HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 17 November 1999
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE

13th 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

COMMITTEE CLERK:

Jennifer Smart

ASSISTANT CLERK:

Irene Fleming

Scottish Parliament

Health and Community Care Committee

Wednesday 17 November 1999

(*Morning*)

[THE CONVENER *opened the meeting at 11:26*]

The Convener (Mrs Margaret Smith): I thank the Justice and Home Affairs Committee for allowing us to take part in its deliberations with the British Medical Association, the Royal College of Nursing and Professor McLean at short notice. That was useful for us. I intend the committee to take item 2 on today's agenda first.

National Health Service (Penalty Charge) (Scotland) Regulations 1999 (SSI 1999/121)

The Convener: This instrument comes under the negative procedure. No motion has been lodged to recommend that nothing further be done under the instrument. After consideration of the instrument, the Subordinate Legislation Committee determined that the attention of Parliament need not be drawn to it. Therefore, I suggest that nothing be done with the instrument. Is the committee agreed?

Members *indicated agreement.*

The Convener: I suggest that, when we consider the Stracathro petition at the meeting on 24 November, we agree to meet in private for the first 15 minutes, at 9.15 am, to discuss how we will question the witnesses who will be in attendance. They will be from Tayside Health Board, Tayside University Hospitals NHS Trust, Brechin and District Patients Association, the Stracathro hospital staff action committee and Angus and Mearns Action to Save Stracathro. Two of those parties will attend jointly.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): Will we receive any papers in advance?

The Convener: We have asked for various submissions, and people have asked whether they can make submissions to us. I have also circulated details to all the local members, including list MSPs as well as constituency MSPs, so that they will know that the meeting is taking place and will have the opportunity to submit any information that they have in advance. We have been trying to get a wide range of submissions.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I assume that that meeting will take place in Edinburgh.

The Convener: Yes.

Margaret Jamieson: When was that decision made?

The Convener: I cannot remember whether it was formally put on record that any member wanted to challenge that fact. I circulated an e-mail to members, the vast majority of whom said that they were happy for the meeting to be held in Edinburgh, although one or two said that we should consider going to the Brechin area. I went ahead with that as a convener's decision; I do not think that it ever came before the committee. Had the majority of members intimated by e-mail that they wanted the meeting to be in Brechin, I would probably have had to bring the matter before the committee. I did not do so because they did not so intimate.

Margaret Jamieson: I do not recall ever being given a choice about where the meeting should be held.

The Convener: Was an e-mail not circulated?

Mary Scanlon (Highlands and Islands) (Con): I remember expressing an interest in participating, as I thought that it was a unique opportunity for us to go out and meet the people.

The Convener: An e-mail was circulated.

Mary Scanlon: I do not remember receiving an e-mail. As I said, this was a unique opportunity for us to go to meet the people, particularly bearing it in mind that the petition had 25,000 signatures.

11:30

The Convener: From what you are saying, I take it that next time we should give more consideration to such matters. Some people who responded pointed out that, because this was the first time that we had considered a petition, there was a question of precedent. I will ask the clerks to look into the matter and to get copies of all the answers that we received, but I am pretty sure that we e-mailed all members about it. I remember receiving comments from several people.

Adults with Incapacity (Scotland) Bill: Stage 1

The Convener: We have had some further clarification of what we should be doing at this stage in our consideration of the bill. We have only a short time to pull together our thoughts at stage 1 and to pass those on to the Justice and Home Affairs Committee, which is the lead committee on the bill. I will ask Jennifer Smart to give us clarification not only of what we are expected to do at stage 1, but of what we can do at stage 2. We have received some further clarification on that since yesterday, so we can let you know what is happening.

Jennifer Smart (Committee Clerk): As members know, at stage 1 the committee is to consider the general principles—the overarching concept—of the bill, rather than to examine individual details. The documents that should be examined are the policy memorandum and explanatory note, which outline the consultation period for the bill and the policy behind it. The committee is called on to decide whether the bill is necessary and whether it fulfils its aims.

The finer detail can be considered at stage 2, when the committee will examine the bill section by section. Amendments to the bill can be lodged at that stage. If the committee is minded to make comments or lodge amendments, there is nothing to stop it having the convener lodge an amendment, which individual members of the committee can then support. There is also nothing to stop any member lodging an amendment at stage 2, if there is no consensus within the committee on an amendment. The aim at stage 1 is not to scrutinise each part of the bill, although it would be permissible to bring areas of concern to the attention of the Justice and Home Affairs Committee.

The Convener: That is a useful clarification. It allows us to continue to have an input.

Kay Ullrich (West of Scotland) (SNP): It means that we can come back to those matters later.

The Convener: Absolutely. However, we have received clarification only in the past 10 or 15 minutes.

Kay Ullrich: That would have saved a lot of heartache over the past couple of days.

The Convener: That is certainly true. I will make some points about the issues that have been raised, which will be circulated in writing to the Parliamentary Bureau and to clerking services. This is our first attempt at dealing with a subject bill, and some things could have been handled better for us by the bureau. We could also have been given more clarification on the legal points of what we are required to do and how and when we are able to do it.

Kay Ullrich: Because we were approaching the bill with what appeared to be an impossible timetable, there seemed to be an element of panic in our approach, rather than measured scrutiny.

The Convener: I can say only that I was acting on the information that had been given to me. The information that was given to you this morning was the result of a meeting that we have had in the past 10 or 15 minutes. That gives us the ability to take the bill forward, possibly using Ben Wallace's report as a starting point. We can add issues to that, change its tone and take out anything with which we are unhappy; I note that Ben did not cover research and a couple of other matters, but I will wait for other members to raise them. We need to ask ourselves whether there are problems that need to be addressed through legislation, and whether we are happy with the general principles of the bill.

At this stage we do not have to say that we agree chapter and verse. It would be useful for us to give pointers on areas of concern or on areas that we think that the Justice and Home Affairs Committee should consider. Does anyone want to kick off?

Mary Scanlon: We discussed some of the points in the report yesterday. Rather than going over what we discussed then, do you have a note of our areas of concern?

The Convener: Everybody now has the *Official Report* of yesterday's meeting.

Mary Scanlon: A précis of the areas of concern would be helpful.

The Convener: We do not have one at the moment.

From memory, I can say that we had a discussion about the definition of adults with incapacity. We picked up on Ben Wallace's point that it was an either/or definition, although there are an awful lot of areas in between. The question of adults with learning difficulties was highlighted. There was much discussion about duty of care, which is covered in paragraph 7 of Ben's report, and about the definition of benefit in part 1 of the bill. The committee discussed a duty of care for welfare attorneys, their responsibility and liability, and how welfare attorneys should interface with the medical profession. There was some discussion about members of the medical profession having to go to the Court of Session if they did not agree with a proxy's decision.

There was discussion about section 44(2)(b) and the inclusion of hydration and nutrition. Members can correct me if I am wrong, but the question of omission was included—that a duty of care should cover the omission of treatment as well as proactive intervention. We did not go into that in particular detail yesterday, so members may want to pick up on it once they have heard from the British Medical Association and the Royal College of Nursing.

It was suggested that there was a lack of clarity because section 44(2)(b) mentioned hydration—

this is the first time that it has been included in a definition of medical treatment in legislation. That caused concern to a number of groups. The overall feeling of those who spoke—Malcolm Chisholm expressed it well—was that, although the intention of the bill was not to create a back door to euthanasia, there was a need for greater clarification, so that it could be seen that that was most definitely not the case.

Can anyone remember anything else?

Mary Scanlon: We mentioned research.

The Convener: We mentioned research yesterday, but it was not in Ben Wallace's paper. If we are using that paper as the basis of what we will submit to the Justice and Home Affairs Committee, we will have to add that to it.

The issue was the definition in the bill that research should be for the benefit of the patient. People such as Alzheimer Scotland and the BMA say that there is a wider need for research and that the individuals themselves may want it. I would if I were in that position. It might be too late for me to benefit from any research in which I participated, but there would be a wider benefit for society and for the group of people who eventually will suffer from the same disease. With Alzheimer's, one might feel that one had a duty of care to one's fellow man.

Kay Ullrich: The issue of managing the funds of incapable patients was raised by the Mental Welfare Commission, which suggested that health boards should assume the role. The problems in residential establishments were also mentioned.

The Convener: I mentioned that briefly yesterday, but as we did not consider it in any great detail, I am happy for members to comment on it.

The other issue, which I raised with the BMA this morning, but on which the committee did not have a final view, was emergencies. Richard Simpson referred to that yesterday. What is the impact on emergency treatment? The BMA representatives seemed quite clear that if there was a road traffic accident, the patient would be treated. Doctors do not wait to find out who is the next of kin.

Malcolm Chisholm: That is at the end of section 44.

The Convener: Richard raised the issue. There could be a need for further clarification. What about on-going treatment? Putting up a drip or taking a blood sample could be seen as interventionist, but that is often part of day-to-day treatment. Do we expect doctors constantly to talk to proxies to find out whether it is okay to do that?

As far as I remember, that covers the broad sweep of what we said. The only other thing was Europe. We have had some clarification on that.

Jennifer Smart: Compatibility with the European convention on human rights is one of the criteria for legislative competency under the Scotland Act 1998. When a minister or the Presiding Officer makes a statement, as required by the act, about a bill's legislative competency, the ECHR has to be taken into account. Jim Wallace and Sir David Steel have made such statements about the Adults with Incapacity (Scotland) Bill. It would be strange for the committee to consider the issue now. In particular, such consideration could be interpreted as raising questions about the content or status of the Presiding Officer's statement. The statement of competency has been made.

The Convener: As things stand, according to the background information that I have, the Parliament is getting things right in that regard much more than it is getting things wrong. It is only in a tiny proportion of cases—1 or 2 per cent—that people are saying that we have got things wrong. That is not to say that the issue should not be raised. The Justice and Home Affairs Committee will probably want to consider the matter. However, the Parliament is covered. We can refer the matter to the Justice and Home Affairs Committee.

Does anyone want to raise a point that was not included in Ben's report? We have already noted that there was nothing in his report about research, so we should flag up research as an issue that should be considered. We also decided that there was a need to expand on the paragraph in Ben's initial report on the definition of medical treatment.

11:45

Margaret Jamieson: We heard some evidence this morning, and I felt that the meaning of the word "medical" was being challenged. The RCN said that we should be talking about nursing care—

The Convener: Clinical care.

Margaret Jamieson: Yes, clinical care. Are we now just talking about treatment? Because if we adopt one particular definition, it cuts off what we are trying to do, which is to ensure that people receive appropriate treatment at the appropriate time.

Kay Ullrich: I think that the point was being made that medical treatment is an old-fashioned term now that there is a team approach. However, we must not get hung up on the fact that medical treatment is just nurses; it is also physiotherapists and—

The Convener: Yes, it is much more than a single decision being taken by a single doctor. It is much more of a team decision. The BMA made that point as well.

Margaret Jamieson: It is all very well to say those things.

Ben Wallace (North-East Scotland) (Con): Convener, is this a stage 2 point?

The Convener: It probably is, but because we had the discussion that we had yesterday, I think that we should put the work that we have done to the Justice and Home Affairs Committee.

Ben Wallace: There is an interesting amendment that we could make. The committee could come up with a view of how to define medical treatment, and lodge an amendment in the name, perhaps, of an individual.

Margaret Jamieson: If you do that, you run into significant dangers. I think that we should remove the word "medical" and leave it as "treatment".

Ben Wallace: Yes, that is an option.

The Convener: At this stage, stage 1, we should inform the Justice and Home Affairs Committee that, after listening to points that have been made to us in submissions, we feel that this is an area in which there may be a difficulty. If we feel that we want to do a specific piece of work on it, we can do that at stage 2.

Also not covered yesterday, and not in Ben's report, are exclusions to the general capacity to treat. Those will be dealt with by regulation, rather than by measures in the bill. The BMA has said that it wants to ensure that such things are open to consultation. I do not think that I want to say any more than that, because this issue concerns aspects that are not in the bill; for example, advances in medical techniques. However, we should not lose sight of the fact that there are exclusions. Some of those are covered by the Mental Health (Scotland) Act 1984, but there are other very important areas such as sterilisation.

Mary Scanlon: I would like to add two points, which we have already skirted round during much of the discussion this morning. One concerns the ability of the attorney to challenge a clinical judgment. Section 47 says that the attorney has the power to say, "Do not treat." There needs to be more clarity.

In paragraph 5.2 of its submission to the Justice and Home Affairs Committee meeting on 17 November, the RCN said that it would expect that

> "a welfare attorney who exercises his or her right to withhold consent to medical treatment would also have the ability to differentiate between different types of treatment."

This issue is very complex, and we also have to take into account the confidentiality of the patient. I would like—

The Convener: We also have to take into account the fact that the patients are in incredible pain and distress in the first place.

Mary Scanlon: Absolutely. I would also like to raise my concern about a possible conflict between the attorney's decision and the best clinical judgment. Given what Ben Wallace said about the fact that the present arrangements leave many incapable adults open to financial and medical abuse, I was uncomfortable when Sheila McLean said that incapacity was a legal definition rather than a medical one. I would like the situation clarified.

Margaret Jamieson: I thank Mary for raising that point. When I heard that definition, I had visions of a lawyer sitting in every accident and emergency room with a cash register. We need to be careful that we are not parachuting a profession in to do the work of other capable professionals.

Mary repeated the assumption that people who are classed as incapable suffer abuse from nurses and doctors. There is no substance to such claims.

Mary Scanlon: I did not say that.

Margaret Jamieson: You said that incapable adults were open to abuse. The numbers of incidents that are proven—

The Convener: I would like us to return to a discussion of the general principles of the bill. I agree with Mary that the law should prevent any kind of abuse, whether it is financial or medical. That is a general principle.

Ben Wallace: I would like to point out that the present arrangements are what we have at the moment, not what the bill would introduce. At the moment, before the introduction of the legislation, people are open to abuse.

The Convener: Many of us shared Margaret Jamieson's reaction to the comment about incapacity being a legal definition rather than a medical one. We want the welfare attorney to have a greater duty of care. Taking into account what Sheila McLean said, the Justice and Home Affairs Committee has a difficult issue to deal with. I think that we all agree that the second opinion that we were talking about should be a medical opinion, not a legal one. Part of what the bill seeks to achieve is to take the law out of whether someone can have access to their cheque book.

Kay Ullrich: In many ways, it was the input of the legal profession that caused the problems.

Ben Wallace: That is why I raised the issue of limited liability.

Dorothy-Grace Elder (Glasgow) (SNP): We have not discussed the issue of joint guardians. They are discussed in section 56 of the bill and are a good idea. We should be concerned about placing people entirely in the care of a relative or a doctor. Despite what Margaret Jamieson said, there have been notorious cases of abuse, such as that of Dr John Bodken Adams in Eastbourne in the 1950s. I think that this section warrants much more careful examination.

The Convener: At this stage, the committee can point out to the Justice and Home and Affairs Committee that we would like it to consider the question of backing up the welfare attorney either with a second opinion or with a secondary welfare attorney. Beyond that, we are into stage 2 territory.

Dorothy-Grace Elder: I have a second question about that. I do not see anything in the bill, although I stand to be corrected, about protecting people from a relative who might be a beneficiary under their estate making major decisions on their behalf. That could be a general practitioner, and I must admit that I did not like the BMA going coy on us today when I asked roughly how long it can take someone to die through the removal of fluids and artificial sustenance.

The Convener: It was a difficult question for them to answer.

I think that Ben wants to answer Dorothy's first point.

Ben Wallace: There is some form of protection for the situation that Dorothy described. Section 44(1) states that the person authorised to make decisions on behalf of an adult with incapacity shall have,

> "during the period specified in the certificate under this subsection, authority to do what is reasonable in the circumstances to safeguard or promote the physical or mental health of that adult."

That defines the authority.

I would like to tone down paragraph 7(iv) of my report, which deals with the doctor appealing to the Court of Session. In view of what Richard Simpson and others have said, I think that it should be a matter of balance and partnership, rather than swinging round to the other side, where the doctor can overrule decisions. That is why I have raised the point about liability, saying that if one gets it wrong, one is liable. At the moment, if one gets it wrong, one has to prove only a pretty low level of reasonable action, in my opinion, and that lets people get away with it.

Malcolm Chisholm: That is a point that I made yesterday. I am quite happy with the idea of balance, but we should remember what Sheila McLean said: that the idea was not capable of being translated into law. In the end, we may have to decide between the two extremes, and my views on that are well known.

The Convener: You can state them for the record again if you want to.

Dr Richard Simpson (Ochil) (Lab): The most striking evidence was Sheila McLean's commentary on the American research that showed that the proxy did not get it right any more often than if it had been left to chance. That terrified me. What are we doing by giving a duty of care to proxies?

Kay Ullrich: It is called being human. Doctors do not spend six years in training to make themselves six times better at guessing than proxies are. That is what the BMA was saying.

Dr Simpson: Doctors have a duty of care and, if they get it wrong, their professional organisation or the General Medical Council will step in to protect the public. I am convinced that we cannot impose a duty of care on the proxy. Legally, that would be too difficult. Professor McLean's example of not needing to intervene in an assault case gave us a good parallel. We should find some way of asking the Executive to reconsider amending section 47 to ensure that the proxy takes further advice.

The balance of the evidence that we have received indicates that the fiduciary care and other elements that are referred to in section 73 on liabilities are not sufficient to require the individual, even acting in good faith, to seek a further opinion.

The Convener: At stage 2, the committee may feel that it wants to lodge an amendment on that. At this stage, we shall simply flag up the general feeling of the committee on that point. We must remember that we are supposed to be talking about general principles. We have sometimes gone beyond that, partly because of lack of clarification as to what was expected of us.

Are there any other points that members feel we should flag up as areas of concern?

Dr Simpson: This is a question that perhaps the lawyers can answer. Under the general principles in part 1 of the bill, section 1(4) describes a number of people who must be taken into account in determining whether an intervention is to be made. Is laying it out as it is in the bill an indication of hierarchy? Does that indicate a hierarchy of wishes in the bill? Do the present and past wishes and feelings of the adult, as far as those can be ascertained, have any primacy? Clearly, they have to be taken into account, but from this morning's evidence it appeared as if the clinical team and the proxy or a relative would have to decide together what the patient would have wanted.

If the layout of this bill gives advance statements primacy, although they do not have force in law and have been excluded from consideration, they will have a significant weighting. If, on the other hand, the implication is merely that all four parties have equal say in any decision, that is fine.

12:00

Ben Wallace: I made that point in paragraph 8 of my report. The priorities need to be redefined, because they are not clear.

The Convener: We will flag that up.

Dr Simpson: I do not understand the legal niceties that are behind the layout of the bill.

The Convener: The clerk will get clarification on Dr Simpson's point and circulate the answer to members.

Kay Ullrich: Ben's report mentions the Millan committee. A number of the submissions mention the fact that Millan is likely to come up with new definitions of mental disorder and nearest relative—as a nominated person, for example. When is Millan due to report—in January?

Dr Simpson: In April.

Kay Ullrich: ENABLE, for example, does not want to hold up the bill by making us wait for the Millan report, but the fact that the Millan committee may come up with new definitions for two such critical terms has implications for the bill.

The Convener: The revised definition of nearest relative will be important, because the nearest relative may be somebody who has been proven to be an unsuitable person to make decisions on behalf of the patient.

Kay Ullrich: The fact that we are awaiting the Millan report clouds the waters somewhat.

The Convener: We should indicate to the Justice and Home Affairs Committee that we want it to consider two aspects of the definition of an adult with incapacity: first, the fact that Millan has not yet reported; and secondly, the point that Ben made in his report about the matter not being clear-cut. Ben also raised the issue—which was further highlighted by the BMA—of temporary incapacity. The example used was that of a Saturday night in an accident and emergency department.

Kay Ullrich: We also need to flag up the definition of nearest relative.

The Convener: Yes.

Ben Wallace: The suggestion is that the Millan committee's definition of an incapable adult will just slot into the bill. What happens if Millan arrives at a definition of a partially capable adult? Where would such a person fit into the incapable adults bill?

The Convener: It is the Adults with Incapacity (Scotland) Bill. Its title was changed from the incapable adults bill to avoid the very difficulty that you describe.

Dorothy-Grace Elder: We ought also to mention the comatose state. Nowadays it is admitted that we do not know much about that in the long term; some patients who had been diagnosed as being in a permanent vegetative state have recovered.

The Convener: That is probably a matter for stage 2 consideration. However, I appreciate that it relates to our earlier report about clarification. If we are going to do something, we should do it by the front door and let people know our intention. We should not get into a situation where people could say that the bill's intention differs from its reality.

Margaret Jamieson: One thing that we need to get right is the definition of the age of an adult. We cannot have different ages in different pieces of legislation; the same age should apply in absolutely everything. We should flag up that concern to the Justice and Home Affairs Committee.

The Convener: The Justice and Home Affairs Committee could take that issue beyond the Adults with Incapacity (Scotland) Bill.

Margaret Jamieson: The difficulty is that different pieces of legislation might define an adult as either 16 or 18. We need to be consistent.

Dorothy-Grace Elder: We should also remember that children's hospitals sometimes treat 17 and 18-year-olds.

The Convener: It is sometimes better for those young people to be in that environment than in a mixed adult ward.

Ben Wallace: As a rule of thumb, is not a 16-year-old an adult?

Dr Simpson: No. Even under old Scots law, girls at 12 and boys at 14 were regarded as being able to make decisions.

The Convener: You can see why that would be.

Kay Ullrich: Do not worry, Ben—you will soon be old enough.

Ben Wallace: As long as women make decisions for me, I do not mind.

Dr Simpson: If the individual is able to make, communicate and remember decisions and can thereby give informed consent, there is no age specification. As a result, doctors, nurses and social workers—all of whom have a duty of care—must determine from discussions with an individual whether that individual can give informed consent.

The Convener: My instinct is to pass the matter to the Justice and Home Affairs Committee; it is a can of worms.

Dr Simpson: The issue should be dealt with separately with regard to children. However, the problem is how to treat a child who is capable of making a decision on a specific issue but is excluded from consideration by the legislation because of age. There would be no alternative but to go to court, as in the case of the 12-year-old who refused to have a heart transplant. The court decided that she was not able to make that decision and the transplant took place.

Kay Ullrich: As for hospital placements, age should not be an issue when it comes to cut-offs, which, unfortunately, vary with the individual and the availability of beds.

The Convener: After our discussions, do any members feel violently opposed to anything in Ben's report?

Malcolm Chisholm: Ben has agreed to modify paragraph 7(iv), which will keep me happy. There may be a problem with paragraph 8; the evidence this morning at the Justice and Home Affairs Committee showed that the law on euthanasia is a total mess. No two witnesses could agree on where the law stood.

The Convener: I agree with Malcolm. People get concerned when they hear the world "euthanasia" and, bearing in mind Malcolm's comments, people's concerns about the possibility of the bill leaving options open and what we heard this morning, it is right that we flag that up. If the Executive wants a bill that allows euthanasia and living wills, it should produce one. However, if the Executive does not want euthanasia and living wills to have primacy over other considerations, we must ensure that the bill does not allow that to happen. It is reasonable that we flag up our concerns and our need for clarification.

Ben Wallace: It is important to recognise that that is not the bill's aim. We should flag up the fact that it could give way to euthanasia, through abuses of the system. That is why I tried to state the bill's aim at the beginning of my report.

The Convener: From statements made by the First Minister, the Deputy First Minister and the Executive, from explanatory notes, from the policy documents on the bill and from sections of the bill, we can say confidently that it is not the bill's intention to allow euthanasia and living wills. However, we could also say that concerns are being raised because some of the provisions give rise to a need for greater clarification, which, in some cases, may require only the insertion of a single sentence. Although it is not our job at this stage, we should say that it must be made crystal clear that that is not the bill's intention.

Roseanna Cunningham picked up on Professor McLean's point that, in a perfect world, everyone would always agree and we would not need the bill. In a perfect world, there would be no ambiguity about legislation. However, the reality is that someone will stand up in court and argue about the bill's provisions in a few years' time. This is our chance to try to get rid of any ambiguity and to have our concerns addressed. In a few years' time, someone's life will be on the line.

Dorothy-Grace Elder: I am glad that you said that.

CARE Scotland highlighted what the bill might unintentionally lead to. I will read out the relevant paragraph:

> "CARE acknowledges that this is a difficult area, but the logical conclusion of a growing acceptance of the withdrawal of food and water from patients with mental incapacity is clear. It would see an increase in calls for patients to be injected . . . and put 'to sleep', rather than 'starve to death' over two weeks. As currently drafted, this clause will lead to the legalisation of euthanasia, both voluntary and involuntary."

The Convener: First, that is a stage 2 issue. Secondly, there is claim and counter-claim. Today we are discussing the general principles of the bill. However, we are possibly exceeding our role, although there are obvious reasons for that. We are saying to members of the Justice and Home Affairs Committee and to the Executive that, if there are doubts that allow people to make claims and counter-claims at this stage, those doubts should be dealt with.

Kay Ullrich: I wonder how many colleagues agree with my personal feeling that, in principle, I want the bill to progress. It is long overdue, given the unnecessary suffering of families over many years. I would not like the bill's progress to be halted because of the grey areas that surround so-called living wills, euthanasia or whatever people want to call it. I want the bill to be passed as quickly as possible; I do not want those issues to get in the way of a much-needed bill. I believe that there is a separate debate to be had on euthanasia, living wills and so on.

The Convener: Is that general feeling held by members of the committee?

Margaret Jamieson: I totally agree with Kay.

Mary Scanlon: There is total consensus on that point, but if the bill might be interpreted differently, we must ensure that such an interpretation is excluded.

Ben Wallace: Our role should be to calm outside speculation.

12:15

The Convener: So the committee agrees the general principles of the bill and that there is a need for the legislation. However, we also want to flag up concerns, against the backdrop of our view that the bill does not intend to leave front or back doors open to the worse excesses that people are concerned about. Our stage 1 submission will include the statement that we want that matter clarified to allay people's concerns. Do all members of the committee share that view?

Members *indicated agreement.*

The Convener: That concludes our discussions on the bill, unless anyone has a burning desire to add further comments.

I ask members to make one final decision. Do members agree to delegate powers to me, as convener, working with Ben, as reporter, to make the changes to his report? We will take into account the comments made by the committee at yesterday's and today's meetings, as reported in the *Official Report*, so that we can make our submission to the Justice and Home Affairs Committee on time. Are members agreed?

Members: Yes.

The Convener: I also want to thank committee members for their patience and for the extra work that they have undertaken in a short time. As members of my committee, they have read submissions and taken on board people's concerns on an important piece of legislation in a professional and competent way.

Meeting closed at 12:16.

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