As has been said, amendment 10 would make it an offence for the driver of a car knowingly to permit another adult to smoke in the car when a child is present. I note that that is also highlighted as the preferred option in a number of submissions to the committee and was discussed in the stage 1 report, with a recommendation that such a change be made. We therefore carefully considered the need for the offence, particularly as reference was made to existing smoke-free legislation in the stage 1 report. Similar requirements exist in relation to workplace vehicles and public transportation in the Smoking, Health and Social Care (Scotland) Act 2005.

I am keen to achieve consistency with existing legislation when there is a good reason to do so. That said, I am not convinced that adding an offence to make the driver vicariously liable for the offence will provide further protection to children from the harms of second-hand smoke. I understand why reference has been made to existing smoke-free legislation, but it is worth noting that that requirement was introduced in the context of work vehicles and that the offence therefore applies to individuals who are acting in a professional capacity.

For example, it is right and proper for a taxi driver to intervene to stop a passenger smoking in the taxi. In such instances, they can rightly refuse to provide a service to the passenger in their professional capacity. That provision does not read across directly to private vehicles because the person who is driving is not acting in a professional capacity. Although I advocate that all passengers should seek to protect children from second-hand smoke by asking others not to smoke in the vehicle with them, applying an offence to the driver could be problematic. For example, is it reasonable to hold a young driver criminally responsible for the behaviour of his or her parents if they make a choice to smoke in front of a younger sibling?

Reference has also been made to seat belt legislation and the requirement for drivers to ensure that children under 14 who are passengers in their car wear a seat belt. However, that legislation does not make it the responsibility of the driver when another adult passenger in the car commits an offence by failing to wear a seat belt. Amendment 10 would make an adult responsible for another adult's offence.

There has also been reference to consistency with similar legislation that has already been introduced in England and Wales. The regulations there have a number of differences from the bill that has been introduced by Mr Hume. For example, they do not require that the offence can be committed only by an adult over the age of 18, so amendment 10 alone would not achieve consistency with the approach that has been taken in other jurisdictions in the United Kingdom. As the committee knows, the Scottish Government consulted on the policy before introducing the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill. That consultation invited respondents to suggest to whom the offence should apply. Sixty-two respondents commented on that, but only eight—13 per cent—suggested that it should apply to the driver.

It is important that we send a clear and consistent message that all adults are responsible for their own behaviour when it comes to protecting the health of children from second-hand smoke in cars. The person smoking should be responsible for committing the offence. There should be no confusion or uncertainty about who is ultimately responsible for an individual adult's decision to breach the law.

I note that amendment 14 would provide a statutory defence that would be specific to the driver. Given that I do not think that the driver should be made vicariously responsible for the offence, it follows that I do not support the defence that attaches to it.

However, some submissions suggested that the offence should be applied to the driver in order to provide an alternative defence to the one that is provided in the bill. The defence that would be provided by amendment 14 is problematic; application of such a defence would require consideration of what the "reasonable precautions" or "due diligence" might be in practice.

For those reasons, I ask the committee to reject amendments 10 to 15, which have been lodged in Mr Chisholm's name.

Jim Hume (South Scotland) (LD): Good morning to the committee and thank you for considering the bill at stage 2.

I set out my views on driver liability in my letter to the committee on 5 October, in response to its stage 1 report, and during the stage 1 debate. I have not been persuaded by the arguments that have been presented about consistency with the legislation elsewhere or the ban on smoking in public places.

I have four key arguments against driver liability. One is that such liability has the potential to distract the driver from the road, which could lead to an accident. To introduce driver liability would unhelpfully move the focus away from the harmful effects on children of exposure to second-hand smoke in a confined space, and it strays into the realm of traffic offences. A driver is not in the same position as the owner of licensed premises: he or she is a private individual, not someone who is running a business. He or she is also not necessarily in a position of authority in relation to other adults in the vehicle, in the way that a bus driver, for example, may be in relation to their passengers. Primarily, the proposals would add unnecessary complexity to a bill that is seeking to be as uncomplicated and easy to enforce as possible.

I thank Malcolm Chisholm for his amendments, but request that he consider seeking to withdraw amendment 10 and not moving the other amendments in the group.

Malcolm Chisholm: I thank the minister and Jim Hume. Jim Hume made some points on which I want to reflect further. On what the minister said, I need clarification—I probably will not get it today—about seat belt legislation, because the committee, in making its report, thought that the proposals would be consistent with seat belt legislation. Clearly, that is something that I, and perhaps the committee, will look at before stage 3.

The minister said that the driver's ability to enforce his or her will would be "problematic". That is, of course, the reason for the statutory defence in amendment 13. The minister said "amendment 14": that detail does not really matter, but one of us must be wrong.

Finally the minister referred to a young driver being criminally responsible, but the point of amendment 15 is to make it clear that "driver" means an adult. A 17-year-old driver would not be criminally responsible under my amendments.

Given that the member in charge of the bill has put forward substantial arguments that I want to reflect on, I will not press the amendments today, although I reserve the right to do so at stage 3.

09:45

Amendment 10, by agreement, withdrawn.

Amendment 11 not moved.

The Convener: Amendment 1, in the name of the minister, is grouped with amendments 2 and 3.

Maureen Watt: The bill aims to exempt vehicles that are being used as a person's home. I support Jim Hume's intention to ensure that the offence in section 1(1) does not apply in a person's home, but I believe that the description "living accommodation" more closely reflects a vehicle that is being used as such. It could include vehicles such as motor homes and caravans, but is not limited to those examples.

It is possible that other vehicles could be designed or adapted as living accommodation—for example, vans with a bed, kitchen or toilet facilities. However, it might not be necessary for it to have all those installations for a vehicle to be considered to be a person's home; there might be other installations or designs that would lead an enforcement officer to believe that a vehicle is being used as a person's home.

Amendments 1 and 2 are in line with Jim Hume's policy intention to exempt parked motor homes, caravans and other vehicles that are designed or adapted to provide living accommodation.

Amendment 3 will remove the test that, in effect, means that a vehicle must be parked

"for not less than one night"

before it can be considered to be a person's home and, thereby, be exempt from the offence in section 1(1). The test would be problematic to enforce. For it to be applied, enforcement officers would need to be certain for how long the vehicle had been parked or for how long it was intended that it would be parked. Removal of section 1(3) does not change the policy intention to exempt vehicles that are being used as living accommodation. Vehicles that are parked and being used as such will be exempt from the offence.

I move amendment 1.

Jim Hume: Amendments 1 to 3 are straightforward and provide a clearer definition of vehicles that are to be exempted. The phrase "living accommodation" more accurately reflects the policy intention. The deletion of subsection (3) from section 1 will remove any difficulty for enforcement agencies in determining what constitutes

"not less than one night".

Therefore, I am grateful to the minister for lodging the amendments, which I am happy to support.

Amendment 1 agreed to.

Amendments 2 and 3 moved—[Maureen Watt]—and agreed to.

The Convener: Amendment 4, in the name of the minister, is in a group on its own. I remind members that, if the amendment is agreed to, I cannot call amendment 12, because of the pre-emption that I spoke about earlier.

Maureen Watt: Amendment 4 removes the defence that the person smoking

> "reasonably believed all other occupants of the vehicle to be adults."

It is difficult to envisage what steps a person might take, beyond asking for proof of age, to prove that they reasonably believed all occupants to be 18 or over. Even if such a step were to be taken, it would be difficult to establish that such proof had been asked for or, indeed, had been supplied. In any case, such steps have a disproportionate impact.

I recognise that, in its stage 1 report, the committee asked the Scottish Government to consider the alternative defences that were supplied in written evidence. I note that many of the suggestions relied on asking the age of the child where there was any doubt. Although that would be prudent, the same problems occur with trying to prove that that had taken place. It is worth noting that many of those who submitted written evidence did not believe that there should be a defence of not knowing the child's age.

A number of offences exist in statute whereby an adult commits an offence when they act in a way that harms the health of a child or, indeed, when their failing to act harms the child. In its consideration of the bill, the committee has referred to the requirement for drivers to ensure that children under 14 who are passengers in their car wear a seat belt. There is no defence attached to that in respect of whether the driver could have known that the child was under the age of 14, and neither does such a defence exist in relation to the offence of a person purchasing alcohol or tobacco on behalf of a young person who is under the age of 18.

A similar offence has been included in the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, which is currently being considered by the committee. The provision in question will make it an offence for someone over the age of 18 to purchase a nicotine vapour product on behalf of a person who is under the age of 18. Again, there is no defence relating to whether an adult could reasonably know the age of the child. I therefore see no reason why a defence of that nature should apply to the offence in section 1. Adults must take responsibility and, if in doubt, should not smoke in a car when a person who might be under 18 is present.

I move amendment 4.

Jim Hume: I support the Scottish Government's amendment to remove the defence, and I am grateful for its consideration of the issue.

Amendment 4 agreed to.

Amendments 13 and 14 not moved.

Section 1, as amended, agreed to.

Section 2 agreed to.

Schedule—Fixed penalty for offences under section 1

The Convener: Amendment 5, in the name of Jim Hume, is grouped with amendments 6 to 8.

Jim Hume: I record my thanks to the minister and her officials for the continuing spirit of partnership that has enabled us all to get to this point.

The schedule to the bill, as introduced, allows for the fixed-penalty regime to be enforced solely by Police Scotland. However, during stage 1, it became clear that there is wide-ranging support for a joint enforcement regime between Police Scotland and local authorities, and both the Scottish Government and I have been persuaded by that argument.

As a result, amendment 5 seeks to replace the current schedule with a new one that provides for joint enforcement between Police Scotland and local authorities, thus strengthening the bill. I have worked closely with the Scottish Government on revising the schedule to make it as similar as possible to schedule 1 to the Smoking, Health and Social Care (Scotland) Act 2005. That will make enforcement simpler for the police and local authorities, as they are already familiar with the fixed-penalty regime that applies under the 2005 act.

In particular, the new schedule provides for fixed penalties to be paid to the local authority of the area in which the offence was alleged to have been committed or to a person acting on its behalf, rather than to the clerk of court. Other references to "the clerk of court" in the schedule have been replaced in amendment 5 by references to "the local authority". Despite the fixed-penalty regime being modelled on that in the 2005 act, paragraph 4 of the new schedule maintains the fixed penalty for an offence at £100 and allows a payment period of 29 days, with no provision for an early payment discount. I am pleased that the Scottish Government has accepted my position on the matter, and I should add that there is provision for Scottish ministers to amend the value of the penalty by regulations.

Amendment 6 seeks to insert a new section to reflect the joint enforcement regime, granting entry and search powers to authorised officers of a local authority and allowing them to obtain the name and address of a person whom they reasonably believe might be committing, or might have committed, an offence under section 1 or whom they reasonably believe to have information relating to such an offence. Those powers are based on similar powers available to local authority officers under the 2005 act.

Amendment 7, in the name of the minister, gives ministers various ancillary powers to make regulations and sets out the procedures to which regulations made under the bill will be subject. Proposed new subsection (3) reflects the Delegated Powers and Law Reform Committee's recommendation that regulations under paragraph 11(b) of the new schedule, in relation to keeping of accounts, be subject to the negative procedure. Amendment 8 is a consequential amendment.

I move amendment 5.

Maureen Watt: I will speak to amendment 7 in my name and the other amendments in the group.

In the memorandum that the Scottish Government sent to the committee in March 2015, we made clear our support for amendment 5 in Jim Hume's name, which suggests that a joint approach to enforcement between local authorities and Police Scotland be considered in respect of the bill. Environmental health officers have played a vital role in supporting the implementation of existing smoke-free legislation, which, I am sure we would all agree, has been a success. A primary aim of this bill is to protect the health of children by reducing their exposure to second-hand smoke. In that respect, the protection of public health is fundamental to the role of environmental health officers in Scotland and they would bring with them a wealth of experience. It makes sense that Police Scotland, too, has a role to play, as it has powers to stop a moving vehicle, while local authorities could enforce the offence in respect of stationary vehicles.

However, although enforcing the offence in section 1(1) will be important, the bill's aims cannot be achieved by enforcement alone. This is all about promoting a change in cultures and attitudes. The harms caused by exposure to second-hand smoke are widely understood and therefore the majority of adults choose not to smoke in their homes and cars when children are present. Last year, we developed and launched to a positive reception our national take it right outside campaign, which aimed to raise awareness of the risks posed to children by second-hand smoke. Our evaluation of the campaign showed that although it had had an impact on behaviour more needed to be done to drive home the message that it is never safe to smoke in enclosed spaces with children present, and we relaunched the campaign last month with a stronger message to take account of the evaluation's findings.

It is my belief that the introduction of the offence in section 1(1) will provide a deterrent and continue to promote that key message. We know that there has been a significant change in behaviours and attitudes since the introduction of smoke-free legislation in 2006. Enforcement in respect of that legislation was measured, and we would anticipate the same approach being taken to the proposals in the bill.

I am pleased, therefore, that amendment 5 provides similar powers to local authorities in respect of enforcement and the administration of fixed-penalty notices to those provided in the Smoking, Health and Social Care (Scotland) Act 2005. That will allow for a consistent approach, albeit with a higher level of fine and no early payment reduction—although I believe that such differences reflect a higher level of complexity in enforcing the offence. Taking a similar approach will help to avoid difficulties associated with operating different enforcement regimes for different smoking-related offences.

The committee asked the Scottish Government to consider additional costs to local authorities associated with enforcing the provisions in the bill. The financial memorandum accompanying the bill calculates the likely number of fixed-penalty notices to be around 200 per annum. We would not expect that to rise as a result of local authority enforcement. The Scottish Government already provides £2.5 million a year to local authorities as part of their baseline grant to enforce current smoke-free legislation. My officials have met the Convention of Scottish Local Authorities and environmental health officers, and those discussions have raised the potential for modest one-off additional costs associated with training, guidance and producing fixed-penalty notices.

I support amendment 6, because without powers to search and enter private vehicles, local authorities would be unable to enforce the offence effectively. It is therefore essential that such powers are provided. It is also right that those who are committing or who have committed an offence, and those who might have helpful information but who fail to provide local authority officers with their name and address without reasonable excuse are deemed to be committing an offence. Otherwise, the legislation could be easily circumvented.

10:00

Amendment 7 in my name reflects the proposed replacement schedule that will be inserted into the bill by Jim Hume's amendment 5 to provide local authorities with enforcement powers. Changing the procedure for regulation-making powers under paragraph 11(b) of the replacement schedule pertaining to the keeping, preparation and publication of fixed-penalty notice accounts from affirmative to negative reflects the recommendation made by the Delegated Powers and Law Reform Committee, and I ask members to support amendment 7.

Nanette Milne (North East Scotland) (Con): I welcome these amendments, which clarify the local authority's role in enforcing the legislation, because I think that everyone agrees that enforcement is one of the key issues with the bill. There now appears to be agreement that Police Scotland and local authorities should take a joint enforcement approach. I hope that the clarity that the amendments bring to enforcement and the public information activity to raise awareness of the legislation that the Government has said that it intends to undertake will result in the desired change in behaviour to protect children from the effects of smoke in the enclosed space of a motor vehicle.

However, the Scottish Conservatives indicated at stage 1 that it was our intention to introduce an amendment to provide for post-legislative scrutiny of the measures to prohibit smoking in motor vehicles with children present. We will therefore propose at stage 3 a sunset clause to test the effectiveness of the legislation after it has been in place for a reasonable length of time, such as three years.

I support amendments 5 to 8.

Maureen Watt: On the point about a sunset clause, we understand the desire to review whether children's exposure to second-hand smoke has been reduced and the number of young people who are taking up smoking. Figures on the number of people smoking are continually monitored in other ways. We have monitored such figures since the start of our take it right outside campaign and continue to do so, and as a result, we refined the message when we relaunched the campaign this year.

Jim Hume: I thank Nanette Milne and the minister for their comments. I have to say that, at this stage, I am not persuaded that we need a sunset clause. There is clear evidence from other countries of the damage that second-hand smoke does to children and that legislation has led to the change in culture to which the minister referred. The bill is about promoting a change in culture and protecting children from the dangers of second-hand smoke in cars, which are well documented in scientific evidence. We know that every week 60,000 children in Scotland are exposed to second-hand smoke, and I believe that the amendments that we have discussed will strengthen the bill.

Amendment 5 agreed to.

Schedule, as amended, agreed to.

After section 2

Amendment 6 moved—[Jim Hume]—and agreed to.

Section 3—Interpretation

Amendment 15 not moved.

Section 3 agreed to.

Section 4—Regulations

Amendment 7 moved—[Maureen Watt]—and agreed to.

Section 4, as amended, agreed to.

Section 5—Commencement

Amendment 8 moved—[Jim Hume]—and agreed to.

The Convener: Amendment 9, in the name of the minister, is in a group on its own.

Maureen Watt: There can be no doubt that we all have a responsibility to protect children from tobacco smoke; indeed, that is why last month I relaunched the take it right outside campaign, which aims to raise awareness of the risks posed by second-hand smoke to children. However, as this is an important new law, I have committed to running a national campaign to raise awareness of the new offence. It is vital that any campaign is aligned with the timing of the bill's commencement, and amendment 9 will allow Scottish ministers to commence the legislation when the campaign has been developed and launched. I have already made clear my commitment to implementing this important legislation as quickly as possible, but I reiterate that now for the avoidance of any doubt.

I move amendment 9.

Richard Lyle (Central Scotland) (SNP): As everyone knows, I smoke. I also welcome the bill, as I am sure that it will help to reduce children's smoke inhalation. However, I ask the minister to make our campaign much better than what I have seen of the English campaign, which I do not think conveys the message forcefully enough.

The Convener: I call Jim Hume to wind up—I am sorry; I mean that I call Jim Hume to speak. The minister will wind up.

Jim Hume: I am always happy to wind up, but it is usually other people I like to wind up.

I am happy to support the amendment and I welcome the minister's public commitment again today to ensuring that the provisions will come into force as quickly as possible. At the time of drafting, I did not put the commencement date in the hands of the ministers as I was not clear at that stage whether the Scottish Government would support the bill. Having received the Government's clear support and having worked constructively with it, I think it sensible to give ministers flexibility with regard to when the provisions come into force so that they coincide with the campaign.

Maureen Watt: In response to Richard Lyle, I have not seen the campaign that is being run in England, but I think that, as initial results show, our take it right outside message has been very forceful. We have shown that smoke lingers for up to seven hours in a room and that it gets under doors and in through windows, and the campaign has also used the picture of a child's lungs. All those facts and images are very forceful, and I hope that our campaign in relation to smoking in cars will be equally effective.

I ask the committee to support amendment 9.

Amendment 9 agreed to.

Section 5, as amended, agreed to.

Section 6 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. Members should note that the bill will now be reprinted as amended. Parliament has not yet determined when stage 3 will take place, but members are able to lodge stage 3 amendments at any time. Members will be informed of the deadline for amendments once that has been determined, and I thank Jim Hume, the minister and her team for attending this morning.

I briefly suspend the meeting.

10:08

Meeting suspended.

10:12

On resuming—

Subordinate Legislation

General Dental Council (Indemnity Arrangements) (Dentists and Dental Care Professionals) Rules Order of Council 2015 (SI 2015/1758)

The Convener: Agenda item 2 is consideration of two negative instruments. On the order of council, no motion to annul has been lodged and the Delegated Powers and Law Reform Committee has made no comments. If members have no comments, does the committee agree to make no recommendation on the order?

Members *indicated agreement.*

Natural Mineral Water, Spring Water and Bottled Drinking Water (Scotland) Amendment Regulations 2015 (SSI 2015/363)

The Convener: Again, no motion to annul has been lodged on these amendment regulations and the Delegated Powers and Law Reform Committee has made no comments. If members have no comments, does the committee agree to make no recommendation on the regulations?

Members *indicated agreement.*

The Convener: Thank you. At this point, we should move on to agenda item 3, which is our evidence session on the Transplantation (Authorisation of Removal of Organs etc) (Scotland) Bill. However, as we are a bit ahead of time, I propose that we take agenda item 5 now and go into private session to make some progress on our draft report on palliative care. Do members agree?

Members *indicated agreement.*

The Convener: Thank you. We will now move into private.

10:14

Meeting continued in private.

10:43

Meeting continued in public.

Transplantation (Authorisation of Removal of Organs etc) (Scotland) Bill: Stage 1

The Convener: The next agenda item is our first evidence session on the Transplantation (Authorisation of Removal of Organs etc) (Scotland) Bill. As members will be aware, Richard Lyle and I were in Madrid yesterday to meet the Spanish national transplantation organisation—the ONT—and transplant co-ordinators. I extend my thanks to all those whom we met; in particular, I thank Dr Rafael Matesanz for his time and assistance with the visit. I think that I can speak on behalf of us both when I say that the visit was useful. A summary of our discussions will be provided to the committee in due course.

I also thank all the MSPs and members of the public who have attended our informal meetings during the past two weeks, when committee members met transplant recipients, organ donors' families and faith and belief groups. Those meetings were informative and we are grateful to everyone who came along to them and gave their time to engage with us, especially the transplant recipients and donor families, who shared some very serious experiences with us. A note of the meeting with transplant recipients is now available on the committee's website, and notes of the other two meetings will be available in the coming days.

Before I introduce the witnesses, Richard Lyle wishes to make a declaration.

Richard Lyle: For reasons of openness and transparency, I declare that Jordan Linden, one of the witnesses, works for me.

The Convener: I welcome our witnesses. Dr Sue Robertson is a member of the British Medical Association's Scottish council and a renal physician in Dumfries; Jordan Linden MSYP is chair of the Scottish Youth Parliament; Lindsay Paterson is policy manager at the Royal College of Physicians of Edinburgh; and Dr James Cant is director of the British Heart Foundation Scotland. I also welcome to the committee Anne McTaggart, the member in charge of the bill, who will have the opportunity to ask questions at the end of the session.

We are not expecting any opening statements, so we will move to our first question, which is from Malcolm Chisholm.

Malcolm Chisholm: Thank you, convener. I want to home in on the conversation between the specialist nurse—or whoever is having the conversation—and the relatives about whether an organ should be donated. That seems to be very much at the centre of many of the debates and disagreements about the bill. My understanding of the bill is that such a conversation will always take place, although there are complications around the role of the proxy, but others will probably ask about that.

I note that the BMA says:

> "the model we have been arguing for is a 'standard' opt-out model whereby if an individual has not registered an objection and those close to the patient are not aware of any unregistered objection, the organs may be used for donation",

whereas the RCPE says:

> "Changing the role of the family to one limited to being consulted on whether they are aware of any (unregistered) objection by the deceased rather than asking for their views and consent has the potential to be highly emotive and divisive."

That conversation seems to be central to whatever system we have, so I am really interested in the difference between the two points of view. Obviously, if the other witnesses also have views on that, I am interested to hear them.

Lindsay Paterson (Royal College of Physicians of Edinburgh): Thank you for the question. This is one of the key issues in the debate about organ donation. We have a variety of fellows across different specialties, some of whom work in intensive care or are renal care or liver care physicians and so on—they work at all different stages of the potential process in organ donation.

Through our conversation with our fellows, it has become apparent that at a stressful time, such as when there has been a totally unexpected traumatic accident, a family who is visiting a patient at what might be the end of their life will obviously be upset. Conversations around organ donation must be sensitive at a time when a family is potentially very stressed and everything is happening very quickly. A clinician who is caring for the patient and talking to the family would find it very difficult to go against the family's wishes at that particularly distressing time. At the moment, clinicians seek families' consent for organ donation, and that is viewed as a key part of the process.

Dr Sue Robertson (BMA Scotland): That is a very distressing time, as we are all aware. The BMA represents doctors from many different disciplines, and we have a slightly different approach to the situation. If the public debate is had and the bill is passed, that will give people throughout society an opportunity to discuss their views with their family and will perhaps remind people that they should do that.

In an opt-out system, people will have the opportunity to opt out, and if they opt out their family will not even be approached. That will protect the views of someone who wishes to opt out of organ donation, and it will also mean that if that person has not opted out, their family will likely be aware of their views. If the person has not got round to opting out, but the family is aware that they do not wish their organs to be donated, the family will be given the option to inform the team at that time.

Approaching the family at that time must be done delicately and by someone who has as much knowledge as possible of the situation. It could be easier on the family if the person who approaches them says, “We are not aware that the patient has any objections to their organs being donated. Therefore, unless you know that they had any objections, we would like to progress this and help somebody benefit from this sad situation.” I think that the families would find that an easier conversation to have than the conversation that they have at present.

The Convener: Mr Linden?

Jordan Linden (Scottish Youth Parliament): I do not have anything particular to say on that. That is something for our medical colleagues to answer.

The Convener: Fine—do not feel pressured. Dr Cant?

Dr James Cant (British Heart Foundation Scotland): Thank you. I apologise for the state of my voice this morning—bear with me, please.

My colleagues described two absolutely vital scenarios, which are not necessarily contradictory. The initial scenario could be one that we have at the beginning of the process. Over time, we may move to a situation in which there is more of an on-going narrative within families and society.

At the moment, we have a cadre of specialist nurses who absolutely have the clinical and interpersonal skills to have those conversations. Any system that we move towards must protect their vital bond and relationship with families, but also enable them to have the conversation. It is quite telling that, when we look at international comparisons, we see that the countries that are doing this best are those where there is an absolute priority on having these conversations in emergency departments and scenarios where death is certain. We need to make that much more part and parcel of the way in which we engage with families and patients.

Malcolm Chisholm: That was all very helpful. I imagine that most of us—indeed, probably all of us—are trying to reduce the family refusal rate, because doing so would provide more organs. The British Heart Foundation says:

> “There is a yawning gap between the wishes of Scots and the follow through to action, not helped by nearly a 50% family refusal rate.”

Do we have a breakdown of the percentage of refusal when someone is on the register and the percentage of refusal when someone is not on the register?

Dr Cant: I do not have that information. I will get it, if possible, and get it to the committee.

Malcolm Chisholm: That is quite an important point, because I imagine that everyone shares the objective of reducing the refusal rate and getting more organs for donation. I suppose that some people have ethical objections, but a lot of people will take a pragmatic view. We would assume that there is a lower refusal rate for those who are on the register than for those who are not, but it would be interesting to know that.

The Convener: Does anyone else f to respond to Malcolm Chisholm’s question? Are there any figures? It seems not. Rhoda Grant wants to ask a supplementary question.

Rhoda Grant (Highlands and Islands) (Lab): To my mind, the bill changes the nature of the conversation at a time when someone is a potential donor from asking for permission, so that ownership of the person’s body passes on to their family, to asking for information from the family about the person’s wishes, so that ownership remains with the person who will be the donor. Obviously, if the person has opted out, their family cannot then opt them in. Currently, it is very difficult to opt out, and that decision is left. The bill will change the nature of the possession of the body and the donor organs.

That raises a question. What if a family is very much against organ donation? Do you foresee situations in which a family is asked whether they know about their loved one’s wishes and they say no, but they object to organ donation for religious reasons or whatever? I cannot foresee a situation in which a clinician would then go against the family’s wishes if that would cause them real distress, as opposed to a situation in which we have a different conversation, if we take things that bit further.

Dr Robertson: You make a very good point. The BMA in Scotland is certainly very clear that, if the person involved in that conversation felt that it would cause dreadful distress to the family to go ahead, there should still be an opportunity for the family not to donate. When we look after patients, we also look after their families, and we are very aware of their distress in such situations. We feel that some situations would cause families undue distress, and we feel that the bill should allow us not to go forward in those situations.

Jordan Linden: I will offer a comment on how we can avoid such situations. It comes down to avoiding misunderstandings and having those conversations in the first place. James Cant spoke about how discussions will change and how families and those involved can have those discussions. This might touch on something that will be raised in the discussion that we might have later about the campaign that will be launched. When people have the information that they need, they can address it and discuss it further to allow them to erode some of the potential for misunderstandings.

The Convener: What in the existing legislation prevents that discussion from taking place? How will the bill ensure that there are more discussions?

Jordan Linden: As young people, we would be keen for publications or campaigns to be young person friendly and engage with young people. Young people should feel that they can associate themselves with the information that they can access.

The Convener: Why would we need legislation to run an information campaign?

Jordan Linden: I meant information on the new proposal—

The Convener: It is good to have discussions and to raise awareness, but we are considering whether the existing legislation needs to be strengthened. What prevents those discussions from taking place now, under the existing legislation? How would more discussions, and more organ donors, result from a change in the legislation?

11:00

Dr Robertson: There is no doubt that more information and more discussion are always welcomed within organ donation. The more people are stimulated to talk with their families about what their wishes are in the sad event of their death, the better. That sort of thing should be going on anyway, and we are encouraged that it continues to go on and—if anything—has become stronger.

At the same time, we think that a move to an opt-out system would mean society moving, with organ donation eventually becoming the norm rather than the exception. As a result, more organs would be available to transplant into patients who need them.

The Convener: We can come back to the question whether the evidence across the world shows that the opt-out system has increased organ donation. At this point, we are looking at the situation under the existing legislation and whether we need the bill to have an information campaign.

Lindsay Paterson: The college's view is that public education and public awareness are key components that need to be taken forward, aside from legislation. Families should be having conversations about potential organ donation. That would mean that when an unexpected accident happened—something very tragic—people at that very stressful time would be aware that they had had that discussion with their family member. Awareness raising among the public is vital.

The Convener: Accidents have been mentioned a couple of times. Where do the majority of our organ donations come from? Do they come from accidents?

Dr Robertson: I do not have the statistics to hand, but we could easily get them. There are a mixture of reasons for sudden deaths. Accidents are one but there is also cerebral haemorrhage—brain haemorrhage.

The Convener: What is the average age of a donor?

Dr Robertson: Again, I do not have that figure. It would depend what organ you are talking about.

Nanette Milne: I seek clarification about the appointment of proxies. When we met the donor families, they seemed concerned that the provision would complicate the system and could possibly delay organ donation, to the extent that organs that would have been useful may no longer be useful. I have also heard it said that the provision is in the bill because it is in the Human Transplantation (Wales) Act 2013 and that it may not be necessary. What are the witnesses' views?

Dr Cant: I look on the proxy role as being similar to the role of an executor. We have perhaps looked to the Welsh example for some guidance. I recognise the concerns that you raise about having a system that is sufficiently timely, is not overly bureaucratic and does not encumber the process. We have to strike a balance between clinical need and the protection that would be relevant for people in particular sections of society who may be estranged from their families. Careful consideration would require to be given to achieving that balance as we move forward. I think that the Scottish Youth Parliament can offer some important insights into particular groups in society for whom the role of proxy would perhaps be more important than for the rest of us.

Jordan Linden: I thank James Cant very much for that. The Scottish Youth Parliament is supportive of the option to appoint a proxy. Our position is based on the research that we did with young people. In our survey, 10 per cent agreed a little, and 70 per cent agreed completely, with the proposal to allow the appointment of a proxy. People are in diverse situations and it is our belief that the proposal gives people more options. In particular, it gives young people aged 16 or over more freedom to choose what happens to their body after death.

A young person on the focus group said:

> "Young people should be given options. They would know best who should help make the final decision after their death, and it would be their decision to choose a proxy or not."

We believe that the option for those aged 16 to 18 to appoint a proxy is in line with article 12 of the United Nations Convention on the Rights of the Child, which requires young people's views and wishes to be respected and taken into account.

James Cant mentioned particular groups. We believe that the option to appoint a proxy is especially necessary for those aged 16 to 18 who are in care and may not feel comfortable with their nearest relative or legal guardian making the final decision about what happens to their body after their death. Our belief is shared with the centre for excellence for looked after children in Scotland. That is the Scottish Youth Parliament's position.

Dr Robertson: The British Medical Association does not object to the idea of a proxy, for exactly the reasons that Nanette Milne gave. Although there are situations in which we believe that it would be very worthwhile, we are mindful of the need to try to keep the system as simple as possible, as the proposal brings a complexity to the situation that would not otherwise be there.

The provision on proxies certainly merits further discussion. There is a place for a proxy in certain situations, but there is a clinical need to ensure that the process operates in a timely fashion. It would be nice if the system was similar to that in the other countries in the UK, because we have a UK transplant population, but the system for Scotland certainly needs to be simple and to have the safeguards that Nanette Milne described. It is a difficult issue.

Lindsay Paterson: Our fellows have mixed views on proxies, but there are certainly a number of reservations, one of which relates to the time element. If an individual may appoint up to three proxies, we need to consider the time that it will take to contact them and the reliability of the database on which the proxy information will be kept, which will always need to be kept up to date. Also, there is potential for conflict if a proxy has different views from the immediate family who are at the patient's bedside. There are some reservations about those aspects.

Nanette Milne: My understanding is that the proxy's details will have to be provided either on the register or otherwise in writing and that the deceased person will have had to sign to confirm. How should the system for the appointment of proxies work?

Lindsay Paterson: I note that the bill—or the policy memorandum, perhaps—says that proxies will not need to be informed beforehand about, and consent to, their listing as a proxy. If somebody is unaware that they are a proxy, that could add to the time problem. That does not fully address your question, but it is an extra element that should be considered.

Nanette Milne: In the proposed system of soft opt-out, are proxies really necessary? Would the system work well without them?

Dr Robertson: If the campaign is done well and the public education is excellent—as it should be for any such change in legislation—we would hope that, with time, proxies will not be required, because the overarching aim is to find out the individual's wishes in the event of their death. However, people might feel that having proxies is an important safeguard for certain groups, such as younger members of society and people who are alienated from their families.

The Convener: I have a question about campaigns; in fact, I have a bee in my bonnet about the issue. People accept that campaigns are good for raising awareness, and we have been told in evidence that they can be very successful and have in some cases doubled donation rates. However, they can also be divisive; they can split doctors and communities and they do not always lead to better outcomes. Have you looked at any evidence about the public campaign and educational awareness and found a sustainable benefit with regard to increased donations?

Dr Cant: You will probably find no one suggesting at any point that soft opt-out will be the magic bullet to cure the problem. I suspect that what you will have seen in Spain—and what we have seen through international comparators—is that it has to form part of a far wider campaign with a far wider emphasis on multidisciplinary and interlinked services. It is only with that working-together approach that we can really hope to increase the number of organs that are being made available and being facilitated for transplant use.

What my research colleagues in the BHF in London have not been able to find much, if any, evidence of is a significant increase in transplant rates in which soft opt-out has not featured as a component. I accept that the evidence base is mixed, but our organisation's belief is that soft opt-out has to form an important part of the multifaceted approach that we would have to take.

The Convener: The Spanish soft opt-out involves final reference to the family. If the family objects, the organ donation does not go ahead.

Dr Cant: I think that this comes back to your earlier conversation with Dr Robertson. Moving the legal framework might change the implication subtly. If the de facto framework changes, it will probably have a significant, long-term effect on the type of conversations that are had and societal expectations. However, I think that you are absolutely right to point out the fact—I think that Dr Robertson was keen to point it out as well—that we are dealing with people and families at the most distressing time in their lives and that, whatever system we have, compassion has to come through.

Bob Doris (Glasgow) (SNP): I want to pursue the role of the proxy a little bit more and then come back to the conversation that currently takes place and whether legislation would or would not change that, because those two things could be linked.

The question that came into my head in relation to a proxy was about time delays that might be built into the system as an unintended negative consequence of passing a bill that includes the proxy role. Does anyone have any concerns in relation to how easy it would be to locate a proxy? After all, a proxy will be available to give an informed view only if they can be located. Has any thought been given to that issue and how long we should wait until we do that?

Dr Robertson: It is difficult to be specific in that respect. We sometimes have to try to locate families because, as Lindsay Paterson has made clear, such situations happen without any warning, and sometimes that can be very difficult. The way in which our society lives, we do not necessarily live in the same place that our families do. We might find it easier to locate a proxy for a person if the proxy is someone who is particularly close and the person in question is estranged from their family. The proxy issue is a concern because of the time delay, but locating a family can often involve delay, too.

Dr Cant: I refer you back to my answer to Nanette Milne, which was that anything that would undermine or prevent a timely process is something that we would have to seriously consider. This system has to be practical and, as Jordan Linden indicated earlier, a proxy might be more important for some groups in society than for others. It might well be that we could consider that as a particular element in, for example, the case of looked-after children. However, we are looking to establish a system that strikes the correct balance between respecting an individual’s wishes and having a more efficient transplant system, and we would have to look at anything that would in any way jeopardise timeliness.

11:15

Lindsay Paterson: Reiterating a number of points that Dr Robertson has made, I believe that time is of the essence when making decisions about organ donation. Decisions often have to be made in a number of hours and, if it is necessary to contact proxies and families, there is no guarantee that we will be able to get hold of anyone in that timeframe. My concern is about trying to contact a number of different proxies and ensuring that a database is kept up to date. Of course, there is no guarantee that the details of the family would be to hand either but, because the time constraints are so tight, trying to get hold of proxies in time is a concern.

Bob Doris: That is helpful.

You have talked about ensuring that any database of proxies is kept up to date and that, in some circumstances, it might be easier to locate the proxy than a family member. Should we not try to locate the proxy as well as the next of kin? Should there be a duty to do both things, or would that build in delay?

Secondly, should the active choice of a proxy stay valid? If I were to nominate a proxy today, would that choice still be valid in 15 years’ time if I had not bothered to change it? Should proxies be valid for one year, two years, five years or whatever? I would appreciate some views on that.

I hope that the witnesses are taking notes, because I have a third question that I am keen to get their views on. What would happen if the proxy and the family member had strong disagreements about what the individual wanted? That is where I will come in with my next question, which relates to the conversation between transplant co-ordinators and families or proxies.

I know that there was a lot in those questions, but I would appreciate it if the witnesses could put on record something about the time delay, whether proxies should stay valid for one year, two years or three years and what would happen if conflicts arose.

Dr Cant: Your suggestion of potentially time limiting the validity of a proxy seems eminently sensible.

In an ideal world, people would look to contact the proxy and the family, but, thinking about the matter in practical terms and going back to the example of looked-after children, I would say that one of the reasons why people might opt for a proxy could be that, in the event of their death, they did not want both the proxy and the family to be contacted. That wish would have to be factored in and respected. However, you are right to highlight the complexities of developing a system that has efficiency and equity but which also allows matters to be dealt with in a timely fashion.

Jordan Linden: Mr Doris's first two questions are for my colleagues but, on the question of conflict, I will share with the committee the views of the young people to whom we in the Scottish Youth Parliament spoke. A significant number of participants agreed that the role of the family should be limited, with 20 per cent saying that they agreed a little and 60 per cent saying that they agreed completely. In fact, that was one of the highest levels of agreement in the survey.

We should be fully aware of the difficulty here. James Cant put it eloquently when he said that we had to have compassion as human beings and recognise the time that the family members are going through. The young people to whom we spoke expressed the need for a young person's decision to be final on the matter. One young person said:

> "It should always be the decision of the deceased person rather than that of the family."

If there is conflict, young people's voices and views should be final on the matter. That is what it comes down to for us.

Dr Robertson: Most of the points that I wanted to make have already been made.

However, I will say that getting in touch with the proxy and the next of kin would be the ideal, and we would hope that that would be done, if at all possible. The fact is that when someone falls ill or is dying and the whole family comes in, the family members will not necessarily agree. There will always be potential for disagreement. That is one of the issues that specialist organ donation nurses are trained to deal with; they can try to help the family come to some agreement about a way forward that the individual would want in the event of their death. We go back to the issue being the wishes of the person who has died with regard to what should happen to their body in the event of their death.

As I have said, ideally we would want both the proxy and the next of kin to be contacted, but the time issue makes things difficult. When we contact families, we often get a mobile phone answering machine, and the existence of a proxy will not eliminate that problem. There is always potential for disagreement, even within a family, and we have to militate against that and deal with the situation, as we are trained to do.

Bob Doris made a good point when he asked how long someone should remain a proxy—I had not thought of that. I agree that acting as a proxy should probably be time limited, but I cannot tell you what the right length of time would be.

Lindsay Paterson: Some interesting points have been made. There should probably be a time limit for being a proxy to ensure that the correct details are listed on the database and the proxy is still the person that the individual wants to be contacted.

We think that family members should be contacted at the same time as the proxy; indeed, our fellows take a strong view that the family should be involved in the process. I appreciate that family members might have different views, but if there is conflict between a proxy's views and those of the family at the bedside and the proxy has a legal position that enables them to put forward a view, that might cause distress to a family, who, in a legal sense, will be placed in a position in which they are unable to put forward a view. Some of our fellows are concerned that conflict in such circumstances would undermine confidence in medical teams if there was a legal obligation to follow the views of the proxy over those of family members.

Bob Doris: The convener has just told me that some of my colleagues want to ask about proxies, too.

I have already said that I want to link the issue of the proxy to the conversation that takes place when there is a possibility of organs being suitable for donation. Do witnesses know what the transplant co-ordinators, specialist nurses and doctors who have those sensitive conversations think about the proposed approach? We have not yet taken evidence from such people, but I understand that currently if the deceased did not carry an organ donor card a person will say that they are keen to use the deceased's organs to help individuals who can really benefit from that donation. Flipping the whole thing around, I wonder whether people could say, "This individual has not opted out and we are keen to use their organs."

How different might that conversation be in practice if the bill is passed? Might it be very similar, but with the unintended consequence of there being an additional layer of complexity, which the transplant co-ordinator or specialist nurse might think was inappropriate? I am wondering whether the doctors and specialist nurses on the ground who have those conversations—as opposed to the BMA—have expressed concern about the proposed approach. If so, is there a way to mitigate those concerns?

Dr Robertson: I am a kidney doctor, so I work with patients who are waiting for transplants. I do not have conversations with potential organ donors in my hospital, because I look after patients who might or might not benefit from organ donation. In such situations, the specialists involved in the organ donor programme are very mindful of not causing distress to the family, and they are well trained in trying to alleviate the stresses involved in that conversation. Although the conversation that might be had in the event of a change to an opt-out system would not be all that different, the nuance of it would be easier to manage. It would make things easier for the family. If organ donation became more of a normal thing instead of being an exceptional thing to do, it might be easier to approach families in that situation.

Bob Doris: Have you been told—

The Convener: Wait a second, Bob. Do the other witnesses wish to respond?

Bob Doris: My apologies, convener.

The Convener: I see that there are no other responses to Bob Doris's initial question.

Bob Doris: I apologise to the witnesses for not giving them an opportunity to respond and for going straight on to a small supplementary.

Dr Robertson, is what you have just said what you intuitively think, based on your work with those who are awaiting organ transplants, or is your view based on conversations that you have had with people on the ground who have to speak to those who have lost loved ones? I am just wondering how you have formed your view on this.

Dr Robertson: I have not spoken to our transplant co-ordinator or our organ donation specialist nurse, but I have spoken to other doctors, because people have heard that I speak on organ donation on behalf of the BMA. I have been asked about the potential opt-out legislation, and when, in those discussions, I have described what the new legislation would require, no doctor has come back to me and said, "That's going to make the conversation more difficult"; in fact, they have said that it sounds like it would make the conversation easier to have. However, as I have said, I have not spoken to the specialist nurses in organ donation.

The Convener: Let us say that we have identified in one of our major hospitals a person who is on life support who would be a good candidate for organ donation. Are we saying that, because the legislation is not in place and that person does not carry a card, there is no discussion between the medical team and the transplant team?

Lindsay Paterson: I am not a clinician, but my understanding is that such a conversation would take place and the family would be asked whether the individual had opted in. If the individual had not made any such views known, the family would be asked whether organ donation is a possibility.

The Convener: Dr Cant talked about changing the general attitude to organ donation and creating an expectation that that conversation would take place. That is a good point.

My other point, which relates to my earlier questions, is about time. Transplants as a result of road accidents are likely to be in the minority; most will relate to older people on life support. Why would it not be possible, in those circumstances, to contact the proxy or establish the views of the patient? There will be a minority of cases in which there is a time-limiting factor. There has been the presumption that the proxy might delay the process. However, given that in many transplant cases the person will be on life support, a decision does not need to be made within half an hour or two hours. Is that the case? Is the criticism of the proxy proposal based on a time limit or just on possible friction between the proxy and the family?

11:30

Dr Robertson: In the situation that you describe, where a patient is on life support and may, for example, have a life-threatening brain haemorrhage—their brain may be dying but their body is being kept alive—we do have more time.

However, in all situations in which there is potential for organ donation, we would like that conversation to be allowed to happen. In some situations there will be much less time. There will be situations in which there is time and situations in which there is not.

The Convener: Time is not a factor right across the board.

Dr Robertson: It is not.

The Convener: It is possible in many instances to have the time to reach the proxy, to deal with the family appropriately and to spend time with them.

Dr Robertson: Such a conversation is not something that anybody will rush.

The Convener: Of course. Mike MacKenzie and Rhoda Grant both have questions on the proxy.

Mike MacKenzie (Highlands and Islands) (SNP): I would like a bit of clarification on the need for a proxy. Assuming that the bill is passed and there is a public information campaign, people will think to themselves, perhaps for the first time, that they need to do something, as potential donors. The first option is to say that they are not comfortable about being a donor and so will opt out, which necessitates their making an active choice. The second option is to do nothing, in which case the assumption will be made that they will be a donor. The third option is to appoint a proxy, which again requires an active choice—the person must go through some process to name a proxy. It occurs to me that the only scenario in which that is likely to happen is when someone wants to be considered as a donor, but thinks that there would be opposition from their family, wants insurance against their family blocking their wishes and so appoints a proxy.

Am I correct in my analysis? Is there perhaps a bit of a danger in looking at the Welsh situation and providing for a proxy rather than just a further degree of opt in? In other words, why has there been no consideration of having a positive opt in, whereby the person who wishes to put the matter beyond doubt and discussion can carry a donor card and prevent all kinds of unnecessary and difficult discussions?

The Convener: That was a supplementary. I invite Rhoda to ask her supplementary, too. The witnesses can deal with both at the same time.

Rhoda Grant: My question is not unlike Mike MacKenzie's. I believe that we have established that if someone has opted out they do not need a proxy, because that wish is taken into account. One imagines that if they have opted in, they do not need a proxy either, because they have made known their views and those views are recorded. It seems to me that the time when a proxy is needed would be when a person is not on the register, which just does not work, because they would not have a proxy. Could that be dealt with better by encouraging people who are estranged from their next of kin to arrange for a power of attorney for making that decision—and, indeed, other decisions? Are we missing the opportunity to tell people that, if their next of kin are not expressing the person's wishes or are not around, the person needs to make provision on a much grander scale for what happens when they are not able to make those decisions? Should we allow the register to speak for itself and the next of kin to speak when the register is silent?

Dr Cant: Those are very good points. I told Nanette Milne that I see the role of the proxy as being akin to the role of an executor or someone who has the power of attorney. Your suggestion to go down the formal and established power-of-attorney road is potentially very sensible. The other suggestion was to have almost a virtual proxy, whereby instead of registering and affirming one's wishes with an individual person so that those wishes could not be overturned by relatives, one could register one's wishes within a system. Both of those are valid suggestions that could offer a practical way through this.

The Convener: Anyone else? Nobody.

To go back to the campaign, does anybody have concerns that a debate that focuses on proxies would harm and reduce the level of organ donation? A discussion about the bill on the radio this morning led on the issue of proxy; it was not about the altruism of organ donation, but about division in families and families' wishes being overridden.

Dr Cant: Yes, is the short and simple answer. Anything that removes the focus from our ultimate aim has to be of concern. Looking at the issue from the political and media points of view, the proxy issue is a very juicy element of what is always a difficult and contentious matter. Coming back to what Dr Robertson said earlier, there is often already a significant amount of conflict within families at what is a very difficult time. Having the proxy would add a new agent, but not a new dynamic per se, because the dynamic of conflict is already in existence in many cases.

The proxy element is an important failsafe. Again, going back to some of the people whom Jordan Linden mentioned earlier, we owe it to certain elements within the community to ensure that they have an appropriate failsafe in order to make sure that their views can be respected. Whether that would be done in a virtual sense by explicitly registering their wishes, or done through a proxy, is open to debate. However, I very much share the concern about people focusing too much on the proxy issue.

The Convener: Is that concern shared by other members of the panel?

Dr Robertson: Yes. As you said, convener, we heard evidence of that concern on the radio this morning. As we have said, the BMA is concerned about the issue being made more complex. The message needs to be simple.

The Convener: Yes. There is no dissent on that. Next is the very patient Dennis Robertson.

Dennis Robertson (Aberdeenshire West) (SNP): Thank you and good morning.

I want to explore a wee bit what Dr Robertson said earlier about the potential for conflict within a family at what is a very difficult time. A family might agree about organs being donated, but there might be disagreement about tissue donation: I am referring to eyes and corneas. We have focused very much on organ donation and have not really explored tissue donation. Is conversation about tissue donation difficult for families because they disagree with it? They might say yes to organ donation but no to tissue donation, or vice versa. Do we have figures that suggest that organs are more likely to be donated and that fewer people are signing up to, for instance, cornea donation?

Dr Robertson: I do not have such figures to hand, but I could try to find them for you. I am not sure whether they are available, but we can find out.

Dennis Robertson: One reason why I asked is that when we had a discussion with some families, one person said that they had no problem with organ donation, but “never my eyes”. However, having spoken to someone else about it, that person said—in a kind of hindsight—that they had changed their mind. Is there evidence about tissue donation compared with organ donation? Does Dr Cant, through the BHF, have such evidence?

Dr Cant: Dennis Robertson has raised a very important and telling point. The figures show that we have very strong support for the principle of donation when we ask people about it in the calm of the here and now, but when there is the trauma of death, that calm reasoning inevitably comes under attack from emotion. A perfect example of where calm and rational thinking perhaps succumbs to emotion is when people differentiate between organ donation and tissue donation. I suppose that that is another thing that lends itself to the option of a soft opt-out, because it changes the framework of conversation and thinking and moves it back towards the slightly more calm and rational discussion that people have in the here and now, in which they will express their support. Think about the scenario that families face at such times: there is no worse time to seek to engage them in this conversation. We want to take the trauma and emotive element out by moving the debate slightly further back.

Dennis Robertson: Is legislation required, or should we just adopt another system? Anyone who has been to hospital will have gone through a tick list: it is inevitable, I tell you. Should one of the questions on that be about circumstances in which death occurs? It does not matter whether someone goes into hospital for just a minor procedure or not; things can and do go wrong periodically. Should we routinely ask that question when someone goes into hospital? That would mean that the register would be updated and we would have the person’s consent—or not—at the time when they were admitted. If we did that routinely, the conversation would take place then.

Dr Cant: Yes—that should be the way forward. Whether or not we move to soft opt-out, what you describe would encourage conversation on family and societal bases. If we moved towards soft opt-out, that would be a very important way of affirming the move.

I remember the first time I went to the States, as a 19-year-old. When I saw my friend’s driving licence, I asked what the simple dot on it meant. The dot on that Colorado driving licence indicated that my friend was a confirmed donor. Donation is so much part and parcel of things there.

We need to look at things in an all-encompassing fashion and we need to provoke and promote the donation conversation with people at every opportunity; you are absolutely correct. We absolutely want to have the conversation, whether it takes place during secondary care or during a visit to the general practitioner. We should be touching on people from as many different access points and avenues as possible.

Dr Robertson: I have perhaps a slightly different spin. I admit people to hospital as emergencies every week. Most people who come to hospital, even for elective surgery, are quite frightened; they are frightened of the unknown—that they might die or something terrible will happen to them. The conversation about donation would have to be very carefully managed, because people would be being asked at a time when they are frightened and vulnerable.

We must ask people when they are not feeling frightened or vulnerable, but when they are at their best. The discussion should be had when a person feels well and at their most robust—for example, during a visit to a GP or when they are getting their driving licence. Our society might not be ready for that decision to take place on entrance to hospital. We may become ready in the future, but we are probably not ready yet. That is a personal view, not a BMA view.

Dennis Robertson: A young person can opt to have a donor card from the age of 12. Under the bill, young people would still be able to get a donor card, but their wishes would not be upheld absolutely, would they?

11:45

Jordan Linden: I can offer comment on what 12 to 15-year-olds said to us: 85 per cent said that the option for them to opt in should remain. Again, the majority believed that 16 is an appropriate age to be considered an adult for the purpose of organ donation.

Dennis Robertson: Do you support the soft opt-out option, in which people can still opt in at all occasions at any time?

Jordan Linden: Eighty-five per cent of the young people whom we consulted said that the option should remain for them to be able to opt in between the ages of 12 and 15.

Dennis Robertson: I am looking at all age groups being able to opt in or would that complicate matters?

Jordan Linden: I do not fully understand your question, Mr Robertson—I am sorry.

Dennis Robertson: I am basically asking whether the opt-in should be available at all times, even if we go down the soft opt-out option. People could still carry a donor card to try to ensure that their wishes would be adhered to. Their status as a donor could be on a driver card—the Colorado method that Dr Cant suggested—or whatever. Do we need more than one system?

Jordan Linden: I understand you now. We did not ask young people that question. However, speaking from a young person's perspective, I certainly think that having a dot or suchlike on my driver's licence to indicate that I am a donor would be helpful. I would not be opposed to that; I think that it is quite a good suggestion.

Dr Cant: Speaking as a former young person—[*Laughter*]—I think that our system is special and significant because we allow really young people to make an affirmative statement about their wishes and what they would like to happen. That is empowering. It enables our young people from a very young age to demonstrate what they see as being their role and potential in society even in the event of their death. I would be loth to see that lost in any new system.

Dr Robertson: It helps parents, too. Parents who have lost a child will tell you that they knew that their child wanted to donate their organs, so they followed their child's wishes, even though they found it hard to do at the time. I certainly have not spoken to any parent who has regretted doing that; they hold it very dear in that situation.

Dennis Robertson: I can confirm that.

The Convener: Does that not draw us again to the importance of when the conversation takes place? According to the British Heart Foundation, 94 per cent of Scots said that they support the principle of organ donation but only 41 per cent of the population are registered donors. Furthermore, not everybody who is registered goes on to donate. Therefore, how can we ensure that confirmed donors are able to express their wishes? By how much would a different system increase the organs that we have available? To what extent does the level of organ donation reflect refusal by families? Is it more important that doctors and other clinicians identify donors right at the start of the process? Would that, rather than any of the other measures, give us more donors at the end of the day?

Dr Robertson: There is no doubt that we are getting better at identifying donors, but we are still losing some potential organs for transplantation because donors are not being identified. We are working on that, but that work must continue—no matter what happens with the legislation, the work to improve the donation rate from suitable organ donors needs to continue; it is not an either/or. To improve the donation rates further, the soft opt-out position would add more organs for donation.

The Convener: However, you cannot tell me how many more. How many do we lose through family refusal? We have spoken quite a bit about family refusal, so how many do we lose through that compared with the number that we have by identifying organs that are available and ensuring that those organs get used? I am just trying to get the focus here.

Dr Cant: I am afraid that I cannot give you an exact, or even a general, figure for how much of an increase we could have. What is concerning is the rate of family refusal. The figures that I have for 2014-15 show that 46 per cent of families refused donation because they did not know what their relative's wishes were. What is also concerning is that, during 2014-15, we saw a 7.7 per cent decrease in family authorisation, so the conversations are not taking place and the rate of family refusal is actually on the increase at the moment. As I said earlier, the single most important thing that legislation could do would be to change the framework so that the default position was an assumption that people have opted in to the system; otherwise, we are relying on conversations that currently either are not taking place or take place in the calm of the here and now but do not translate into actions when a person dies.

The Convener: I do not understand that. We have confirmed donations. You have just told us that the family refusal rate for people who have expressed their wish could be up to—was it 46 per cent?

Dr Cant: What I said was that 46 per cent of families refused organ donation because they were not aware of their relative's wishes.

The Convener: But there is only one conversation and, ultimately, even if a person has expressed their wish, signed a donor's card and perhaps even discussed a proxy, the important discussion is not the one that is held around the dinner table one Saturday night—if people have such conversations—but the one that takes place in a clinical situation at the point of death. Irrespective of whether a person has expressed their desire to be a donor or signed a card in the past, we have all conceded that the family will make the decision at that point, so how does the bill change that? How does it get us more organs?

Dr Cant: It changes the dynamic of the conversation and of the system and it changes the expectation in Scottish society. It will not solve the problem on its own; the change has to take place on a multifaceted basis and a significant amount of public information must go with it. The fact that legislation exists at all will in itself provoke a significant amount of public discussion.

The Convener: Or controversy, as we have conceded. All of us in the room want to see an increased level of organ donation; we are just trying to examine whether the legislative process is the way to do it, whether the family refusal rates or the conversations that are taking place are the problem or, indeed, whether if practice was changed so that the system could identify potential donors as soon as possible, with suitable organisational support, that would ensure that an increased supply of organs was available for donation. The question is which area we should focus on to give us greatest benefit.

Dr Cant: One thing that we can absolutely guarantee is that controversy will increase. Because it is such an emotive subject, it will always generate significant passion on both sides. The BHF policy position is that, given the balance of the evidence that we have seen in international studies, a multifaceted approach is required and a soft opt-out is an integral part of that.

The Convener: I have three more bids for questions—from Bob Doris, Dennis Robertson and Rhoda Grant—and then, because of the time, I will wrap up the discussion.

Bob Doris: I have a couple of questions, but I will maybe just stick with one at the moment and ask the other one at the end if there is time, because my colleagues also want in.

I did not catch the radio this morning, where there was a focus on the proxy provisions rather than the commitment that we all have to increase the number of organs that are available to save lives or improve the quality of lives. The committee has a duty to thoroughly and robustly scrutinise every aspect of the bill. If we do not do that, we are not doing our job properly. However, it feels a bit like a poisoned chalice. I was not obsessing about the proxy provisions and nor am I obsessing about authorised investigating persons, but I am going to ask questions about them, because that is my job as a committee member.

It would be interesting to know the witnesses' views on who the authorised investigating persons should be, as there is a lack of clarity in the bill on that. It appears that the authorised person would not necessarily be the specialist nurse or medic on the ground. If the bill were passed, the authorised investigating person would have a duty in law to seek to identify and locate the proxy, if one existed, to seek to identify the next of kin and to ensure that all due process has been followed in an appropriate manner.

Although not all organ donations are time sensitive, the witnesses will understand why I want to know whether that process could lead to undue delays. As soon as we put something in a legal framework, there is the potential for people to take a precautionary approach. If for whatever reason there is a lack of clarity during the process that the authorised investigating person is going through, they could say, “No—don’t take those organs.” Could that be an unintended consequence? I am not saying that it will be, but those are concerns that have been raised.

Who should the authorised investigating persons be and what should their role be? Would that role be burdensome and could putting it in a legal framework create unintended consequences?

The Convener: Who wants to respond? Dr Cant, we are testing your voice to destruction.

Dr Cant: You certainly are.

I can give you a limited response. The BHF sees specialist nurses as playing an absolutely vital role. You make an incredibly important point about the balance between ensuring that anyone who is designated to fulfil the role feels legally and morally protected and ensuring that we have an efficient and timely process. It will not be easy to achieve that balance, but it is absolutely vital that we do so.

My organisation would look to colleagues in NHS Scotland for their expertise on how best to proceed. They are best placed to advise on that.

Lindsay Paterson: Dr Cant raises important points. At the moment, we do not know who would be responsible for that, because it would be set out in regulations but, currently, much of the role as outlined, particularly the investigative tasks, falls to the specialist nurse in organ donation. Queries arise about whether the legal responsibility would be an additional burden and what kind of pressures would be involved in becoming an authorised investigating person, particularly with regard to legal authorisation.

Dr Robertson: Although the BMA can see a clear advantage in having people in that role, it would need to be very carefully thought through, to work out how many people would be needed. Some of the role is currently carried out by specialist nurses in organ donation, so they would be the obvious people to do that. At present, they may not be fully skilled and appropriately trained to take on an overarching legal requirement but, initially, they would be the obvious people on the ground.

Whoever does the job, we would have to be certain that they would be available at any moment of any day of the week. The role would need to be properly resourced and people would need to be properly trained. It is an extra requirement that would require resources.

12:00

The Convener: What about the transplant team? I can see a role for the specialist nurses, but I also see that there is a clinical role in establishing the point of death and the cause of death, as well as a role for the procurator fiscal in the event of the death of a young person or a violent death. A doctor rather than a nurse might be required.

I can see that there is a softer role of communication, but I am wondering what the transplant team does. There is a separation between the doctor who is trying to save a life and the person who, when that is no longer viable, assesses whether the organs are viable and deals with the potential for donation and any legal requirements. Who does that now?

Dr Robertson: At present, the transplant team does that. As described, it sounds as if there is a possibility that somebody would have to make a decision about whether the transplant team has done its job appropriately, but I am not sure whether I have the meaning of that correct.

The transplant team is regulated: we are all covered by, for example, the General Medical Council or the General Nursing Council regulations. We all work within a legal framework and the transplant team is very careful to have due process, because it knows that the issue is very difficult.

Whether there is a need for someone additional to the transplant team or whether it would be possible to designate a transplant team member to be the person in that role is a matter for consideration.

Rhoda Grant: I have a supplementary to that question.

Is there a need for such a post? This is new legislation, but the common law already exists. If there were an issue about the legality now, it would be tested by the courts under the common law. Does the donor team not look at all those aspects as part of its day-to-day work?

The Convener: I see nods of agreement.

Dr Robertson: As I said in my answer to Mr Doris, the transplant team do that job anyway. I do not know that you need another layer, but I am not a lawyer.

Dennis Robertson: We have heard a few times today that the organ donation conversation is a very difficult one.

We know that there are teams of specialist nurses and donor co-ordinators. How many families say initially that they are prepared to make an organ donation, or accept the fact that a donation should be made because their loved one has expressed that wish, but later, during the conversation with the specialist nurse or co-ordinator, when specific and extremely sensitive questions are being asked, walk away from that decision and say that they have changed their minds? Do we have that figure?

The process requires extremely personal and difficult questions. Should we try to make people aware of the need for that type of question at a much earlier stage, for example when they sign up? It hits people like a brick wall when they are asked the questions by the co-ordinator just after a loved one has died, whether that be a child, parent, sibling or whatever.

Dr Cant: You make a really important point. I do not know that such statistics exist. Given the nature of the matter, it would be difficult to assess, but the dynamic that you have described absolutely exists and in many cases it can be a practical barrier to the process of gaining parental agreement. I think that the questions would be intrusive for many parents at any time, but given the traumatic situation that they find themselves in, the questions must accentuate the pain.

Dennis Robertson: It is not just parents; it is any loved one. It could be a husband or wife, for example. The questions are quite intrusive. Should people be made aware that such questions could be asked before they make decisions?

Dr Cant: Yes. I agree.

Bob Doris: We are trying to cover the full range of issues with the bill, and there are issues that relate to adults with incapacity. It appears that the bill, as currently drafted, would prevent a welfare attorney from appointing or withdrawing the appointment of a proxy or objecting to the removal of an adult’s organs. A few submissions raised concerns about that. I think that the General Medical Council and the Scottish Government have raised concerns that an adult with incapacity could not opt out and that their appointed guardian would not have a legal basis for objecting to that.

I wonder about getting the balance of rights correct in any soft opt-out system for a certain group of vulnerable people. Would that make the system not an opt-out system at all, as others would be locked into that process? Have you considered that?

The Convener: Is the answer no? That is okay. We will have an opportunity to ask others that question.

Jordan Linden: There is a caveat for us in thinking about vulnerable young people who may have learning difficulties or disabilities. Again, the issue goes back to information. If the bill continues, it is essential that there are appropriate materials and an appropriate campaign with information to allow vulnerable young people to make an empowered and informed decision. That is the only thing that I can say about that. That was certainly the message that young people shared with us in the survey.

The Convener: I think that committee members have completed their questioning, so I invite Anne McTaggart MSP, who introduced the bill, to ask questions.

Anne McTaggart (Glasgow) (Lab): I thank the convener and members of the committee. I have a few wee points to make, convener. Is that okay? Can I just race through them?

The Convener: Yes. You have three minutes.

Anne McTaggart: From the outset, the Scottish Government and I have shared the same ambition, which is to increase the number of donors and transplants and to save more lives. Someone asked earlier whether the bill is necessary. It is absolutely necessary, otherwise I most certainly would not be putting myself and others through this process.

We need to increase transplantations. The approach has not worked to date. Whatever we are doing is not working. We have fully backed the Scottish Government's transplantation plan to 2020. The Government has done well in trying to increase the number of transplantations, but as I am sure Dr Cant mentioned, deceased donor rates fell by almost 7.5 per cent last year. That makes Scotland the worst-performing part of the UK. I am not happy with that figure, and many around the table will not be happy with it. First quarter figures for this year show that we are heading for an even bigger decrease of 10 per cent in deceased donor rates. That is the most worrying figure.

Someone asked earlier whether the bill is necessary and how we know that it will work. We know that it will work because what has been done to date has not worked. We have looked at international evidence in deciding what to do and there has been an increase of between 25 and 30 per cent. We do not have to circle all round the world; we have used the Welsh Government's Human Transplantation (Wales) Act 2013 as a basis—the new system in Wales will go into operation on 1 December, as people are aware. The Welsh Government also used the international evidence. We have to do something different, as whatever we are doing just now is not working. International evidence shows us that that 25 to 30 per cent increase will happen if we move to a soft opt-out system.

I am still within the three minutes, convener.

The Convener: That was for your introductory remarks, but you need to get to questions.

Anne McTaggart: I will. The committee carried out a survey and got 856 responses—85.28 per cent of the respondents believed that the bill would lead to an increase in the number of organs and tissues that are made available for transplantation in Scotland. There are questions about the possible new pressures on SNODs and NHS Blood and Transplant, as specifically mentioned in the written evidence. Can the panel members explain what the SNODs do and what NHSBT currently does?

The Convener: What is a SNOD? That was SNOD, not snog.

Anne McTaggart: I am sorry, that is entirely my fault—I am up to here and back with the bill. It stands for specialist nurse in organ donation. They are senior nurses. CLOD stands for clinical lead in organ donation.

Dr Robertson: I cannot give you the full details of what SNODs do, but they are an integral part of the transplant team at every stage. A referring unit refers to them directly and they come to that unit and co-ordinate everything from then on. They are a highly skilled group who have a lot of different skills compared with a standard nurse. They are very good at speaking to relatives and that is why the relative refusal rate is so disappointing. I am sure that it is incredibly disappointing to the specialist nurses as well. They do a huge amount behind the scenes to make sure that everything happens as it should, in as timely a fashion as possible.

If you want to know more about what the specialist nurses do, we could interview one of them for you or get them to write their job description so that you know exactly what they do. However, they are an integral part of the team at every level.

The Convener: We will take evidence on and around that anyway.

Anne McTaggart: Controversy was mentioned earlier. We have had controversial bills go through Parliament before. Should we shy away from something that we think is controversial? Can you think of any other legislation that people may well have thought of as controversial at the time but which they have changed their mind on and now see as a good thing?

Jordan Linden: Thank you very much for your question—it is a nice, non-technical question without SNODs and CLODs and all the various acronyms. There are two bills that may have been perceived to be controversial, both of which I am proud to say that the Scottish Youth Parliament grabbed and campaigned on. The first of those bills was the Marriage and Civil Partnership (Scotland) Bill, on equal marriage. When we launched our love equally campaign at the Scottish Parliament, calling for the consultation to come more quickly, the consultation came much more quickly and then we had the legislation. The second is the Scottish Elections (Reduction of Voting Age) Bill. The Scottish Parliament unanimously voted for votes at 16, but we are still fighting for that cause at Westminster so that young people can cast their vote in all elections.

As someone who chairs the Scottish Youth Parliament and who does not shy away from controversial subjects, I would say that we absolutely should not shy away. If something is controversial, it is important to ask why it is controversial. If it is controversial because it causes conversation, I think that that is a wholly good thing. As colleagues on the panel have said, conversations are just the starting point for making a difference in Scotland on this issue.

12:15

Anne McTaggart: I have been taking notes, but I can hardly read them, so you will have to bear with me.

I turn to a different type of conversation. A lot of time has been spent discussing the proxies. This bill is not the Anne McTaggart bill; it is the Scottish Parliament's bill, and it will be for every member of the Parliament to be part of the consideration process. The bill is open for conversation. Just as we talk about having conversations with families on the issue of organ donation, the bill process will involve a conversation. I think that everyone should have a right to discuss what is in the bill, in order to make it the best bill possible.

The idea of a time limit for the proxies has been mentioned—I am sure that Dr Robertson mentioned it. What evidence do you have from doctors about what difference the bill may make when it comes to having conversations with family members? If someone had definitely opted out of donation, such a conversation would not take place. What effect would the bill have on the conversations that take place? How do doctors feel about speaking to families, depending on whether or not their relative is on the register? Can you expand on that?

Dr Robertson: At the moment, someone can register to give their organs in the event of their death but, as we know, although nine in 10 people say that they would wish to do that, only four in 10 people have their names on the register, for many different reasons. There is a big gap in number between those who would like to give their organs and those who have registered to do so. The advantage of the opt-out system is that if someone does not want to give their organs, they register that and their family will not even be approached. In that way, the people who do not wish to give their organs have their views respected in the event of their death.

There is a slightly different nuance in approaching the family to ask whether they are aware of the person having had any objections that had not been registered. I think that that is a less difficult conversation to have with the family at that very stressful time. Such a system is more likely to allow us to respect the wishes of the person who has died.

Anne McTaggart: Ultimately, that is what we all want from the bill—we want to make the process easier for the family of the deceased person, as well as making it possible for more organs to be donated.

The Convener: That concludes this evidence session. I thank the witnesses very much for their attendance and for their oral and written evidence.

We will now have a very short session in private.

12:18

Meeting continued in private until 12:33.

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