HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 16 November 1999

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HEALTH AND COMMUNITY CARE COMMITTEE

12th Meeting

CONVENER:

*Mrs Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS:

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Dorothy-Grace Elder (Glasgow) (SNP)
Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Ms Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:

Mrs Margaret Ewing (Moray) (SNP)

COMMITTEE CLERK:

Jennifer Smart

ASSISTANT CLERK:

Irene Fleming

COMMITTEE ADVISER:

Dr John Forbes

Scottish Parliament

Health and Community Care Committee

Tuesday 16 November 1999

[THE CONVENER *opened the meeting at 09:37*]

The Convener (Mrs Margaret Smith): This morning, we will discuss the Adults with Incapacity (Scotland) Bill. This is the first chance that the committee has had to consider the bill. You will remember that Ben Wallace volunteered to be our committee's rapporteur on the bill. He has liaised with the Justice and Home Affairs Committee and has attended some of its meetings. Richard Simpson and I also attended one of the meetings.

Our discussion of the bill will be in public. I suggest that we then discuss in private item 2 on the agenda, the Arbuthnott draft report, as committee reports should not be made public until they are formally published. I suggest that we also discuss in private item 3 on the agenda, our line of questioning when the Minister for Health and Community Care and the Deputy Minister for Community Care are with us tomorrow.

Do we agree to do that?

Members *indicated agreement.*

Adults with Incapacity (Scotland) Bill: Stage 1

The Convener: Jennifer Smart will clarify what the committee is being asked to do at stage 1 of the bill.

Jennifer Smart (Committee Clerk): The Health and Community Care Committee is being asked to consider the bill as the secondary committee, the lead committee being the Justice and Home Affairs Committee. That committee has to report by 22 November at the latest so our report has to be given to it before then. The Justice and Home Affairs Committee is hearing evidence tomorrow while we meet.

This committee has a problem with the length of time that it has been given to consider the bill. One solution would be for the committee to hear further evidence in advance of stage 2. It would not be possible for the committee to report again, but members would have heard the evidence in preparation for stage 2, when the amendments are considered.

Stage 1 allows a discussion of the general principles of the bill as they affect health.

Kay Ullrich (West of Scotland) (SNP): Convener, may I speak?

The Convener: I would like to make a point first, Kay. I want to ask the committee to express its concern at the way in which we have been forced to consider this important issue. It became clear to me, when I attended the Justice and Home Affairs Committee meeting, that many of the key points in the bill relate to the medical points in part 5. Because of the way in which the bill was parachuted in to us, we have not had time to hear evidence from key people. That is not to undermine the work of the Justice and Home Affairs Committee, as it is considering the bill thoroughly and has a longer time in which to do so. I ask the committee to formally register concern about the fact that we have had insufficient time to consider the bill.

I asked the clerk to consider what we can do at stage 2 of the bill and it seems that the committee cannot make comments and amendments at stage 2. We can, however, take evidence as a committee and then feed in amendments as members of the Parliament. This flags up an important point: while the Parliamentary Bureau is in dialogue with the lead committee, it should also ensure that the secondary committees have the opportunity to hear evidence at stage 1.

Although we can hear evidence at stage 2—I will listen to members' views on whether we should do that—today is our only opportunity to discuss aspects of the bill as a committee. Our comments today should be on the general principles of the bill. Was that what you wanted to raise, Kay?

Kay Ullrich: I wanted to express concern about the fact that the Justice and Home Affairs Committee is meeting at the same time as we are tomorrow. That will give us no chance to sit in on that meeting. There are controversial points in the bill, particularly those that relate to health. I am concerned that we will not be able to scrutinise the bill properly.

The Convener: The only thing that we can do at this stage is to flag up areas of concern for the Justice and Home Affairs Committee. We can also make members of that committee aware of the fact that we have not been able to consider the bill in depth and that they will have to do extra work on the medical aspects of the bill. I became aware, reading the *Official Report*, that some members of the Justice and Home Affairs Committee thought that we had been doing the same kind of work on the medical side that they had been doing on the legal aspects of the bill.

Ben, would you like to place before us your initial report?

09:45

Ben Wallace (North-East Scotland) (Con): This report was written over the weekend and submitted yesterday lunch time. It has been written without seeing the submissions from Alzheimer Scotland, the Southern General hospital or the British Medical Association that are now sitting on our desks. I would like people to note that those are serious contributors and that their views should be taken into account in addition to the report.

Going back to the convener's comments, the short notice that we have had and the speed with which we have had to act do not allow for a fully competent report. The timetable has also been an issue in relation to the previous messes that we have had with matters such as Scottish statutory instruments. I think that this committee should say in the strongest language to the Parliamentary Bureau, or whoever directs the timetabling of those matters, that it must consider that carefully because we are not doing this justice. There are major concerns in nearly all the submissions, and I hate to think that this committee will tick its box, when it should have made a more complete inquiry.

The report is on members' desks now. Do you want members to read through it, convener, or will I read through it as we go?

The Convener: Could we take a five-minute break, to allow people to read Ben's report before we comment on it? I have not seen it before now either.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I have to go to an Equal Opportunities Committee meeting for 10 o'clock. Can I put in my tuppenceworth before I go?

The Convener: Yes.

Malcolm Chisholm: I have read Ben's report. We should thank him for a thorough report. I think that the main controversies are about section 44(2) and section 47. Ben touches on that in his report, which I read as soon as I got it.

I do not agree with Ben, as I do not think that the problem is that the medical people have to appeal rather than the welfare attorneys or guardians. I think that the problem is elsewhere: it is in section 44(2). I have sympathy with those who think that that section should be deleted from the bill altogether. The act must make clear that certain matters are not a decision for either the welfare attorney or the doctor. That is what has made all the headlines about euthanasia and so on. We have been told that that is not part of the bill. That must be made explicit. If it is made clear that those matters are not up for grabs for anyone, I am happy that the decision should remain with the welfare attorney or guardian, rather than with the doctors. That is a fairly significant disagreement with Ben.

The Convener: Gordon Jackson made an eloquent argument at the Justice and Home Affairs Committee for leaving out section 44(2), as it opens up a can of worms.

There is a need to be explicit about what the bill is trying to achieve. For example, there is a question-mark over the use of the word benefit vis-à-vis an adult with mental incapacity as it is open to different interpretations. Do you have any other comments, Malcolm?

Malcolm Chisholm: I have made my main points. I think that those two sections of the bill are the two that members will want to consider in terms of amendments.

The Convener: Are you happy with the definition of adult with incapacity as it stands? It is a definition within the (Scotland) Act 1984, with the possibility of its being changed in the future, depending on what the Millan committee reports. Are you happy with that definition?

Malcolm Chisholm: That situation is unavoidable because of the time scale. I do not think that it is a fundamental problem.

The Convener: Thank you, Malcolm. We will now have a five-minute break to give committee members the time to read Ben's report. We will come back at 9.55.

09:49

Meeting suspended.

10:04

On resuming—

The Convener: I hope that everyone has had an opportunity to read Ben Wallace's report. I appreciate that committee members have not had the opportunity to read through the great pile of papers and submissions that have come in from other organisations, in some cases overnight. That is one of the concerns that we raised at the beginning of the meeting. The concerns about the way in which we are being asked to comment on this bill I will take to the next meeting of the conveners committee, which is a joint meeting with the Parliamentary Bureau. Many of the difficulties arise because we are the secondary committee on this bill. Perhaps that will have to be taken into account in future.

I will now hand over to Ben to give—

Hugh Henry (Paisley South) (Lab): Before you do that, I wish to say that the contents of this bill are significant. I know that we are the secondary committee. One of the questions that I asked you before was whether we can separate out the remits of the Justice and Home Affairs Committee and the Health and Community Care Committee, because I do not want to go over the ground that another committee has gone over.

There are significant health-related parts of the bill and I am not happy about brushing over items of such significance so quickly with so little notice. What are the implications if we say that we cannot finish our deliberations today and that we want the opportunity to give the bill the scrutiny that it deserves?

The Convener: The clerk will answer that question.

Kay Ullrich: Hugh, before you arrived, others expressed the same concerns. Hugh's question with regard to the implications takes those concerns a little further.

The Convener: I have asked those questions privately. I will hand over to the clerk.

Jennifer Smart: The timetable was set for the committee by the Parliamentary Bureau. If we fail to report by 22 November, we will fail to feed into the deliberations of the Justice and Home Affairs Committee. The stage 1 debate for the bill is on 8 December.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Having read Ben's report and the submission from the Southern General hospital, I have concerns. We are not doing ourselves any favours if we hurry this matter. I propose that we adjourn until 11 o'clock. I am not prepared to participate in this meeting without having read the information that we have received.

Mary Scanlon (Highlands and Islands) (Con): I second that.

Kay Ullrich: The problem is that we would then only have until 12 o'clock because I will have to leave then, and I assume that other members are in the same position. I agree that we cannot do this bill justice in such little time. There are so many important implications of this bill that we would serve no one if we rush through it.

The Convener: Bear with me. I am trying to find a way out of this.

We have other things on our agenda, including the draft report on Arbuthnott and our questioning of the Minister for Health and Community Care, which, as we agreed, we will consider in private for the reasons that we highlighted at the beginning of the meeting. I will find out whether it would be possible for us to do some of that later today without having official reporters present because it will be a private discussion about a draft report. That would free up the rest of this morning's meeting and allow us to adjourn.

If it is acceptable to committee members, the clerk will find out if accommodation is available for us so that we can deal with other parts of the agenda later today. That would allow us to adjourn and spend the whole of this morning reading through the papers and discussing the Adults with Incapacity (Scotland) Bill.

Ben Wallace: When was the bill lodged?

Jennifer Smart: As far as I can remember it was lodged on 8 October.

Ben Wallace: So the Executive lodged a bill on 8 October, which allowed at most two months of discussions.

Jennifer Smart: The recess fell after 8 October and the bureau did not meet to set the timetable for consideration of this bill until after then.

Ben Wallace: That is why we are in this position.

Jennifer Smart: And the financial resolution—

The Convener: Which tail-ends it.

Jennifer Smart: Yes. It will fall on 8 January.

Hugh Henry: We must say that we need adequate time to do our job properly. We are not here to rubber-stamp the Executive's bills; we are here to scrutinise.

The Convener: This bill is far too important to rubber-stamp it.

Kay Ullrich: As Richard pointed out, we are amending an act that was published in 1585, yet we are rushing through our considerations in half a day.

Mrs Margaret Ewing (Moray) (SNP): In response to one of my questions last week, Iain Gray kindly pointed out that the Millan committee will be bringing out a report on the Mental Health (Scotland) Act 1984 early in the new year, although no specific date was given. This committee should propound the argument that the discussion of this bill should wait at least until the Millan committee's interim report because it would be helpful for all of us.

Kay Ullrich: The definition of incapacity could be changed.

Ben Wallace: We are in danger of the bill falling if we do not—

The Convener: Yes, the bill will fall.

Dorothy-Grace Elder (Glasgow) (SNP): Even an hour or so is too little time to show respect for those organisations that provided submissions.

The Convener: Dorothy, no one on this committee will disagree with that point. You are absolutely right.

Dorothy-Grace Elder: Is it in any way possible to delay this discussion? What would be the repercussions if we did so?

Ms Irene Oldfather (Cunninghame South) (Lab): I agree. We have documents before us and it would be difficult to pick out the important points in one hour.

The Convener: Having read through the bill, the explanatory background information and all the paperwork that we have been given to date, my feeling, as convener of this committee, is that a joint committee should have been established to scrutinise this bill. The fundamental problem arises from that not having been done. Having listened to part of the Justice and Home Affairs Committee meeting that discussed this bill and having read the transcripts of another, that committee is concerned that the crucial parts of this bill are the medical aspects. That committee feels that while its remit to consider the entire bill is satisfactory, it does not normally focus on health issues.

Problems arise also because this is a new process—it is the first time that we have done it—and we are the secondary committee, which has resulted in a problem with timetabling. Every member of this committee wants to do their job properly, but feels that we cannot do justice to the bill and to those adults with incapacity, and to their carers, families and the members of the medical profession who deal with them. I can only echo what members of the committee have said. However, as things stand, we have to feed into the Justice and Home Affairs Committee. That is why I am telling members that even if our contribution is simply to raise concerns, we must raise every single concern that we have, after which we must leave the matter in the hands of the Justice and Home Affairs Committee because of the way in which this process has been set up.

That is not a satisfactory arrangement. We will write and express our deep concerns at the way in which this matter has been handled, and try to ensure that it does not happen again. I will raise the matter at the conveners meeting with the Parliamentary Bureau and also with the Presiding Officer, because it calls into question the repute of Parliament if we are not given time to scrutinise legislation, which, after all, is one of our main functions.

I support completely what everyone is saying but this may be our only opportunity to deal with this bill so, within the constraints that we face, we must try to take advantage of that. If we do not, we may find that we get to the end of the time that is available to discuss the bill in detail—which is the only opportunity that we will have to do so—only to find that we have missed our opportunity to have our concerns taken on board by the Justice and Home Affairs Committee in its deliberations and taking of evidence.

Kay Ullrich: But as you said, the concerns over this bill are medical concerns. My problem is whether, if we highlight areas of concern and submit them to the Justice and Home Affairs Committee, we are deemed to have scrutinised the bill.

10:15

Ms Oldfather: I also have some concerns about that, because the information that we have been given within the last week is all technical. On its own, it is pretty substantial. We have been presented this morning with some of the issues that we, as parliamentarians, need to address, which will affect the people who will have to implement the legislation. We do not do ourselves any service to try to rush through this within the next hour or hour and a half.

Kay Ullrich: My concern is for the people who desperately need this bill.

The Convener: We are being asked to say whether we are in favour of the general principles of the bill and to highlight any concerns that we have. Obviously, the full scrutiny of the bill will happen at stage 2. That is the point at which members of this committee can put down amendments. From what I have heard, there is nothing to stop the committee continuing to send a reporter along to the Justice and Home Affairs Committee and having other members of the committee sitting in on that committee—as Margaret Ewing is doing today in this committee—and asking questions there. The only thing that may stop us is the timetabling problem.

At stage 2, we could decide, as a committee, that we want to hear evidence. What we could not do is make submissions and amendments. However, we could make them as individuals who happen to be members of the committee. In a way, saying that that is what we feel we have to do would circumvent the letter of the law. It would enable members of this committee to take part in the full scrutiny at stage 2.

However, as a committee, we could take a more active role by calling the British Medical Association or other organisations from whom we wish to hear, such as those involved with Alzheimer's disease. We could then, as individual members, lodge amendments that are the result of arguments that we have heard in the committee. There is still scope for the committee to scrutinise the bill, but at this stage we are considering its general principles and highlighting our initial concerns. Now is the time for members to highlight everything that they are concerned about. I know that the situation is not satisfactory, but we are working within the constraints that have been placed on us.

Ben Wallace: Can I make a suggestion? The Minister for Health and Community Care and the Deputy Minister for Community Care will be with us for three hours tomorrow. We would probably not wish to do this, but if we were to cut their visit to an hour and a half—

The Convener *indicated disagreement.*

Ben Wallace: —we could donate today to the Arbuthnott report, go away and read the submissions, and ask the people who are giving evidence to the Justice and Home Affairs Committee tomorrow to give their evidence to us afterwards.

The reality is that we cannot delay this and that we are not the lead committee—that is the mistake. We cannot do anything about that; we can sit and pontificate all day about how we should have been the lead committee. That is the Parliamentary Bureau's fault. However, we have to report on our objections to the bill's general principles, because on January 8, the bill will fall if it does not get through that procedure. The lead committee does not have to take our input into account and will just carry on.

Kay Ullrich: We should consider Ben's proposal because we have three hours tomorrow. We can assume, can we not, that the Minister for Health and Community Care will always be with us?

Ben Wallace: We could ask her about this topic, saying, "It is your Executive that wants the urgency", and she can answer questions on it.

Hugh Henry: No. We cannot ask the minister to get involved in this, but the idea of truncating her session and using the time in other ways is a sensible one.

The Convener: We have heard three possibilities—well, members have heard two and I made another one privately to the clerk. One possibility is that we do something about the rest of the agenda. If we discuss Arbuthnott and tomorrow's questioning of the ministers in private this afternoon, that would free up the rest of the meeting. We have to be out of here by 12.30, which gives us two hours—the full meeting—to read through and discuss the Adults with Incapacity (Scotland) Bill.

The second option is to identify whether we can schedule an extra meeting for later in the week. By necessity, that would probably have to be Friday, which would not be acceptable to many people. However, if we managed to schedule a meeting for Friday and, at short notice, managed to invite some witnesses in, that would probably allow us to make some recommendations before the Justice and Home Affairs Committee meets next Tuesday.

The third option is to truncate the ministers' time with us tomorrow. I have two problems with that. First, we have to be realistic about the situation vis-à-vis our on-going relationship with ministers; it is essential that we have a good working relationship with them. We discovered a few weeks ago that an hour with a minister was not an acceptable length of time.

Kay Ullrich: Cancel it.

Hugh Henry: Cancel her.

Ben Wallace: And we want the bill by January.

Margaret Jamieson: The bill has a very tight time scale and I have real concern that we are coming up with views that are ill thought out and will affect individuals out there. We can say to the Minister for Health and Community Care, "Look, we have a difficulty in terms of timing. We want to do the job properly. Can we postpone the meeting?" I do not think that the minister will have a problem with that.

Kay Ullrich: That would also do away with the need to discuss tomorrow's questioning of the minister. She will understand. The Executive is introducing the bill.

Ms Oldfather: I agree 100 per cent with that. The committee has to look forward a little more. We are trying to take on too much and we have to realise that certain things, such as this, will be priorities. We cannot fit it in with things such as three hours of questioning with the ministers or the Arbuthnott inquiry. We are trying to do too much. We are not doing ourselves a service and we are certainly not doing a service to the people that we represent. We should postpone tomorrow's meeting with the ministers.

Dr Richard Simpson (Ochil) (Lab): I almost agree with that.

The Convener: I cannot allow you to almost agree, Richard. We need a bit of unanimity on this.

Dr Simpson: Well, hear me out. The range of topics that we were proposing to question the ministers on tomorrow would have taken 36 hours, not three and a half. Tomorrow's session was doomed to be a failure anyway. I am sorry, as I know that I have not been at the committee to make that point. It has been difficult being on three committees, including the Standards Committee.

I make a specific suggestion about tomorrow, which is that we do not totally cancel the ministers' visit, but ask them to come only to tell us about the Executive's forward planning. That will allow us to determine how we relate our work process to them. We do not ask any other questions, but ask the ministers to make a five or 10-minute presentation on the forward plan, which we can then discuss briefly with them for half an hour before going on to the rest of the session. That would allow us to formulate our forward work, which—taking Irene Oldfather's point—is crucial. We need to focus on what we are doing.

The Convener: I have a greater degree of sympathy to that than to cancelling the ministers' visit. I spoke to them yesterday about the way in which I wanted the meeting to proceed, in terms of their statements about what they consider to be the headline issues, their work load for the coming year and so on. That would be a way of taking forward dialogue and setting our minds as to what we should be addressing.

Obviously, we had asked for questions. I had been going to suggest that we found ways of locking them into areas, rather than asking specific questions. Richard's suggestion would be a useful way forward because it would mean that we were still hearing from the ministers. They have been doing work in preparation for tomorrow's meeting. In respect of that, it would be useful at least to hear about their forward work plan. However, it would also free up extra time to look at the bill. Do people feel that that is a better way to proceed?

Dorothy-Grace Elder: I doubt whether we will get through it in half an hour. We are talking about 10 minutes from each minister—that is, 20 minutes—and 10 minutes for discussion, which is "Here's your hat. What's your hurry?" Would it not be better to reschedule the meeting with the ministers so that we can hear what they have been preparing?

Mary Scanlon: I am inclined to agree with that.

The Convener: One of the problems is that the ministers were originally scheduled to come at the beginning of October, but other things took over and the meeting had to be rescheduled. It was initially meant to be a meeting that set the general scene for them and for us, but it has slipped into November. If it continues to slip, we will lose the point of having the meeting. There is a range of possibilities, but we have to devote more time to the Adults with Incapacity (Scotland) Bill. I would prefer to find a way to do that, in terms of the timing, that we all agree on.

Hugh Henry: Are we not generally agreed that there should be a discussion tomorrow for which time should be allocated? The only argument at the moment is whether the ministers should be there at all or whether they should be there for half an hour.

Kay Ullrich: I think it is just tokenism.

Dorothy-Grace Elder: It is a waste of their visit.

The Convener: Can I take a view from the committee?

Dorothy-Grace Elder: I agree that it is all or nothing and that we are pretty much in an emergency situation over this. The minister will understand. Perhaps she could be asked to state in advance, in writing, her ideas about the Executive's work programme. That would assist us. We will never be able to stick to half an hour.

Hugh Henry: That is right.

Margaret Jamieson: I think that we should just press ahead with it.

Ms Oldfather: I tend to agree, although I have to go to Brussels tomorrow. It is really up to the rest of the committee, but it is more appropriate to set aside the proper time to discuss this. We are all agreed on that.

The Convener: Any comments about the bill that you have, Irene, you can put through me.

Mary Scanlon: I would rather do justice to what is in front of us. The reputation of the committee and the Parliament depends on the way that we treat this. I would rather have a full three-hour session, focusing on the serious, critical issues in front of us, than tampering and being half-hearted. We did not have a full discussion last time and the terms on which we parted were not good. I would prefer there to be a proper, structured session rather than a half-hearted, quick discussion. I hope that we can develop a partnership with the minister. A forward plan, on paper, is perfectly adequate. Let us sit down and do the business that we are here to do.

Dr Simpson: I am not unhappy with the written plan.

Kay Ullrich: My views are known.

Ben Wallace: I am happy with the plan not to meet the ministers. Is it realistic to get evidence from the people who are giving evidence to the Justice and Home Affairs Committee, while they are here?

The Convener: The people who are giving oral evidence to—

Ben Wallace: The BMA, the Royal College of Nursing and Professor Sheila McLean of the University of Glasgow.

The Convener: What time will they be giving their evidence?

Ben Wallace: They will be here at 9.30 am, the same time as us.

The Convener: Are they giving evidence at the beginning—

Ben Wallace: The middle. The committee has got a European document first.

The Convener: I will see whether the clerks can liaise so that we can be there to take that evidence jointly.

Dr Simpson: They could join us here in the chamber.

The Convener: We are meant to be in committee room 2 tomorrow.

10:30

Suggestions are coming up now, and I do not know what the logistics are without talking to our clerk and the Justice and Home Affairs Committee's clerk, but there would seem to be some merit in our being there to listen to the medical evidence. That would also allow us to have a chance to read further submissions overnight. [*Interruption.*] I have just been told that the Justice and Home Affairs Committee will meet across here tomorrow, so bring your coats.

I am happy with the committee's stated view, and we will give the ministers as much notice as possible so that they will not be asked to come to committee tomorrow. I will couch that in terms of us being sorry that we will not get the chance to hear them tomorrow, but we see our pre-eminent duty as finding time to examine the bill. We have had such a short time to discuss it.

I ask members to bear with me for a few moments while I discuss some logistical points with the clerk.

Dorothy-Grace Elder: I wonder if the Minister for Health and Community Care could be told informally by telephone. It would be a courtesy, and it would help her with her busy schedule.

Members *indicated agreement.*

The Convener: I want to take guidance on what committee members want to do with the rest of this morning's agenda. If we are not questioning the ministers tomorrow, item 3, on agreeing our line of questioning to the ministers, is unnecessary, and falls. We then have item 1, which we are discussing at the moment, and item 2, which is a consideration of the draft Arbuthnott report.

We have a couple of options. One is to conclude this morning's discussion on the Adults with Incapacity (Scotland) Bill and concentrate on it tomorrow. Bearing in mind, however, that a lot of that three hours may be taken up with hearing evidence from other people—[*Interruption.*] I keep being reminded of reasons why those things do not work.

I have completely lost my thread now.

Dorothy-Grace Elder: It happens.

The Convener: We could move now into discussing the draft Arbuthnott report, and leave all our discussion on the Adults with Incapacity (Scotland) Bill to tomorrow. We should bear in mind that if we go to the Justice and Home Affairs Committee, much of our time tomorrow will be taken up listening to other people's evidence. That is important, but it will cut into how much time we have to discuss our concerns and the points that we want to make. One option is to continue to discuss adults with incapacity this morning and to discuss the draft Arbuthnott report as well.

Another option—which I have just been told may not be an option—is that, as the Arbuthnott draft report was going to be discussed in private anyway because it is a draft report, we could close the meeting and meet again later today, in committee room 2. I have just been told that no notice has been given of that meeting. Does that mean that we cannot do that?

Ms Oldfather: Could we not adjourn the public meeting and do Arbuthnott just now?

Margaret Jamieson: We are beginning to get into a right mess. This morning, we complained that we have just received papers and have not read them. We have indicated that we have real concerns about that. If we are to hear evidence on the Adults with Incapacity (Scotland) Bill, we need an opportunity to read the documents before questioning people. We cannot talk about it because we have still not read the papers.

This meeting was called, but there is no stipulation about when it must end. It is only stipulated that we must be out of the chamber at 12.30. That does not mean that the committee meeting finishes. These rules are evolving and being changed. There is nothing preventing us running over. I think we have got to do that. I am really concerned.

Dorothy-Grace Elder: Would the meeting be quorate?

Margaret Jamieson: The meeting has been called. We are here.

The Convener: As long as there are three of us. We have committee room 2 this afternoon if we want to continue this meeting there.

Margaret Jamieson: I so move.

The Convener: I have another committee meeting, but I will have to let it go.

Ms Oldfather: I have a constituency obligation at 4 o'clock, so I have to leave here in good time for that.

The Convener: I appreciate that this is all totally unsatisfactory to all committee members.

Ms Oldfather: Convener, we have an agenda before us. The first item is the Adults with Incapacity (Scotland) Bill. We have taken a decision on that. The second item is "Fair Shares for All", the Arbuthnott report. Item 3, on the line of questions to the Minister for Health and Community Care and the Deputy Minister for Community Care, falls, because we are not seeing them. Why are we not continuing to item 2 now? I cannot understand that.

Margaret Jamieson: When are we going to pick up on item 1? That is my difficulty.

The Convener: My only point is that, if we spend a lot of tomorrow listening to evidence in the Justice and Home Affairs Committee, that cuts down our time for discussions. If that is want we want to do tomorrow, I think that we have to find a way to get extra time for discussion today. That is what I was trying to say.

There are two options: one is to continue, and finish this meeting at 12.30; the other is to do something this afternoon.

Hugh Henry: Can I suggest, convener, that we move on to the Arbuthnott report now? Depending on what time we finish that, we can return to the bill late this morning and continue into this afternoon, examining the non-contentious items. If we can clear everything except the areas that are of concern, that will allow us to focus on the issues tomorrow.

Mary Scanlon: Can I propose that, this morning, we simply concentrate on the Arbuthnott report review? Let us get one report correct. We have John Forbes here. Let us do it thoroughly and properly. Can we read all our papers? I take Hugh's point, but I do not know from the BMA's information what they consider non-contentious or otherwise. I appreciate the suggestion. Can we just use our time and concentrate on Arbuthnott, and do one thing right?

The Convener: With the proviso that we may have to continue to meet this afternoon, and that, at the end of this morning's session, we will suspend the meeting and reconvene this afternoon. We would need to be quorate to continue meeting as a committee. That would be in committee room 2. I am aware that that would mean members having to change their plans.

We will now move on to agenda item 2. As I discussed with members at the beginning of this morning's session, this discussion on a draft committee report is held in private. Is that okay?

Members *indicated agreement.*

10:38

Meeting continued in private.

12:32

Meeting resumed in public.

The Convener: Having completed this morning's business, I propose to adjourn this meeting until 1.45 pm when we will resume in committee room 2 to continue with item 1 on our agenda. Tomorrow's meeting will convene at 11.15 am. Are we agreed?

Members *indicated agreement.*

Meeting adjourned at 12:33.

13:51

On resuming—

The Convener: This morning, it was made clear that members wanted more time to talk about the Adults with Incapacity (Scotland) Bill. Ben Wallace, who was our reporter at the Justice and Home Affairs Committee, will give us his report, after which I would like to hear what committee members think about the general principles of the bill and the key areas of concern. It is essential that we flag up areas of concern at this point so that the Justice and Home Affairs Committee can consider them.

Tomorrow, we will attend the Justice and Home Affairs Committee to hear the evidence that it is taking; we will make our final deliberations at a meeting following that.

Ben Wallace: Members will have read my report. I do not want people to be too concerned about the fact that it mentions euthanasia. I recognise that the bill does not aim to introduce euthanasia, but I thought that it was right to note the fact that it is one of the issues surrounding the bill. We should discuss the ethics of the issue.

As I said this morning, I tried to stay within the committee's remit and concerned myself with the health and welfare of incapable adults and with the medical clinicians who might have to treat them. I did not concern myself with the levels of penalty or aspects of liability.

I will not read out the report, but I welcome comments. In paragraph 6, I mention the definition of incapable adults. My first concern is the word "incapable", as defined by the Mental Health (Scotland) Act 1984; the definition is repeated in section 76 of the Adults with Incapacity (Scotland) Bill. My concern is that the Millan committee is reviewing the matter; we should consider whether we want to pass that on to the Justice and Home Affairs Committee. The goalposts could shift. The concept of learning difficulties almost assumes incapability and we may find that the Millan committee's redefinition—under the Mental Health (Scotland) Act 1984—says that that is no longer true. That would affect who was covered by the new act. We should understand that.

It worries me that the definition of learning difficulties is taken in such broad terms as to be included in "incapable". There is no recognition of partial-capable or assisted-capable decision making, which other countries strive to recognise. A person might not be able to make a decision on their own, but perhaps they could come to a logical and sound decision if they had help. It would be useful to examine how other countries include that in legislation.

Dr Simpson: Can we take each step at a time? Definition is the first step.

The Convener: I have several points that I hoped to get through.

Dr Simpson: Rather than hearing everybody's points, which may be similar, perhaps we should deal with one issue at a time.

The Convener: Ben, would you prefer to get to the end of your report and then take it from there?

Ben Wallace: I would not mind dealing with the definition of "incapable adult" and then moving on to the next issue.

For the purposes of the bill, an adult is defined as being 16 years old. Other legislation uses different ages to define an adult; we should investigate whether there may be a clash and whether, from a medical point of view, doctors treat 16-year-olds as adults.

The Mental Health (Scotland) Act 1984—and therefore section 76 of the bill—rules out specific conditions that make someone incapable. For example, if someone has an alcohol problem, it does not mean that they are incapable. However, I suggest that the affliction of a drug addict or an alcoholic could make them confused, even though the condition is temporary. There is no real recognition in the bill of that short-term confusion—a person is either incapable or not. That needs to be clarified and I would be interested to hear Richard's views.

The definition of "incapable adult" produces an all-or-nothing situation, both in its treatment of decision making and in the assessment of the adult. The committee should discuss that concern.

Dr Simpson: I share Ben's concerns. The issue of partial or diminished capacity is important, particularly in relation to learning disability. ENABLE has given us written evidence that it would prefer the bill to refer to severe learning disability. I am not sure whether that is legally correct; that is a matter for stage 2 consideration.

On the general principles, I would like us to be more cautious about rendering people with specific or minor learning disabilities part of the group of incapable adults referred to in the bill. The term is not defined well enough.

The issue of temporary incapacity is a problem, of which Ben gave us a good example. If someone arrives at the accident and emergency department with partial or diminished capacity as a result of drinking or an overdose, it may be difficult for them to make decisions that one would regard as appropriate. At that moment, a decision has to be made on whether such a person is definitely incapacitated; a midway zone is not possible. The question of "partial" or "temporary" in the definition is important.

Margaret Jamieson: That point is partly covered in the Scottish Law Commission's submission. On page 3, it mentions the principles of the Council of Europe, and its formula. It is all down to definition. The Law Commission submission mentions

> "adults who, by reason of an impairment or insufficiency of their personal faculties".

We need to be specific. Like Richard Simpson, I have real concerns about including people with a specific learning difficulty. That difficulty could be minor, and it would be quite inappropriate for such people to have their rights removed because they fall under that banner.

14:00

Malcolm Chisholm: My reading of the bill was not that all people with learning difficulties would be included and were deemed to be incapable. When I read section 76(1), I thought that the existence of intervention orders was a recognition that some people might be incapable in one area or for one decision; I did not think it meant that those people were generally incapable. The bill recognises gradations of incapacity; ambiguity exists, however, so perhaps the bill needs to be more explicit.

The Convener: That needs to be examined by the Justice and Home Affairs Committee.

Does anybody have any points about the specified age of 16?

Dr Simpson: There are two confusing points about that. First, the age of consent in Scotland has always been different from that in the rest of the United Kingdom. Now, as I understand it, consent means that someone is capable of making an informed decision. Secondly, professionals have to make a decision that the person they are discussing something with is capable of making an informed decision. That has nothing to do with age. When 16 is referred to, I think that it refers to other legal matters in terms of capacity. I therefore suspect that it is not a medical issue.

Hugh Henry: I agree. The age issue is not our concern. All I would expect is some consistency of approach, but that is another point for the Justice and Home Affairs Committee.

The Convener: Our reporter raised that point. I assume that such points are made on the understanding that at some point, there will be an acknowledgement of this committee's remit and interest, and of the fact that the points were made in the course of Ben's research. I am working on the assumption that the issues highlighted by our reporter will be recognised.

Ben Wallace: Paragraph 7—the largest part of my report—deals with safeguards to protect the individual. I looked at the question from a welfare or medical treatment point of view, rather than from a judicial one; I approached it from the patient's point of view and also bore in mind the need to protect carers.

The next paragraph mentions the parts of the bill that include

> "measures intended to ensure a course of action that best benefits the adult."

I was worried about some of the loopholes, and the lack of responsibility or duty to live up to that statement. My report continues:

> "While there is a requirement in Part 1 section 1 subsection (2) that interventions must benefit the person with incapacity, there is no corresponding requirement that the decision *not to intervene* must benefit them."

I would seek advice on whether that is just a petty observation or something that has a knock-on effect—medically—on how people are treated. Perhaps I could ask the British Medical Association about that tomorrow.

Duty of care is an issue. Clinicians and doctors have a duty of care. Under the current proposals, the guardian, proxy, or welfare attorney—whoever it is—must satisfy themselves only that they act in reasonable or good faith. No duty of care is placed on them. Their decisions must benefit the patient, but there is no duty to seek informed advice. If, for example, I was the carer—I have no medical background and am totally naive about the issue—there would be no onus on me to seek medical advice. As long as I could prove to the courts that—in my view—I did what I thought was reasonable at the time, I would not be held liable for my decision. There must be many medical conditions of which I do not have enough knowledge to have any idea what the right decision would be.

Without any duty or obligation on carers, I fear that there could be a problem with less educated or less fortunate people, people without initiative, or people with another agenda, becoming welfare attorneys or proxies. We must understand that some people may have a financial interest by virtue of the fact that they are the next of kin. A duty of care or some kind of obligation must be inserted into the bill.

That brings us to the question of safeguard priorities. In addition to looking after the patient, if carers had that duty of care, they would have to meet the requirement in section 1(4)(a) of the bill to take account of

> "the present and past wishes and feelings of the adult".

What takes priority for the Executive: the wishes of the individual who is incapable, or the doctor's duty of care, irrespective of the carer?

Alzheimer Scotland sees things the other way round from me. If a doctor disagreed with a carer and said that a patient must be treated, the doctor would have to take the carer or welfare attorney to the Court of Session to overrule their decision. I discussed the issue earlier with Richard Simpson. I was a bit extreme. I would have liked it to be the other way round: the carer would have had to take the doctor to the Court of Session to have his or her decision overruled. There will be instances where patients are in pain only in the short term. Do we want a busy doctor in a Highland hospital to go to the Court of Session to overturn the decision of a carer on whom there is no duty to make an informed choice? Richard Simpson suggested that carer and doctor should agree together in a partnership. Alternatively, there could be a local ethics committee under the health board. Richard will expand on that.

The Convener: Presumably, most of the time decisions would be agreed upon in partnership. However, we need a law that covers the extremes.

Ben Wallace: That is where the issue is skirted round. At the end of the day, is the worst-case scenario that the view of the doctor or clinician is upheld over the view of the carer or proxy? That is a difficult decision. That is why I felt that I must mention the euthanasia statement. The priorities must be spelled out in the bill. I do not see a clear priority there as yet.

Finally, section 44(2)(b) includes "nutrition and hydration" in the definition of medical treatment. Nutrition and hydration may be medical treatment, but they are also a comfort, just as nursing can be given to heal or to look after someone who is dying. The definition of medical treatment, which has been queried by the Justice and Home Affairs Committee and this committee, should perhaps be widened or removed. With the current definition, we could be in a position where patients can be denied food and drink, and so caused tremendous suffering, if someone says that a patient should receive no medical treatment.

I think that there is a lack of liability in part 7, sections 73 and 74. As I state in my report:

> "proxies shall incur no liability for any breach of duty or fiduciary duty if they have acted or failed to act reasonably or in good faith."

The limit of liability on the individual carer, the proxy, is too narrow, especially when people who have a financial interest will be in that position.

Mary Scanlon: I noticed, when I skirted over the BMA submission in our limited lunch break, that it covers the point that Ben has covered. Section 19.3 states:

> "Decisions to withhold or withdraw conventional treatment on the basis that it is not providing a benefit to the patient, should be made by the clinician in overall charge, following discussion with the rest of the health care team and where appropriate those close to the patient. Where a clinician's view is seriously challenged and agreement cannot be reached by other means, review by a court would be advisable."

Will we recommend that?

The Convener: We should hear what other members think about that.

Margaret Jamieson: That tackles the issues that Ben raised. It considers care in the widest sense. If someone receives help from the social services, they will have an attached social worker. Ben's problem relates to someone who has sustained head injuries in a car accident, where that type of support would not be on tap and decisions must be made quickly.

I am happy that nutrition is included in the bill. That has been a grey area for too long. I am happy with what the BMA is saying. We should perhaps broaden it into the care team rather than specify the health care team. If the patient were a client of ENABLE or any other group, it would automatically be involved in making the decisions.

The Convener: I have been reminded that our remit is to flag up points of concern. I take it that members have a point of concern about who will have the ultimate decision.

Malcolm Chisholm: As I indicated this morning, I take a different view on this. I think that we have to consider this next section with the next one. Where the bill has run into most difficulty in terms of public opposition is that it appears to have reopened the door to euthanasia. That area must be explicitly taken out of the bill. Once euthanasia and related issues have been taken out of the bill, I am more relaxed about the welfare attorney or guardian having the right to make these decisions. People are worried about the welfare attorney or guardian having those rights because they think that will be a back door to euthanasia via the welfare attorney or guardian. If they do not have any rights in that area, I do not have a problem with them having the say over treatment.

Ben is being slightly unrealistic when he states in his report that:

> "This unrealistic and impractical proposal may lead to patients having to wait in severe pain while the legal procedures are followed."

I do not think that a guardian will watch someone in agony and not opt for treatment. As long as we remove those areas, where nobody wants to tread, from the bill, I am comfortable with the proposals in this section.

The Convener: That takes us into two matters that I would like to flag up.

Part 1, section 1 is saying that what is intended is that interventions must benefit the person. The definition of the word benefit—the law case is saying that benefit in that case led to a particular person's death. Although we can take it at one level and say that the whole bill is about benefiting people, do we need to tighten that up?

Picking up on what Malcolm has said about section 44(2)(b), in which nutrition and hydration is defined as part of medical treatment, although I am happier to have something written in black and white, this seems to go part of the way down that route but stops short of explicitly stating that this is again a question of benefit and it is not about omission. They have failed to be explicit about omission.

Do people want to comment on whether we need section 44(2)(b) to be there at all? Members of the Justice and Home Affairs Committee are saying, "Take it out completely", because it is causing ambiguity. Do you want that sort of thing to be left in, while the duty of care and benefits and so on is made more specific? I do not want to get into the nitty-gritty of it, but it is a fundamental issue. That ambiguity is probably the reason why all the people who should have been happy that living wills and so on have disappeared from the bill still have concerns about it.

14:15

Dr Simpson: Three issues are relevant here. One is treatment, where it is a positive intervention. The second is withdrawal of that treatment, so that once you have defined what your positive treatment is, can withdrawal of it be seen as benefiting the patient? Let me illustrate that: if death is imminent, to continue feeding and hydrating a patient at that point may be inappropriate. However, hydration and nutrition should never be withdrawn as a means of achieving death; in other words, it should not be—

The Convener: The death of somebody who was not going to die.

Dr Simpson: The third issue is non-intervention, which is not laid out here at all. It is the medical treatment we are talking about, and under a medical duty of care the doctor is under a general duty—nothing to do with the bill—to undertake such treatment as will be beneficial to his patients. So there is a general duty of care there. That may be enough to say whether there should be intervention or non-intervention.

Doctors still have to make a decision about whether to say, "This patient is beyond saving and therefore we will not intervene". They do that in the case of major road traffic accidents in which five or six people need treatment. Doctors have to triage the accident victims and say, "We cannot do anything about that person". If a doctor thinks that they are beyond care, they do not have a duty to hydrate them and start doing things to them. Those decisions are being made.

The issue of balance was mentioned. In practice, most decisions will be made by the health team. It is a matter of whether cases can be divided systematically according to whether there is a long-term perspective. Long-term incapacity, even if it is temporary, will still go on for a length of time. You have to set up arrangements for someone with severe learning disability, because their degree of incapacity requires support over a long period.

On the other hand, decisions have to be made there and then for someone with an acute condition, who has to go into an accident and emergency unit. There is no time to wait for certificates to be issued under subsection (3). We will be in real trouble if neurologists and accident and emergency teams are asked to write out certificates and say, "This patient is incapacitated", before they start treating them. Where the bill has failed again—and I raised this in relation to other reports that we have received—is that a number of circumstances were not run past it to see whether it survives. I think that that should be done.

The Convener: A reality check.

Dr Simpson: A reality check. I am not sure whether it fulfils that in terms of the emergency situations to which doctors and health teams are having to respond. I am sorry. That is not all that helpful, except to say that I am concerned about this point.

The Convener: I have a vague recollection of reading somewhere that the bill will allow doctors to deal with emergencies. Can you shed some light on that, Ben?

Ben Wallace: There are situations where a doctor can issue a 24-hour or short-term incapacity certificate. There seems to be—this is the reality check—no concept of the dimension of time in parts of the bill. That also applies to the partial incapacity in assisted decision making: either one is in a situation where one could get permission or come to an arrangement, or one is not. I could not see a reference to a here-and-now problem. I have been through the bill and the closest reference to a situation is where a doctor—a GP—can issue some sort of 24-hour certificate.

Dr Simpson: The certificate is referred to at section 44(3)(b)—sorry, we are getting into detail—which says:

> "or such shorter period from that date as may be specified".

So one can make the period as short as one likes. However, one must still have a mechanism whereby a certificate that says that a person is incapacitated is issued to the emergency team before they resuscitate an individual and do things to them that almost amount to assault but that are covered by the duty of care. That is how I understand the position.

The Convener: Do committee members feel that mechanism is not realistic and that we do not want to impose it on emergency teams trying to save lives?

Dr Simpson: The question must be asked, but I may well have read the bill wrongly. As you say, convener, we are all learning.

Malcolm Chisholm: I am surprised that you say that, but I do not really know about it. We should flag up that matter.

The Convener: We will come back to this discussion tomorrow, so we should ensure that we have received clarification on that point before then.

Dr Simpson: On the question of the balance, I think that it would be better to have a mechanism that did not involve the Court of Session in any dispute. For example, a patient with Alzheimer's disease is managed in a residential or nursing home—I think that Alzheimer Scotland mentioned this point in its evidence—and is being treated with neuroleptic drugs, which, under the guidelines, would not be regarded as appropriate in most circumstances. The next of kin, acting under section 1(4)(b), says, "I do not want my relative to be treated in this way any more", to which the doctor says, "Yes, we should continue to treat them". The way in which the bill reads at the moment means that the treatment has to be stopped and the doctor has to go to the Court of Session to continue it. I think that Ben is saying that that is pretty impractical.

We need to establish an intermediate mechanism, such as an ethical committee of some sort within the health board to which the medical team and the other person can refer such cases in the first instance. Alternatively, there should be a requirement upon the individual who seeks to stop the treatment in the face of the doctor's disagreement to seek a second medical opinion. Ben may know if the requirement on the proxy, whoever that may be, to seek a second medical opinion is contained in the bill. Alternatively, can the proxy simply say, “Bang, that’s it”?

The Convener: No, they can say, “Bang”.

Dr Simpson: There must be a mechanism for either a second opinion or for the team and the individual to seek mediation at a local level for less serious cases. There is always a third stage: either party can go to court in the event of disagreement. It should be for either party to do that, rather than for one to have the right to do so over the other.

Margaret Jamieson: In such circumstances, there cannot be withdrawal of treatment while that right is being exercised, which could complicate matters for the patient.

The Convener: The bill says that treatment continues while the dispute is pursued.

Margaret Jamieson: I do not think that it is stated enough. It needs to be central to what Richard is talking about.

The Convener: Are members happy about that? Are there any further comments on this aspect of the bill?

Mary Scanlon: I agree with what has been said about additional safeguards. Apart from anything else, it is costly and time consuming to go to court.

The Convener: Ben’s argument is that, as a result of costs and so on, people may not take that recourse.

Ben Wallace: It is not whether I think that it is practical—

The Convener: Yes, it is not the practical but the financial implications. There are all sorts of other implications that are not to do with the primary issue, which is the care of the patient.

The other point in section 7 of Ben’s report is the issue that doctors are bound by a duty of care, whereas the bill creates the role of welfare attorney, who does not seem to have that same duty of care. Generally speaking, most people will act in a way that is of benefit to the incapacitated individual. However, beyond that point, there is no duty of care imposed upon them and they seem to have no responsibility for their actions.

Ben Wallace: The bill removes a lot of the liability on the doctor’s duty of care and gives it to someone who does not have the same level of duty of care, someone who has to satisfy a much lower level of what is right.

Paragraph 7a(vi) of my report says:

> “This section does not make clear the extent to which the ‘satisfaction’ should be informed either medically or financially.”

The bill removes the duty of care from the doctor. He will not be working in partnership; he will be working under an individual who may well not be trained or who could be ignorant of the situation and who is working to priorities that include the past and present wishes of the incapacitated adult. The responsible person simply has to prove that he or she is reasonably satisfied.

The Convener: Having done that, is it correct that that person is not liable for the decision that they have taken?

Ben Wallace: That is a completely different subject, but it is like the difference between the evidence required for a criminal conviction—beyond reasonable doubt—compared to a civil conviction.

Mary Scanlon: That is a crucial point. An attorney cannot make a clinical judgment.

Malcolm Chisholm: I must repeat my concerns on this point. We are all influenced by different examples, which is a problem. Guardians and welfare attorneys are going to have varying degrees of care. I still think that a lot of the examples that are being given to us could be dealt with by making it clear that no one has the right to end an individual’s life. We are not talking about that.

I spoke to a woman recently who has looked after an individual with severe learning difficulties for nearly 30 years. I regard that person as one of the unsung heroines of society. No one could possibly question her absolute commitment to her daughter’s welfare, yet she has had several arguments with doctors about her daughter’s treatment. No one is criticising the medical profession, but the reality for her is that she knew what was in her daughter’s best interests in certain situations better than a doctor who did not know her daughter, because she had been with her daughter for 30 years.

We must be careful about translating the bill into one where the welfare of incapable adults is for the medical profession to decide. I am not hostile to the medical profession, but we are in danger of moving towards that situation. I do not think that we want to do that.

The Convener: The position in the bill must be refined. At the moment, I feel that this bill does not take a clear final line on whose responsibility that is. Once a decision has been taken, there does not seem to be a clear line on who is responsible for it.

14:30

Dr Simpson: I am not sure that I agree with that. It is clear that, if the guardian or welfare attorney decides that treatment is not to be initiated or is to be withdrawn, the doctor cannot contravene that wish without going to court. That has merit, in the sense that it is clear. However, I believe that it is as unbalanced as the reverse situation that Malcolm described, in which the doctor could pursue treatment and the welfare attorney would have to go to court to prevent it. Both those situations are unacceptable. It is not just that I prefer a compromise—I believe that these matters must be worked out in the best interests of individuals.

Ben Wallace has problems with section 73, which states:

> "No liability shall be incurred by a guardian, a continuing attorney, a welfare attorney, a person authorised to act under an intervention order . . . for any breach of any duty of care or fiduciary duty owned to the adult if he has or they have—
>
> a) acted reasonably and in good faith and in accordance with the general principles set out in section 1".

That will depend on how the law interprets what is regarded as benefit. If someone strongly believes in euthanasia and insists that their relative should not be treated, the doctor would have to go to court to oppose that. Is that not the case?

Malcolm Chisholm: We must make it explicit in the bill that that is not a choice either for doctors or for guardians. The issue of euthanasia must be removed from the bill. People are saying that it is there by accident or that it has come in through the back door, but if it is dealt with it will not form part of our discussions. No one is allowed to withhold treatment when someone is not about to die; that is not an option for doctors or carers. Once we have removed the issue from the bill, we can deal with the situations that remain.

The Convener: Malcolm, at the moment our job is to raise concerns about the bill that is in front us, although I take your point.

Malcolm Chisholm: I think that we should deal with this in two parts. We should deal first with euthanasia and then with the remaining issues.

Ben Wallace: I would say that the bill does raise the issue of euthanasia. As a carer, I would have to take into account the present and past wishes of the incapable adult. Let us say that I have no medical background and my wife is in a critical condition, having made it clear now and in the past that she wanted to die. I could say, without having to talk to a doctor, that treatment should be withheld. It does not even have to be pointed out to me that I am in contravention of this bill. I could simply say that I knew what my wife wanted, and someone would then have to take me to court to overturn that. My liability would be so limited that all that I would need to say was that I genuinely believed that my wife was fine. That is in the bill.

Hugh Henry: The points about the duty of care were well made, and it would be reasonable to include them in the bill. However, Malcolm Chisholm is right. If we say in general terms that we do not think that this is the way in which to deal with this issue, and that we have concerns that the bill introduces ambiguity and doubt, that will be sufficient at the moment. We should remember that, at this stage, we are commenting on the bill as a whole, rather than undertaking detailed scrutiny.

The Convener: Yes. Because we have raised these concerns, amendments may be lodged and the bill may be changed. All that we can do at the moment is to raise concerns section by section about what is in front of us.

Hugh Henry: Malcolm is absolutely right—a number of individuals and organisations have raised a fundamental issue. It would be proper for us to express our concern about the way in which this subject has been handled and how it is clouding debate on the bill, and it would be proper for us to point out that the wording should be further considered because of where it could lead. We, and other individuals, would then have the opportunity to lodge amendments during the detailed scrutiny stage. At the moment, it is sufficient to say that we are concerned about the wording and its implications.

Let us move on. Are there other areas about which we are similarly concerned, and that we need to consider?

Mary Scanlon: Those were good points and I do not disagree with any of them. The main issue is the role of the attorney who has the right to refuse treatment. The two major cases in England and Scotland have clouded the rest of the bill. We have to address whether water and the life-support machine can be switched off.

Ben Wallace: The limited liability provision allows someone to get away with it. It does not come up to the standard to match the benefit or the care provided. It is not about euthanasia—it has nothing to do with that. However, if we were to alter the provision, it would be from the limited liability angle. We have discussed paragraph 8 of my report. It is for the committee to decide whether it agrees with it or not.

The Convener: Having read the bill and the various explanatory background notes, I thought of a few issues that I would like to raise. Other members have already covered a lot of them.

Hugh Henry: May I suggest that we first ask whether any committee members have other issues to raise? At the end, you can do a sweep up of anything that we have not covered, convener. I have one issue that I would like to raise.

The Convener: All right. Who has a real constraint on their time? Hugh, Richard and Ben.

Hugh Henry: I have to be away at 3 o'clock.

I wanted to raise the issue of research, which was put very powerfully by Alzheimer Scotland.

The Convener: That is a point that I was about to raise.

Hugh Henry: I do not think that we should try to reach a conclusion this afternoon, but we should indicate our concern. The organisation made its point well; I retain an open mind on whether I agree or disagree with what it said. Nevertheless, it has raised a concern that is worthy of further deliberation.

It also raised the issue of the European convention on human rights. Given some of the recent debates on that, the point was well made. At the very least, I would like to put a marker down for the Justice and Home Affairs Committee that some clarification and re-examination are needed, and that, at the next stage, this committee will want to go into the issue in further detail.

The Convener: For the sake of the *Official Report*, can you be specific?

Hugh Henry: There is a lot in section 48 of the bill, but given the limited time, I do not want to go into the details. It is sufficient to say that concerns have been raised about research and section 48—for example, would further legitimate research be prevented, and could there be an unforeseen barrier to that research? We should ask that those questions be considered.

The Convener: So the question is whether section 48 will be a barrier to non-therapeutic research and continuing research into chronic conditions.

Dr Simpson: There are two issues. First, research into causes is precluded by the bill; Alzheimer Scotland and two other witnesses have said that. That is because research into causes is unlikely to be of benefit to the individual—there would be difficulties in making that assumption.

Secondly, the bill precludes randomised controlled drug trials, which is the standard method for obtaining evidence about the efficacy of drugs. A randomised control trial is carried out against a placebo—an inactive compound. Although there is evidence in some areas of psychiatry that those patients who get the placebo do better than those who are given no treatment at all, it is difficult to sustain that argument in the context of the bill.

Those two measures might damage individuals, particularly if they have Alzheimer's, because further research would benefit other people with Alzheimer's and, if the individual were able to express a wish, they might want to participate. There is a considerable difficulty there.

The proxy's role provides protection against inappropriate research being carried out—that is very important. However, the bill totally precludes what could be valuable research in several areas that might ultimately benefit patients.

The Convener: Because research has to be linked to the specific benefit to the specific patient?

Dr Simpson: Beyond that, the problem is that it may be precluded by the European convention on human rights and biomedicine. We are considering whether to sign up to that at the end of the year. If we sign up to it, we need to ask whether the proposals in the bill or any amendments that we make to them would be precluded by the convention.

The Convener: Do you have anything else to say, Hugh?

Hugh Henry: No, that was my main point.

Dr Simpson: I have not had time to read fully the evidence on the Mental Welfare Commission. However, the role of the commission is being changed in several respects—I would like to come back to this subject after I have had a chance to consider the evidence. Two sections deal with the Mental Welfare Commission, but perhaps that question should be sent to the Justice and Home Affairs Committee.

The Convener: Some of the duties of the Mental Welfare Commission are being transferred to the health boards. We may want to discuss the whether health boards should be responsible for patients' finances.

Margaret Jamieson: As things stand, such matters depend on where the licence for an establishment is held. It falls to the registration officer of the health board to ensure that patients' funds are held and dispersed appropriately. There does not seem to be any change to that arrangement, although it is individualised—

The Convener: A limit is imposed, as well. It does not involve property and shares and so on. A figure of £5,000 is mentioned.

Mary Scanlon: I have a brief point about the letter from the Scottish Intensive Care Society, which rightly says that intensive care

> "is a continuous process with interventions varying in invasiveness".

It also says:

> "Between the two extremes are many interventions that are performed regularly and for which no consent is currently sought."

There seems to be a concern that doctors' decisions may be delayed by constant reference to the attorney.

14:45

Hugh Henry: One of the problems that I have is that the submission refers to the document, "Making the right moves", but does not mention specific sections of the legislation.

The Convener: That ties in to the question about treatment in an emergency situation. I remember reading about it—we will have the relevant section by tomorrow.

Mary Scanlon: Although we do not want to talk about euthanasia, we should be aware that many of those who have sent submissions to us are worried about the issue.

The Convener: Malcolm Chisholm's point was well made. We have to clear up some of the ambiguities.

Margaret Jamieson: My concern is that we should meet the requirements of the European convention on human rights. I feel that we might be wasting our time going through the bill if it is not going to meet the test that will be applied. I do not think that the test has been applied to the bill yet.

The Convener: The Justice and Home Affairs Committee will have to question the Executive on that.

Most of the points that I wanted to raise have been picked up on; I do not know whether other points are raised in the submissions, some of which we received only this morning. A constant stream of submissions comes in and it is fair that we should deal only with those that we have had overnight.

Tomorrow, we will attempt to come up with the key points that we want to raise with the Justice and Home Affairs Committee—some committee members are not here this afternoon, as this meeting was tacked on owing to circumstances this morning.

Hugh Henry: I would like to thank Ben Wallace for his work. His report was helpful and he had obviously given some thought to it. One of the benefits of such a report is that it helps to focus the debate, although we might not agree with the detail.

The Convener: I echo that and I recognise that Ben has done a lot in a short time, working with others to put the report together. The subject is complex and I know that all members will take an active interest in stage 2 of the bill. This afternoon's discussion has given some indication of the concerns about the bill.

We have not put on record whether we welcome the bill. There has been a lot of discussion about the necessity for the bill in terms of the rights not only of incapable adults, but of carers. I know that people have been waiting for clarification on a number of points—some medical, some financial—that impact on people's lives. It is important that we get it right.

Meeting closed at 14:49.

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