HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 19 January 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
2nd Meeting 2000 (Committee Room 3)

CONVENER:

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER:

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS:

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*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 19 January 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:04*]

Adults with Incapacity (Scotland) Bill: Stage 2

The Convener (Mrs Margaret Smith): Let us get started. There are only two items on the agenda and, given the number of members here, the meeting might be short. Some colleagues are ill with flu, but others are debating amendments to the Adults with Incapacity (Scotland) Bill in the Justice and Home Affairs Committee. We wish that committee godspeed as it has a great deal of work to get through in discussion of that bill. We hope that it will be able to do the work at stage 2 as well as it did when it produced its report on stage 1.

The Health and Community Care Committee is interested in part 5 of the bill, which deals with medical treatment, care and research. Amendments have been lodged by the Executive and by individual MSPs, as is the form for stage 2 consideration of a bill.

It is difficult to find one's way through the marshalled list of amendments—for some of us it is a trip into the unknown. The second and more important difficulty is that some of the Executive's amendments have not been lodged. Jim Wallace indicated in the chamber on 9 December that the Executive wished to make changes to sections 44 and 47. Those key sections of the bill were highlighted in our committee's report to the Justice and Home Affairs Committee. There are concerns about those sections and most members of the committee were pleased that comments have been made on, for example, section 44 and definitions of medical treatment.

I would like to talk the committee through part 5 and take comments on each section. Amendments have been lodged by individual MSPs and other medical and research issues have been raised with the committee and me by a range of organisations such as the Mental Welfare Commission for Scotland, the Millan commission, and Alzheimer Scotland—Action on Dementia. Some of the issues raised have not been touched on by any of the amendments that have been lodged. There is work that we can do beyond what is suggested by the amendments that have been lodged and those that we expect from the Executive.

I need a steer from members as to whether the committee is happy to allow items such as sections 44 and 47 to pass it by, knowing that Executive amendments to those will be lodged. I know that Malcolm Chisholm has particular views on section 47. On section 44, we must decide whether we are happy to wait for the Executive to lodge its amendment, or whether the committee should pre-empt that by lodging an amendment. If a similar Executive amendment is lodged, the committee could then withdraw its amendment.

Mary Scanlon (Highlands and Islands) (Con): I understood that all amendments had to be lodged by 17 January. Has that changed, given that the Executive has not lodged all its amendments?

Jennifer Smart (Committee Clerk): When only a few amendments have been lodged by the deadline, there is a danger that the committee that is considering the amendments might go through them very quickly. The Justice and Home Affairs Committee has given an undertaking that it will not go past part 2. Therefore, you have time to lodge amendments to part 5. I remind members that every member has the right to lodge amendments.

Mary Scanlon: I want to raise the point that I raised last week. I was happy with Jim Wallace's response in the chamber. I do not want to sit all day examining potential amendments. Certain organisations raised with me the fact that they felt that he had not fully addressed the issue of same-sex partners or the issue of involuntary euthanasia in part 5. If the amendments will arrive at some point, I do not want to waste time reinventing the wheel today.

The Convener: I will attempt to clarify the information that we have as we go through the bill section by section. That will let us decide whether we should spend time putting amendments together ourselves or simply state that we are happy with what we expect a future amendment to be. I hope that we can conclude our deliberations on the bill today. Bearing in mind the fact that we lack some of the Executive's amendments, that remains to be seen.

We have written to the Procedures Committee on the points that members raised last week on the lodging of amendments and our inability to know what was intended. We asked whether there was an argument for the Executive's amendments being lodged in advance of members' amendments so that members could see what the Executive intended to do. There are substantial differences—section 47, for example—between

what was published as a draft bill and what has made its way out of stage 1.

We will start our examination at section 44.

Ben Wallace (North-East Scotland) (Con): There is another option. Because we are not a joint committee, we could examine the bill from the point of view of stage 3. The stage 2 amendments from the Executive and the Justice and Home Affairs Committee have now been lodged. The Executive will not lodge any more.

The Convener: It will. That is the problem. In place at the moment are the amendments that are covered in part 1—the Justice and Home Affairs Committee is dealing with them today. The Executive has not lodged amendments, other than minor ones, for later in the bill.

Ben Wallace: The amendments do not match up with what was said in the chamber.

The Convener: That is right. I have brought the minister's speech with me. When we get to points where amendments have not been lodged by the Executive, we can have a brief discussion about what the minister said and decide whether his approach seems reasonable.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): It is unacceptable for major amendments to be announced on 9 December but for us not to have them by 19 January. To be charitable, perhaps the Executive has run into considerable difficulties with the amendments and they are still being worked on. Other people might take a different view and say that the fact that the amendments are not published makes it difficult for us to comment on them. If the amendments are lodged on Monday and debated on Wednesday, outside people cannot respond to them. That is a serious point, as the bill has changed fundamentally in two ways. The point should be made that, when substantial amendments are announced in the stage 1 debate—an unusual procedure anyway—they ought to be lodged in reasonable time to allow them to be discussed.

10:15

The Convener: I will ask Jennifer Smart to circulate a copy of the letter that she sent to the Procedures Committee. The point that you made about the substantial nature of the changes brought forward by the Executive was raised in that letter, Malcolm. I do not think that we raised the specific point about the fact that, six weeks after the announcement, we still do not have the amendments before us. It is a point worth making.

Hugh Henry (Paisley South) (Lab): There are a number of issues. The lodging of amendments without this committee's being given adequate notice is an important one. The way that the process is being handled calls into question the purpose of this committee's having any role in the process. On a range of issues, the committees are not able to play the role that they should be playing. If that goes on, the process will be robbed of credibility.

The Convener: On this point, and as regard this bill, we are bound by two decisions. The standing orders say that this committee has no formal status vis-à-vis the bill at stage 2, whereas we had the status of secondary committee at stage 1. There was a timetabling problem at stage 1, which has been dealt with. Assurances have been given that such a problem will not arise again. At stage 2, the situation is that amendments will be lodged in the individual member's name and there will be no amendments from this committee.

The problem is that the contentious issues that relate to the bill are medical research and care issues. Obviously, those are more within the remit of this committee than the remit of the Justice and Home Affairs Committee. Standing orders say that amendments will be available to the lead committee two days before the committee considers them and that the amendments will not necessarily be made available any sooner to other committees. At our meeting last week, we said that that was not acceptable and meant that it was difficult for us to make comments on amendments before the lead committee had a chance to make substantive decisions about them.

Today, despite the fact that it is a week after we registered our view, we still do not have a marshalled list of amendments for part 5, which is the part of the bill that we want to focus on, although we have no formal status at stage 2. Because of the circumstances surrounding the bill, and in the light of the substantial changes that Mr Wallace talked about in the chamber, we felt that it was worth having another look at part 5 of the bill.

We agree with what you are saying, Hugh, which is why we wrote to the Procedures Committee last week.

Hugh Henry: As we meet, the Justice and Home Affairs Committee is discussing some of the matters that we have discussed in this committee. Indeed, some members of this committee are at that meeting. Whether or not we want to lodge amendments, either individually or on behalf of the committee, it does not make sense for us to meet when our time would be better spent attending the Justice and Home Affairs Committee and trying to influence the debates on the amendments.

The Convener: As you know, Hugh, there is a timetabling problem that goes beyond the passage of this bill—it is more about how the Parliament works. The Justice and Home Affairs Committee is considering part 1 of the bill today. Hugh is right to

say that some of our colleagues have lodged individual amendments, while others have simply supported those amendments.

I want to move on to a discussion of part 5 of the bill and the stage 2 process. I apologise in advance if I falter from time to time.

Mary Scanlon: When will we see Jim Wallace's amendments to part 5?

The Convener: The only guarantee is that the Executive's amendments will be available two days before the Justice and Home Affairs Committee considers them.

Mary Scanlon: When will that be?

The Convener: The Justice and Home Affairs Committee has decided to consider part 5 last. Off the top of my head—well, we do not know.

Jennifer Smart: The Justice and Home Affairs Committee does not know how long it will take to consider the other parts of the bill.

The Convener: Amendments to the bill are being lodged all the time. I heard that there were 140 amendments, but there are probably substantially more now. Richard Simpson was responsible for 66 of them.

Ben Wallace: Hugh Henry has a point. Why do we not just attend the Justice and Home Affairs Committee when it discusses stage 2 of the bill?

Malcolm Chisholm: If we were to do that, we would not have a Health and Community Care Committee meeting until Easter.

The Convener: The Justice and Home Affairs Committee will meet twice a week from now on. Frankly, the only reasonable proposition vis-à-vis members of this committee attending those meetings would be if we sent you as a reporter, Ben, or appointed someone else to be a reporter. Given the time commitment—

Malcolm Chisholm: I think Ben has a point.

The Convener: Ben, we are trying to say that part 5 of the bill concerns us most, because there were substantial differences between your report and what Jim Wallace said in the chamber about the bill.

Other people have said that they would like us to address certain issues. I hoped that today we could put to bed our discussions about part 5 and pass on the results, one way or another, either as amendments in my name as the convener or by individuals lodging amendments in their own names.

I hoped that we could also consider whether it would be a good idea to ask someone to shadow the Justice and Home Affairs Committee as a reporter. However, the Justice and Home Affairs Committee will have two meetings a week until Easter. On top of that, members have fairly substantial commitments to this committee. We have been meeting once a week and I do not see any reason why that will not continue, as we have already arranged briefings.

It is not realistic for all members of the Health and Community Care Committee to attend all meetings of the Justice and Home Affairs Committee. It is more important for this committee to reconsider part 5 of the bill. We might progress that work by writing to the Justice and Home Affairs Committee, if we are minded to support an amendment that we have been told about but have not seen, or we might lodge amendments in my name.

We could attend the Justice and Home Affairs Committee meetings at which part 5 will be considered. By that time, we will have given prior notice of our views on part 5 and will be able to take part in those discussions, but we will not be able to vote on amendments at those meetings. We will make strenuous attempts to ensure that they do not clash with meetings of this committee. I will ask the clerks to try to sort that out as soon as possible. It is a movable feast, as far as the Justice and Home Affairs Committee is concerned, as it does not know how many amendments it will receive or how long the process will take.

As things stand, I now intend to ask for comments on part 5 and give members an update on each section.

A couple of amendments to section 44 have already been lodged. Amendment 118, in the name of Phil Gallie, may be of significance to this committee. The amendment reads:

"In section 44, page 27, line 5, leave out <person> and insert <medical practitioner>.

Jennifer Smart: Convener, you may wish to point out to members that the amendments to part 5 of the bill are at the end of the marshalled list because they will be considered last.

The Convener: Amendments to part 5 of the bill are at the tail end, page 22, of the marshalled list.

The point about medical practitioners was raised by the secretariat of the Millan commission. At present, the beginning of the section reads:

"Where any person who is responsible for the medical treatment of an adult".

The Millan commission and others have suggested that "doctor" or "psychologist" should replace "person", whereas Phil Gallie's amendment refers to "medical practitioner". At least members of the Justice and Home Affairs Committee will have the chance to debate that point. If members are happy with that, we can move on as no one seems to have a burning

desire to amend the wording to "psychologist".

The Executive has lodged a minor amendment to section 44(1). The amendment reads:

"In section 44, page 27, line 7, leave out from first <of> to second <of> in line 8 and insert <in relation to>".

Ben Wallace: Are you talking about amendment 82?

The Convener: Yes. The Executive has lodged a similar amendment to part 5. Are we quite happy with amendment 82?

Members *indicated agreement.*

The Convener: Section 44(2) deals with the definition of medical treatment. Like a number of members, I was happy with Jim Wallace's comments in the chamber on this point.

Amendment 119, in the name of Phil Gallie, reads:

"In section 44, page 27, leave out line 17".

If agreed, that amendment will remove section 44(2)(b), which was a major stumbling block and which refers to

"ventilation, nutrition and hydration by artificial means".

The Executive has made a clear statement of intent on section 44(2)(b). Mr Wallace said:

"We propose to amend the definition of 'medical treatment' to remove reference to particular procedures and to define treatment simply as 'any procedure or treatment designed to safeguard or promote physical or mental health'. The positive nature of the new definition will underline the fact that the purpose of this bill is to help, not to harm, adults with incapacity."—[*Official Report*, 9 December 1999; Vol 3, c 1381.]

We raised concerns on section 44(2)(b) in our report to the Justice and Home Affairs Committee and Phil Gallie has lodged an amendment to delete it.

The committee may want to state that it supports the minister's proposal and that it awaits the Executive's amendment. If members agree with that, there is not much to be gained by our deciding anything further on that paragraph today.

10:30

Malcolm Chisholm: I support strongly what the minister said, which is not incompatible with Phil Gallie's amendment.

During the stage 1 debate, I said that although I was pleased with the Executive's proposed amendment and felt that it dealt with the problem, I wanted to hear what the lobbying bodies had to say. Some people have told us that the proposed amendment is not adequate. I have an open mind on the matter; there is still discussion to be held.

I hope that the Executive's amendment will deal with the matter and, to some extent, I think that it will, but we must address people's concerns. The alliance for the promotion of the bill has said that the Executive's proposed amendment will make no substantial difference. I do not know whether that is true.

We must address the concerns of people who are saying that the proposed amendment does not alter fundamentally the fact that ventilation, nutrition and hydration by artificial means are—in practice and case law—medical treatment. A question exists over that, to which I am not sure of the answer. Notwithstanding that, I support the proposed amendment.

Mary Scanlon: We must reserve the right to have input after Jim Wallace's amendment has been lodged.

The Convener: The Mental Welfare Commission and the Millan committee welcomed the Executive's statement of intent, as have many other organisations, but Malcolm Chisholm is correct: some other organisations feel that the Executive has not gone far enough. We might have to return to that point.

Although the Executive's amendment has not yet been lodged, we know what its general thrust will be, and I certainly support it. Does anyone have further points to make on section 44(2)(b)?

Ben Wallace: Richard Simpson produced a list of amendments last week, which we did not have time to discuss. I note that many of them do not appear in the marshalled list, and I wonder why. Richard was very concerned about the word "medical".

Malcolm Chisholm: He has not lodged those amendments yet; the list was a draft.

Ben Wallace: Does he intend to?

The Convener: I think so.

Malcolm Chisholm: He will lodge his amendments, but I suppose he is still open to suggestions.

The Convener: I think that he wants to change "medical" to "clinical" throughout. Is that correct?

Ben Wallace: No. He wants to delete "medical" and leave just "treatment".

The Convener: I see. I think he also mentioned wanting to use the word "clinical" rather than "medical", to highlight the fact that a clinical team is involved rather than a single medical practitioner. In Richard's absence, however, we cannot progress on that.

We will move on to section 44(3)—

Dorothy-Grace Elder (Glasgow) (SNP): Excuse me, convener. I want to thank you for

tipping me off to get straight over to the chamber for 10 o'clock. I made it there just in time to move my amendment.

The Convener: Good.

Dorothy-Grace Elder: My amendment was defeated resoundingly, except for Richard Simpson—bless him.

The Convener: I am glad that members of the committee are sticking together.

Dorothy-Grace Elder: Be warned, folks, of the need to attend the Justice and Home Affairs Committee if you have amendments to move. You should also beware misprints—there was a misprint, by omission, in my amendment on the marshalled list.

Have we moved on from the paragraph regarding feeding and hydration?

The Convener: We were just about to move on. The situation is that—

Dorothy-Grace Elder: May I make a remark on that paragraph?

The Convener: Yes.

Dorothy-Grace Elder: I most definitely cannot go along with hydration and artificial nutrition being classified as treatment.

The Convener: Were your fears allayed by what Jim Wallace said in the chamber? I read it out earlier.

Dorothy-Grace Elder: I am not sure what he said.

The Convener: Jim Wallace said on 9 December that the Executive proposed

"to amend the definition of 'medical treatment' to remove reference to particular procedures and to define treatment simply as 'any procedure or treatment designed to safeguard or promote physical or mental health'. The positive nature of the new definition will underline the fact that the purpose of this bill is to help, not to harm, adults with incapacity."—[*Official Report*, 9 December 1999; Vol 3, c 1381.]

That is the thinking behind the Executive amendment to section 44(2)(b), which has yet to be lodged.

Dorothy-Grace Elder: So we have another chance to discuss it?

The Convener: Yes. We will not be able to take a definitive position today on all of part 5, simply because all amendments—in particular, the Executive's amendments—have not yet been lodged, as the Justice and Home Affairs Committee will deal with part 5 last. We are working with what we have at present, and we could still lodge amendments on points raised with us by outside groups.

This is our first chance to have a discussion on some of the part 5 issues in the light of Jim Wallace's speech on 9 December. Unfortunately, we still do not have the final amendments, so we will have to revisit those issues when the amendments have been lodged. I will speak to you after the meeting, Dorothy-Grace—and Irene Oldfather—about what you missed earlier, some of which concerns procedural issues.

Dorothy-Grace Elder: Thank you. I do not want to take up too much time, but may I ask whether the committee felt that Mr Wallace's proposed alterations still left the gate open for artificial hydration and nutrition to be included in the new definition? From what the convener read out, it seemed that that could be the case.

Jennifer Smart: May I again remind members that any MSP can lodge any amendment to the bill?

Irene Oldfather (Cunninghame South) (Lab): We understand that, but we are discussing the matter as a committee. I, too, would like to understand more clearly the point that Dorothy-Grace raised.

The Convener: The situation is that we have heard the Executive's intent on section 44(2)(b), but we do not have the final wording, so we cannot make a final decision. Malcolm Chisholm mentioned that paragraph a few moments ago. Fundamental concerns about section 44(2)(b) have been raised with us by a number of people outside the Parliament. Ben Wallace also highlighted the issue in the report that we submitted to the Justice and Home Affairs Committee.

We will have to return to section 44(2)(b), but today we will tidy up much of the rest of part 5. There is nothing to stop us taking further evidence on that particular paragraph, apart from the fact that we are very short of time. I understand, however, that most of the people who want to talk to us will make themselves available if need be.

Dorothy-Grace Elder: Could we ask Mr Wallace for clarification on section 44(2)(b)?

The Convener: I think we can, once we know the exact wording of the Executive's amendment. As things stand, it is difficult for us to work on that paragraph in the absence of lodged amendments. We are doing what we can with what is available.

As I said, I am happy to speak later to members who missed anything that was discussed earlier in the meeting, so that we do not have to go over everything again.

Section 44(3) raises the issue of the length of time that a certificate giving authority can last. As it stands, the bill says that a certificate can last a month or less. That covers quite well the situation

of somebody who is incapacitated due to a particular action and unable to make a decision for a couple of days, perhaps because they are unconscious. However, both the Mental Welfare Commission and the Millan committee have raised the issue of chronic incapacity or long-term disorders. The bill as it stands is unsuitable if someone has a chronic disorder, because the certificate would have to be renewed every month.

Irene Oldfather: I absolutely agree. Groups such as Enable have raised the same point. We must consider that subsection.

The Convener: I suggest that that is one point on which we might want to put together wording for an amendment. Does anyone have any other comments? No. There are two ways, therefore, in which we can proceed: either we can concoct the phraseology now, round the table, or the deputy convener and I can come up with the wording and circulate it to members to check that they are happy with it, which is the course of action that I would prefer.

Jennifer Smart: I must inform members that the wording would have to be checked for competency and everything else. Coming up with the wording does not guarantee that the amendment will be accepted.

The Convener: Of course. All the amendments that are lodged must be checked for competency by the clerks to the Justice and Home Affairs Committee. Just because Malcolm Chisholm and I decide on the wording and you all think that it is okay does not mean that the amendment is competent.

Jennifer Smart: The committee must be clear that what it is doing is agreeing a principle; it is agreeing that the convener and deputy convener will decide upon the wording of the amendment.

Irene Oldfather: And that the wording will be circulated to members for comment.

The Convener: Yes. The thrust of the amendment will be that it does not seem reasonable to have to renew the certificate month after month if a person has a chronic incapacity.

The clerk points out to me that if members are not happy with the wording, the amendment cannot go forward as a stage 2 committee amendment. The point that I make to the clerk is that there is no such thing as a committee amendment.

As long as the majority of members are happy—if one person is unhappy, we will proceed anyway—the amendment will be lodged in my name, with other members of the committee named as supporters of the amendment. We can have only four supporters. Nothing will be lodged as a committee amendment. If, when the Justice and Home Affairs Committee considers amendments, or at stage 3, anyone comments on an amendment that has been put together by the committee, I will clarify the way in which we put it together; that it was put together following discussions in the Health and Community Care Committee and that it has either the unanimous or qualified majority support of the committee, so that people will know that the amendment came through the Health and Community Care Committee in some way, shape or form.

Are members happy with that? If so, Malcolm Chisholm and I will work on an amendment to that subsection.

Section 44(4)(a) deals with the issue of the use of force or detention, which some people have raised. Everyone has a serious question in their mind about why force or detention might be necessary and how it would be exercised. Paragraph (a) outlines that the authority shall not authorise

"the use of force or detention, unless it is immediately necessary and only for so long as is necessary in the circumstances".

People have pointed out that the Scottish Law Commission's first draft bill added the phrase "to avoid serious harm to the adult or to others" at the end of that paragraph.

Irene Oldfather: The Millan committee raised the same point. It seems a reasonable amendment, and I would support it.

The Convener: Are there any other comments?

Dorothy-Grace Elder: Could we insert a line to say that force or detention should be supervised in some way—that someone else should be present—rather than a carer being one to one with a patient?

10:45

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): That would be the ideal situation. I am uncomfortable with the word "force". What degree of force will people use? They should not go beyond the powers set out in the Mental Health (Scotland) Act 1984.

Hugh Henry: We are beginning to move away from the legal aspects into the practicalities. It is not for us to establish guidelines on how things should be implemented. Our role is to put in place a proper legal framework, which will protect all those concerned, including patients and staff.

The Convener: Is there general agreement on the need to give some kind of context for when the use of force or detention—even if we do not like those particular words—is acceptable to avoid serious harm to the adult or to others?

Irene Oldfather: That is acceptable, but like Margaret Jamieson, I do not like the use of the word "force". Could we modify that in some way?

Members: We could say "restraint".

Ben Wallace: Force might have to be used to get someone into detention.

Margaret Jamieson: That is true.

The Convener: That is a can of worms. We could go on all day.

Are we agreed that we will pull together an amendment? I am interested in Margaret's comments about the Mental Health (Scotland) Act 1984. Are members happy that the deputy convener and I should consult Margaret about that? We could base the amendment on that. I confess that Margaret is probably more knowledgeable about the act than I am. We will come back to members with the wording.

Ben Wallace: We could change that sentence to say "the use of reasonable force".

Margaret Jamieson: That opens up an even bigger can of worms. There could be a dozen interpretations of "reasonable" around this table, never mind in the environment in which someone is looked after. The courts would have to determine what was reasonable.

Ben Wallace: The word "reasonable" is inserted in many acts, particularly those dealing with the police force and the military, to ensure that the force used does not become excessive. The word "force" on its own does not put any onus on the person using the force not to go beyond reasonable force. The insertion of the word "reasonable" would mean that the overuse of force would be illegal under the act.

Members *indicated agreement.*

Hugh Henry: As always, Ben Wallace speaks with the voice of moderation.

Ben Wallace: Especially when it comes to force.

The Convener: Yes. He has been trained to moderate his force.

Ben Wallace: When you have had two soldiers tried for murder for use of force, you know about such things.

Dorothy-Grace Elder: I suggest that we also insert a line that says that a record should be kept in instances where force is used. That would surely deter those who use force unreasonably. Only last week there was a dreadful case that led to a nurse being struck off.

The Convener: We are straying back into the area of practice, which to some extent is covered by the type of form that you mentioned. It raises the matter of a code of practice, which follows on from the bill, and which the committee might be interested in considering later.

We will now consider section 44(5) and section 44(6). Unless I am missing something, there is nothing to discuss here. Are there any comments?

Irene Oldfather: I support Richard Simpson's proposed amendment, which would change the permission to treat while court challenges relating to section 44 certificates are resolved to a requirement to treat.

The Convener: On which line can the proposed amendment be found? Please read out the amendment.

Irene Oldfather: I am trying to find it. I made a note of it, but I cannot see it in Richard's notes. It refers to the general principle in subsection (6).

Ben Wallace: The amendment refers to part 5, page 29, line 16. Richard Simpson wants to add a new subsection, referring back to section 44, which will say:

"Until the treatment has been decided by the court of session the person responsible for the treatment of the adult or any other person authorised under section 44 shall do what is necessary in his opinion for the preservation of the life of the adult or the prevention of serious deterioration in his medical condition."

The Convener: That is on page 3 of Richard's proposed amendments. As it applies to section 47, we will deal with it later.

Irene Oldfather: It refers to section 44(6).

The Convener: We will consider the proposed amendment when we discuss section 47. If we discuss the amendment then, we will go back to section 44(6) anyway. Can someone remind me that I am doing that?

Let us not consider subsection (7) until we have looked at subsection (6).

I read in a paper about handling amendments that as long as one has lodged an acceptable amendment, other people will look through it and check that one has not missed how it relates to other sections. We will make use of that assistance.

We will move on to section 45, which deals with exceptions to authority to treat. That is another area in which people have raised a number of issues.

Jim Wallace said:

"Section 45 of the bill allows certain treatments to be excepted from the general authority to treat in section 44 of the bill. In finalising which treatments should be excepted, we have made it clear that we will take on board the views expressed in the Parliament and by the Millan committee. That remains our position. I want, however, to be open with members about our current thinking and, with that in mind, I

will now outline the specific treatments that, subject to comments, we propose at this stage should be covered by regulations made under section 45. We recognise that electroconvulsive therapy is a controversial treatment and we intend, therefore, that ECT should be possible under this bill only where a favourable second medical opinion has been obtained. For three other treatments, we believe that Court of Session approval should be necessary. Those are psychosurgery, sterilisation and the implantation of hormones to reduce sexual drive."—[*Official Report*, 9 December 1999; Vol 3, c 1383.]

Therefore, four treatments are, or will be, covered by Executive amendments, which we do not have before us now. Also, Scott Barrie has lodged an amendment that refers to three of those treatments: ECT, hormone implants and psychosurgery.

One organisation—I think that it was the Scottish Association for Mental Health—said that it might be necessary to employ a treatment such as sterilisation to treat a serious malfunction or disease of the adult's reproductive organ. There might be medical reasons, rather than the wrong sorts of social reasons, why sterilisation might be the right course of action.

When we see how the terminology of the Executive amendment is couched, we might want to return to that point. Does the committee agree that sterilisation should be included among the exceptions?

Members *indicated agreement.*

The Convener: The issue of abortion was also raised. Jim Wallace said that the Executive has not commented on it because it is a reserved matter.

Ben Wallace: Although abortion is a reserved matter, does not the bill create a gap? In a few years, people might question why a devolved act talking about health and incapacity does not provide an answer in relation to abortion.

The Convener: My understanding is that the bill does not create a gap, but we can get clarification on that point.

Dorothy-Grace Elder: The fact that there is any area that we cannot address harms the whole ethos of our work.

Ben Wallace: I am anxious to know where one would look for the relevant legislation on abortion and adults with incapacity.

Irene Oldfather: I wish to clarify another point that the Millan committee made about the section: in the proposed amendments there were references to sections 97 and 98 of the Mental Health (Scotland) Act 1984, but not to section 103, which authorises the treatment of detained patients without consent, including the giving of medicine for mental disorders within the first three months.

The Convener: That point was also raised by the Scottish Association for Mental Health, which said that all those provisions should be specifically excluded from the bill. It is difficult to grasp why the association says that. Perhaps the committee will wish to take evidence from it at this stage. We are not rushed on part 5. People have consistently told us that we can hear from them about those matters.

11:00

Malcolm Chisholm: I support doing that, if we have time. As I said during the stage 1 debate, I support the position of the Scottish Association for Mental Health—I think that an amendment expressing its views has been lodged by Scott Barrie. I am mystified by Jim Wallace's comments, if for no other reason than the Millan commission's recommendations on ECT will create a major debate. Given how controversial ECT and psychosurgery are, it is quite wrong in principle for such pre-empting to take place with only a second medical opinion, which, within some hospitals or psychiatric communities, will just rubber-stamp the first opinion. As a result, I am totally opposed to what has been proposed, and I accept the SAMH's amendment.

The Convener: Has Scott Barrie lodged an amendment?

Malcolm Chisholm: Yes.

The Convener: Let me just look for that.

Yes, that is right. Scott Barrie has lodged an amendment that covers those points.

Ben Wallace: It is amendment 153.

The Convener: My only concern is that I am not sure whether Scott Barrie is saying that the whole section should be taken out. Is that what he is saying?

Members *indicated agreement.*

The Convener: So he is taking the SAMH line.

Members: Yes.

The Convener: Is it therefore necessary to discuss the matter at length if an amendment has already been lodged that supports the SAMH position?

Margaret Jamieson: I suggest that we recommend Scott Barrie's amendment.

Irene Oldfather: I have not seen a copy of the amendment.

The Convener: So the amendment takes out the section and leaves the matter to the Mental Health (Scotland) Act 1984 and the forthcoming Millan commission's in-depth deliberations. Is the amendment generally supported by the

committee?

Ben Wallace: What was the fourth treatment to be covered by Executive amendments?

The Convener: Sterilisation.

Ben Wallace: And does Scott Barrie's amendment cover the other three treatments?

The Convener: Yes.

Ben Wallace: So are we going to insert some form of wording that covers the Executive's fourth treatment?

The Convener: Members will probably have to do that after the Executive has lodged its amendments. As Scott Barrie has lodged this amendment to cover those three treatments, it is reasonable to expect him to cover any other issues that the Executive might raise in its amendments. That said, is the committee happy to support Scott Barrie's amendment?

Members *indicated agreement.*

Margaret Jamieson: The amendment also means that we do not have to revisit this part of the legislation should changes have to be made following the Millan commission's report.

The Convener: I do not know whether any other committee members have supported the amendment. Would the committee be happy for me to sign Scott Barrie's amendment to highlight the fact that we have discussed the issue and support his position?

Members *indicated agreement.*

The Convener: Thank you for leading me through that one, folks.

Does the committee have any comments on section 46? Most of Dr Richard Simpson's proposed amendments delete the word "medical".

Irene Oldfather: I think that I have the right section. Richard proposes to make it a requirement to give permission for treatment while the intervention or guardianship order is in effect.

The Convener: Another of his amendments deletes "may" and inserts "shall" in section 46(2). Section 46(2) says:

"Until the application has been finally determined, the person responsible for the medical treatment of the adult or any other person authorised under section 44 may do w hat is necessary in his opinion for his preservation of the life of the adult".

Richard's amendment changes "may" do to "shall" do. Do we agree with it?

Members *indicated agreement.*

The Convener: As before, I will sign my name in support of that amendment.

Does the committee have a view on Richard's deletion of the word "medical" from the phrase "medical treatment" almost throughout the bill?

Irene Oldfather: I am happy to support such a deletion, because "treatment" encompasses a wider social dimension; it covers other professions that are associated with treatment generally, not just medical treatment.

The Convener: Richard's other point is that clinical teams deal with people. As the British Medical Association told us, the balance of care is very much in the hands of nurses.

Irene Oldfather: A wide range of professions is involved, including dentists and opticians.

The Convener: Are we happy to accept Richard Simpson's deletion of the word "medical" from the phrase "medical treatment"?

Ben Wallace: I have one concern about that deletion. As I am not expert enough in law to know what is covered by the word "medical", I do not know how the deletion of the word would affect the legislation.

Margaret Jamieson: It is quite clear that the phrase "medical treatment" excludes nurses.

Ben Wallace: Does it?

Irene Oldfather: I would say so.

Margaret Jamieson: The word "medical" applies only to doctors, and does not cover dentists, nurses, chiropodists, podiatrists and others, which is why Richard Simpson has asked for its deletion. That point was raised in the evidence that we received from the Royal College of Nursing. The BMA also said that the word caused a difficulty. Although doctors might be available for individuals in hospitals, most individuals are cared for in the community and doctors might not be easily accessible.

Ben Wallace: I do not want to exclude those professions; I just do not know how the word "medical" is interpreted in a court of law.

Margaret Jamieson: The amendment opens up the umbrella.

Irene Oldfather: Although my first reaction was the same as Margaret Jamieson's, I have just noticed that section 44(2) says that "medical treatment" can be defined as

"surgical, medical, nursing, optical or dental procedure or treatment".

Margaret Jamieson: Yes, but it does not go any further.

The Convener: I will speak to Richard Simpson about the rationale behind his amendment and seek further clarification from the Executive about that point. As Richard has lodged these

amendments, the point will be discussed; however, it will be better for us and the bill if we can agree a position on as many points of contention as possible throughout part 5.

Does that take us through section 46?

Dorothy-Grace Elder: The definition of "medical treatment" in section 44(2) has another reference to

"ventilation, nutrition and hydration by artificial means"

as being part of treatment, whether or not we use the word "medical".

The Convener: Yes, but that definition will change throughout the bill once the issue has been sorted out. We will have to return to that.

We will move on to section 47, which has also given cause for concern. As a result, I do not expect that we will agree on it. The bill says that where there is disagreement, it is up to medical practitioners to apply to the Court of Session for authority to carry out proposed medical treatment. On 9 December, the Minister for Justice commented on that and talked about an Executive amendment to the section. He said that

"the Executive believes that some changes to part 5 are desirable to create a more balanced approach to treatment decisions. We accordingly propose to lodge amendments at stage 2, which will help to allay some of the concerns that have been expressed. We propose an amendment to section 47, which will allow a doctor to seek a second medical opinion in cases in which the guardian or welfare attorney has refused consent to the medical treatment that has been proposed. If that second opinion confirms the need for the treatment in question, the doctor will be able to proceed. However, anyone with an interest in the personal welfare of the patient, including a doctor, welfare attorney, guardian or relative, will be able to appeal to the Court of Session if they are concerned about the course of action that had been proposed by a doctor, even when that action is supported by a second medical opinion."—[*Official Report*, 9 December 1999; Vol 3, col 1380-81.]

I have had a large number of letters on section 47, particularly from parents, some of which were heart-rending. Some are tabled—including a letter from Parent Pressure. We are trying to give people who deal with such situations daily as much support as we can, not only through the bill, but as a Parliament through the carers strategy and so on. We must take the representations that have been made to us very seriously. On the other hand, the Scottish Law Commission put forward the same point of view as is expressed in the Executive amendment. There is a difference of opinion.

Malcolm has already expressed concern that the move is towards medical opinion rather than towards carers and parents. A related issue is that of applying to the Court of Session. Case law always seems to be based on high-profile cases and situations of life and death, but the average family would not want to have to go to the Court of Session for the majority of issues with which the bill deals. Perhaps other courts could be mentioned instead of only the Court of Session.

Margaret Jamieson: That is to take things too far. Richard's amendment deals with a case when there is disagreement after a second opinion; in such circumstances, people "may apply to" the Court of Session. The amendment gives a breathing space in terms of the second opinion.

The Convener: Will you read out the relevant section of Richard's amendment?

Margaret Jamieson: At section 47 line 5, insert after "treatment"

"they shall jointly seek a second opinion from a person appointed for that purpose by the health board or its successor organisation. If thereafter either the person responsible for, or any person authorised under section 44 in relation to treatment or any guardian, welfare attorney or person authorised to intervene disagrees with the second opinion they may apply to . . . *the court of session*."

I think that that covers the point.

The Convener: It allows a period in which people can discuss a second opinion and gives thereafter the right to all sides to have recourse to the law.

Margaret Jamieson: It gives a space for conciliation.

Irene Oldfather: It redresses the imbalance in the bill and allows for joint responsibility. It moves more in favour of the proxies.

11:15

Malcolm Chisholm: I totally oppose Richard's amendment. I do not think that it is practical. It begs the question: who will the second opinion be? It is not very different from what Jim Wallace is proposing, because presumably the second opinion would be a medical opinion; even if it was not, the amendment does not address the concerns of the parents who have written to us.

We should invite Parent Pressure to talk to us. Those parents are in despair about what is being proposed, because the kind of work that they have done with children for decades is now being questioned. A very negative view of carers is being put forward. The question of euthanasia has to be dealt with separately from section 47; there are many ways in which that can be done. It is wrong for us to say to such people that their involvement in decision making, which they have had with their grown-up children because of their care and expertise for many years, will be taken away by a second opinion, no matter whose opinion that is. Richard's amendment changes the Executive's position only slightly; it does not do so fundamentally.

The Convener: It does not fundamentally change the position on the second opinion, but it changes it in terms of recourse to the law.

Malcolm Chisholm: We cannot assume that the second opinion will be impartial in terms of the carer and the doctor. That will depend on who gives the second opinion and, in practice, the second opinion is likely to be a medical opinion, so what is suggested in Richard's amendment is not fundamentally different from what the Executive proposes.

The Convener: This is one of the most difficult parts of the bill and it has been further complicated because the Executive has moved its position. What do others think? Should we, as Malcolm has suggested, hear from parents and take evidence on section 47? There are different sides to the argument; I believe that the Executive amendment moves back to the position taken by the Scottish Law Commission in its draft bill. I do not think that the Justice and Home Affairs Committee spent a lot of time on section 47; section 44(2)(b) and other provisions took up more of its time. Section 47 was changed and has taken on a significance that it did not previously have. It might be a good use of our time and of benefit to the Justice and Home Affairs Committee if we were to take evidence.

Mary Scanlon: I was very moved by some of the contributions from carers, which I think everyone has received. These are people who have cared for children for a long time—in one case for about 30 years. Although I have some sympathy with what Richard is trying to achieve, when the second opinion comes from a person appointed by the health board, the process becomes a kind of rubber-stamping exercise and we would have to question the objectivity and impartiality of that person. I would like to examine this question further.

The Convener: The question of the independence of the second opinion has been raised by others. Is the second opinion in the bill independent or does it come from within the clinical care team already involved? The question of independence is hanging there—we need some guidance on that.

Mary Scanlon: That would be helpful.

Ben Wallace: I am likely to agree with Richard but we should look for some way of safeguarding that second opinion. We could insert the words—I have just written this down—"where the second opinion is bound to take into account the proximity of the carer's and guardian's knowledge". All the letters that we have received from carers state that those people know their wards, because they live next to and look after them. The second opinion should be bound to draw together the first medical opinion and the knowledge of the carer or guardian. That will not happen in every instance because the carer does not always live with the person for whom they care. Richard's suggestion makes the person giving the second opinion judge and jury, because if the doctor who gave the first opinion or the adult do not agree with it, the case goes to the Court of Session.

Hugh Henry: What Ben suggests would make the decision on whether proper consideration has been given to a case either completely meaningless or excessively complex. There is a clear difference of opinion and it would better if the committee made no formal decision on the matter at this stage. We should seek more information and make further amendments at a later date.

The Convener: Yes. We should face the fact that the members of the committee will probably not all agree on that section, but we can take evidence on it, which might be taken on board by others later in the process.

Jennifer Smart has reminded me that we do not have a lot of committee time available in which to take evidence.

Hugh Henry: We do not necessarily have to interview people—we could take some written evidence for background information from those on both sides of the argument.

The Convener: I hear what you are saying, Hugh, but we might read evidence from Parent Pressure with which we have sympathy, and then read evidence that expresses an opposing point of view, but with which we also have sympathy.

The committee would benefit from speaking to all those involved—they would not necessarily need to be here at the same time. In that way, we could let them know what points have been raised and we could ask them how they would deal with those points. We need to be able to ask oral questions rather than taking written statements. Although we have all been bombarded with good written statements from a range of people, that sometimes leaves us even more confused than we were at the beginning of the process. The only realistic way round that problem is to take oral evidence.

We should bear in mind what we will be doing in the near future. We will be having Executive briefings on health board allocations and other finance issues. It is important that we have those briefings. We will also be having a briefing on community care. We should look for another slot for a meeting.

Hugh Henry: We do not want slip back into the ways that we got into before Christmas, when every issue that came up necessitated another meeting. Before we knew it, we were doing

nothing but having meetings. We need to be a bit more disciplined. If we do not fit discussion of this issue into the time available, something else will begin to slip. I can think of other issues that are just as important. Before we know it, we will be doing nothing but meeting. I am not minded to agree with your recommendation, convener.

The Convener: I think that it is part of the discipline of this committee to handle the issues as they arise. We have outlined why people did not concentrate on section 47 at stage 1. Now, at stage 2, we find that it may not have been given the consideration that it requires. We can say either that we are in a position to do something about that, or that we do not have enough time to deal with it and let it go.

I feel that the second option would not be the best course of action for us to take. I do not suggest extra meetings lightly. I have just made the point that our next two meetings are Executive briefings in which people are lined up to speak to us about certain issues. The clerks have spent a great deal of time and effort getting people from a range of organisations to talk to us about community care. It would be very difficult to find another slot for that community care briefing, without causing the review to slip. The Executive briefing on health board allocations on 26 January would be easier to reschedule. I will listen to what the committee has to say, but I feel that I would gain from that briefing and that it would facilitate scrutiny of the bill both by the Justice and Home Affairs Committee and at stage 3.

Ben Wallace: I agree with Hugh Henry. Some issues must have a higher priority than others. Over the next few months, few bills will come before this committee. Legislation must take priority over the briefing on health board allocations—which is an information briefing, rather than an action briefing—or any other briefing, for that matter, even if that means pushing something further down the queue.

Dorothy-Grace Elder: This legislation is too important. It will affect people for decades to come.

Margaret Jamieson: We need to be conscious of the fact that we will be under pressure from many quarters to make changes and discuss issues. We need to have self-discipline. If someone has said something, there is no point in someone else repeating it. We need to hold ourselves in check, so that we can get through our business. I do not see why, in the space of two and a half hours, we cannot take the evidence, discuss it and have the Executive in to deal with the health board allocations.

The Convener: But we have other business.

Margaret Jamieson: You say that we have other business. We have to consider three petitions, but we will have the relevant information before the meeting and will know whether we intend to support a committee inquiry or not. That will not take very long. We need to consider the practice—

The Convener: The other factor is the timetable of the Justice and Home Affairs Committee.

Margaret Jamieson: May I finish? I stopped only because you were speaking to the clerk.

The Convener: Sorry.

Margaret Jamieson: We need to examine the practice of other committees. I have seen the paperwork that some committees are handling—they can keep to their timetable of meetings once a fortnight. We need to examine how they are managing that, because we seem to get bogged down every time that we get round this table.

Malcolm Chisholm: I was not aware of the petitions. I was going to say that we could, as Margaret Jamieson said, deal with section 47 next week. The only difficulty would be whether that would give enough notice. However, I think that most of the organisations would be willing to come. That is certainly an option, although the petitions make it problematic.

We ought to address this issue as a matter of principle. I have taken a special interest in it, but it is the only issue that was not really dealt with in pre-legislative scrutiny by the Justice and Home Affairs Committee. It could not be dealt with, as the amendment was not mentioned until the stage 1 debate. We are talking about a medical issue that the Justice and Home Affairs Committee has not addressed and probably will not address. We have a duty to address it.

Jennifer Smart: I remind the committee that the Justice and Home Affairs Committee is meeting not only weekly. It is meeting all day on 25 January, on the morning of 1 February and on 2 February. The problem is that any amendments would have to be lodged two clear sitting days prior to that.

Malcolm Chisholm: Basically, we must have a date in January.

Jennifer Smart: If the Justice and Home Affairs Committee reached part 5 of the bill by 25 January, amendments would have to be lodged by Friday 21 January, which is this Friday.

11:30

Malcolm Chisholm: I do not think that the Justice and Home Affairs Committee is planning to go as fast as that. The other group that has an interest in this issue is Alzheimer Scotland—Action on Dementia, which is opposed to the Executive's

proposal and is planning to propose amendments at the beginning of February. As long as we meet in January, we should be all right.

The Convener: I suggest that we move back the Executive briefing on health board allocations, if we can, to allow us time on 26 January to take evidence on section 47. We can investigate the petitions situation. It may be possible to put them back to a later meeting, or we may have to take them on 26 January. Is what I have proposed acceptable?

Hugh Henry: I accept what has been said about the need to take some evidence, but I am not sure that we are not simply putting back the need for more meetings. If we put things back to a later date, that will lead to further problems.

Margaret Jamieson made a valid point about how we manage our business and what can be considered at one meeting. Ben Wallace was right to say that legislation must take priority over other business. If we launch full inquiries in response to every petition, we will do nothing but hear evidence from petitioners. The word will get out that the committee is prepared to take evidence on any petition, and for every Stracathro there are another half a dozen issues around Scotland.

We need to find a way to deal adequately with petitions that does justice to those who have submitted them, but does not allow them to dominate the committee's work. If we are ruthless about how we use our time, we can decide to take on additional agenda items, even if it means that other things have to be squeezed. We can come back to the discussion about health board allocations later in the year. I fear that what you are proposing will inevitably lead to more meetings somewhere down the line.

The Convener: I have two points to make. I know that you have missed a few meetings, Hugh, but we have done a full report on one petition. When we—

Hugh Henry: Excuse me, but what do you mean by, "I know that you have missed a few meetings"?

The Convener: We have looked at only one petition—

Hugh Henry: No. Hold on a minute, convener.

The Convener: No, you—

Hugh Henry: I am the convener of another committee.

The Convener: Well—

Hugh Henry: I have other responsibilities to attend to. I have had problems attending to them because of the demands that are put on me by the way in which you slot meetings in at virtually no notice. To respond to your requests to attend those meetings, I would have to neglect my duties on my other committee. You want to be careful in your use of language.

The Convener: What you have just said in your contribution is that we are considering petitions in a way that we have not been considering them.

Hugh Henry: No. I did not say that.

The Convener: You said that to launch inquiries into all petitions would take up too much time, but we have done a report on only one petition.

Ben Wallace: Do we need to have the official reporters here for this discussion?

The Convener: We have done one report on one petition. I agree that it would not be a good idea to have a report on every petition. What we are talking about now, however, is legislation. This issue was not considered substantially at stage 1. Today we are talking about a totally different issue.

I ask the committee to make a swift decision on whether we want to take evidence from people about section 47 of the bill. That is the issue on the table, not what we do with petitions. Do we want to take evidence on that section or do we not?

Irene Oldfather: There is a wider principle at issue and it is a point that has been raised on a number of occasions. Can we have a fortnightly cycle of meetings and can we know when those meetings are so that members who are on other committees or who have constituency engagements can try to plan their timetables? I raised that question at our previous meeting and I was just told, "Keep the next two Wednesday mornings free." I found out only yesterday that we were having a meeting this morning. I had arranged to visit a hospital this morning and I had to cancel at short notice. The points that are being raised are valid and we must take them on board and decide how to manage the committee's time. Almost everyone on the committee agrees with that.

Mary Scanlon: I suggest that we spend less time talking about our agenda. At every meeting, we seem to spend the last hour, or sometimes up to 50 per cent of the meeting, deciding what to do. I fully support what Margaret Jamieson and Irene Oldfather have said. Let us be disciplined, let us decide on priorities and let us progress with our community care work. Let us not ignore this crucial issue. We simply need to be disciplined and avoid wasting time in committee. We all know that we have enormous work loads, so let us use our time properly by concentrating on legislation and on the priorities that we have already identified.

Ben Wallace: Convener, may I—

The Convener: Does everybody have to speak on this issue, or can we move to a decision?

Ben Wallace: I have a suggestion, which I made a few months ago. The convener and deputy convener should draw up a prioritised list that shows where petitions fit in. Meetings should be compartmentalised so that each has three slots. Legislative issues could fill the first slot, with discussion finishing after an hour and a decision being reached. The final slot could be for discussion of future agenda items so that we can decide which slot items will go into. Otherwise, we will do nothing but waffle on this committee.

The Convener: The deputy convener and I will discuss timetabling outwith the meeting and will report back. Does that suit everybody?

Dorothy-Grace Elder: I do not think that we are particularly undisciplined. We are all new to this. This is a big committee and our work has many facets. We must be seen to be flexible when a major issue comes up, as well as deal with legislation.

The legislation that we are currently dealing with will be effective for 20, 30 or 40 years—or longer. It will affect tens of thousands of people, if one counts the family members who will also be touched by it. We must not get it wrong and we must be seen to be trying our best. We all have constituency situations to deal with—I have three in the east end—but we must accept that our work on this committee will involve some personal inconvenience. The convener is right to say that we must be flexible. An urgent petition is coming up, and I am sure that Paul Martin MSP would want me to mention the situation at Stobhill.

The Convener: We touched on that earlier.

Dorothy-Grace Elder: We cannot be so efficient that we are just not doing our job.

The Convener: Let us not touch on it any more. On 26 January, we will take evidence on section 47. After the meeting, the deputy convener and I will meet to discuss potential participants at that meeting. We will circulate that list to all committee members today for comments, additions or deletions. We will also discuss timetabling of that meeting and what other issues we should focus on.

Members *indicated agreement.*

The Convener: Section 48 concerns authority for research. I have forgotten where I was with Richard Simpson's amendments.

Mary Scanlon: Phil Gallie has lodged a substantial amendment to this section.

The Convener: That is right. Amendment 121 in the name of Phil Gallie inserts comments about what constitutes basic care and what constitutes ordinary treatment. Amendment 83 is a minor Executive amendment to section 48(1) that adds the words "in relation to".

A number of people have raised the issue of research. Organisations such as Alzheimer Scotland have pointed out that research benefits not just the individual, but others. In his statement on 9 December 1999, Jim Wallace said:

> "I propose, therefore, to bring forward at stage 2 an amendment based on the Council of Europe's Convention on Human Rights and Biomedicine, which has already been accepted by many European countries and is seen as an international standard. That will permit research in exceptional situations; research that aims to benefit, through significant improvements in the scientific understanding of an individual's condition, disease or disorder, the person concerned or other persons in the same age category who are afflicted with the same disease or who have the same condition."—[*Official Report*, 9 December 1999; Vol 3, c 1383.]

The Council of Europe's Convention on Human Rights and Biomedicine has been mentioned by other organisations including the British Medical Association.

Two or three other suggestions have been made. The Millan committee proposed that there should be a condition requiring the researcher to explain the procedure that is to be used and any foreseeable risks that may be involved. The Mental Welfare Commission proposed the idea that it should be a condition that research should not be carried out if it could not be carried out equally effectively on adults capable of consenting. That is a point that we should discuss. The BMA raised a point about section 48(3)(f), pointing out that the primary carer may not necessarily be the nearest relative. Again, that is an issue that we could discuss.

That is where we are on authority for research, which members had raised concerns about. The Executive is minded to lodge an amendment that addresses some of our concerns. Are there any other comments?

11:45

Irene Oldfather: I understand that in England and Wales, and in the United States, safeguards are built in. For example, they ensure that there is no reason to believe that the research is against the incapacitated person's wishes, that a practitioner from an independent research team can take a view on it, and that a report is given to ethics committees that includes an account of the action taken to gain assent from relatives and to keep them informed. I do not know whether there are any amendments that take account of the safeguards that are in place elsewhere.

The Convener: On the points that Irene made, the requirement in section 48(3)(c) is that

"the research has been approved by the Ethics Committee".

That would probably apply to the ethos of the research, rather than the practice of involving a particular individual.

I would be keen to put in the bill something that says that research could not be carried out on subjects who are capable of consenting, because that would cut out any unnecessary research.

Irene Oldfather: That takes account of my first point, which was to ensure that there is no reason to believe that the research is against the person's wishes.

The Convener: Is the committee happy with that view, and for me and the deputy convener to move forward on it, or are there any concerns?

Irene Oldfather: I have one other point to make, which was raised by the Scottish Neurosurgical Consultants Forum, concerning, on some occasions, the short time scale from the onset of illness to relatives being asked to make judgments in emotional circumstances. I am not sure that has been taken account of, because I have not had time to check the marshalled list of amendments.

The Convener: The problem is that the list of marshalled amendments is not a full list of marshalled amendments.

Irene Oldfather: Perhaps I can flag it up as something that you should take into consideration in your deliberations with the deputy convener.

The Convener: Okay. There does not appear to be an amendment that deals with your concern.

The wording in the Convention on Human Rights and Biomedicine is:

"The convention requires that any such research must fulfil the following criteria:

1. The research has the aim of contributing, through significant improvements in the scientific understanding of the individual's condition, disease or disorder, to the ultimate attainment of results capable of conferring benefit to the person concerned, or to other persons in the same age category, or afflicted with the same disease or disorder, or having the same condition.

2. The research entails only minimal risk and minimal burden for the individual concerned."

That is what the Executive is saying it will come forward with. It will not move beyond what you were suggesting, Irene.

Irene Oldfather: I am not sure that that deals with a short time scale for the onset of illness. I do not know on how many occasions that would be relevant, but it is a point that was raised by the Scottish Neurosurgical Consultants Forum, and we should consider it.

The Convener: We could try to get further information on that point, but there is already one amendment from Phil Gallie on the general issue, and it looks likely that there will be an Executive amendment also, so some of our concerns on research have been covered. I will try to investigate Irene's concern, and we may come back to it briefly.

Margaret Jamieson: Can we have guidance with regard to medical research and adults who are capable? I would not want to be part of any amendment that slanted towards using people as guinea pigs because they are incapable for a short, or a lengthy, period.

Dorothy-Grace Elder: I am particularly concerned about comatose patients. By referring to the Scottish Neurosurgical Consultants Forum, Irene indicated that it is concerned about the large number of young people who are injured in traffic accidents and so on.

The Convener: As we do not have an Executive amendment, we are in the same position as we were with section 44 and, to an extent, section 47. We will seek clarification on some of the points.

Are there any points on 48(5) or 48(6)?

There are none, so I wish to raise this point in passing. Members will notice that amendment 121 in the name of Phil Gallie, which would be inserted after section 48, begins:

"Prohibition on intentionally causing death or harm".

That picks up on points of concern that were raised by the Scottish Council on Human Bioethics, CARE for Scotland, and organisations like them. There will be an opportunity to debate any concerns when that amendment is discussed at stages 2 and 3. The issues were well aired at stage 1, so unless members have a burning desire to rehearse them again, we should move on.

Ben Wallace: Are we talking about Phil's amendment?

The Convener: Yes. I am pointing out to members that Phil Gallie has an amendment.

Ben Wallace: I wonder if a lot of that is not already in the bill.

The Convener: That is the point. Some of it will be.

Margaret Jamieson: We talked about what Richard said with regard to the removal of medical treatment. The amendment does not mention dental treatment, so it would be possible to withhold it.

Ben Wallace: The act defines dental treatment as medical.

Mary Scanlon: Until we see Jim Wallace's amendment, we can only—

The Convener: We can only go so far.

Mary Scanlon: We are sweeping up concerns, but if they are fully addressed and we are satisfied with the responses, the amendment may not be necessary. The amendment is there as a precautionary measure in case the concerns are not addressed.

The Convener: I think that he also has an amendment on the duty of care. I cannot recall what it is. As we are discussing part 5, I thought that it was worth bringing those points to members' attention.

Bearing in mind the actions that we have suggested the deputy convener and I take, we will be back in touch with committee members later today. I wish to move on to agenda item 2, on reports from our sub-groups that we set up a considerable time ago. We are looking for a report back—

Ben Wallace: Convener, I know that we have just finished part 5. Do we intend ever to discuss part 7, which is contentious—or perhaps not—and concerns liability and duty of care? I know that whether we believe in the vested interests of duty of care and so on was a concern that was expressed in the debate in Parliament.

The Convener: I will be guided by the view of committee members. Do members want to discuss that?

Malcolm Chisholm: It relates to the discussion about section 47. That can take place either now or next week.

The Convener: I suggest that it is better to have that discussion next week, given the preparation that is required. It relates in particular to section 73.

Progress Reports

The Convener: Three sub-groups were set up. One, involving Hugh Henry, Duncan Hamilton and Ben Wallace, examined smoking. The poverty sub-group involved Kay Ullrich, Irene Oldfather and Malcolm Chisholm. The third sub-group was on access, and involved Mary Scanlon, Richard Simpson, Margaret Jamieson and Dorothy-Grace Elder.

We will follow that order. Does anyone from the smoking sub-group want to make any comments about what they have been doing?

Mr Duncan Hamilton (Highlands and Islands) (SNP): We have a summary paper of how far we have progressed. We had a meeting on 29 September. We set out the division between smoking and passive smoking and the issues involved in each. Since that, we have pursued evidence and have consulted various groups, as listed on the paper. If members could quickly read through our priorities, we will take questions.

The Convener: The paper's first section asks:

"Does the Committee need to commission further independent research?"

Do you want to comment on that question?

Mr Hamilton: The answer is that we do not know yet.

The Convener: It is just that we have money available at the moment.

Mr Hamilton: Studies have been carried out in America. The most recent—or most topical—one was the New Zealand study into passive smoking. Since then, there have been a few criticisms of that report. If the sub-group could consider what has been said since publication in September, we might be able to return with a formal request for additional research, however I do not think that we can do that at this stage.

Ben Wallace: The EU is also doing its own investigation.

The Convener: Those of us who met the Westminster Select Committee on Health on Monday discovered that its members are also doing work on the same issue, in particular on the tobacco industry. It is progressing from the past agenda to examining the industry itself. It would be a good idea to dovetail with it and see what it is coming up with.

Are there are any other comments from any—I was going to say smoking members, but you know what I mean: smoking sub-group members, or others?

Dorothy-Grace Elder: I am not in the smoking

sub-group, but I suggest that it examine the revenues obtained by the Treasury from smoking—it is about £5 billion or £10 billion a year. It is big, big dosh relative to the amount that successive Governments—not just the current one—have spent on education against smoking. I think that it is only about £3 million in Scotland. That matter needs to be brought up to date.

Mr Hamilton: That is covered by an assessment of the Government's current position and the resources that lie behind it.

Dorothy-Grace Elder: It is a question of the money itself. It will be useful to explore the matter, as we will be able to challenge the tobacco companies as well as the Government.

Irene Oldfather: I want to pick up on Dorothy's point. If we consider this matter across the European Union, we find that massive farming subsidies are given to support tobacco growing in Mediterranean countries. The proportion of money set aside for health promotion and anti-cancer information is infinitesimally small in comparison.

Dorothy-Grace Elder: I am glad that you raised that, Irene. I recall that, a couple of years ago, President Clinton was unable to visit Virginia for political reasons, because he was anti-smoking.

If we take the example of California—although we do not want to do so on many loopy things—

Ben Wallace: Dorothy, are you from California?

The Convener: Let us not go into that.

Dorothy-Grace Elder: Everyone holds up California as the great example of a state that has managed to quell smoking. It is a great example, but I believe that it has spent six times as much as Britain on such measures—proportionately.

Mr Hamilton: That could also be taken as part of the international comparison, which we are considering.

12:00

Mary Scanlon: I think that the programme as set out in the sub-group's paper is excellent. However, I would like there to be some emphasis on underage and young smokers. Children seem to be smoking at a younger age. When I was preparing for the drugs debate, I was told that the earlier children start smoking, the more likely it is that they will start dabbling with drugs.

Mr Hamilton: That is a good point. It might also come under our consideration of the strategy currently being adopted by the tobacco companies. It may relate to how the companies are focusing on different market sectors—different socio-economic groups and age groups. I take Mary Scanlon's point on board.

Mary Scanlon: Education in schools is perhaps also relevant to that.

Dorothy-Grace Elder: The Treasury makes £10 million a year in tobacco revenue and VAT from child smokers in Scotland alone. That figure comes from the amount of cigarettes assumed to be sold illicitly to children.

The Convener: We will return to time scales at the end, but I would be grateful if we could now have a report from one of the members of the poverty sub-group.

Malcolm Chisholm: This is obviously a massive subject. We have met only briefly, but we have been doing other work. I have read a lot of the pertinent literature. Nobody can dispute the facts. Everybody knows that there is a link between poverty and poor health. That was highlighted in the news recently: the University of Bristol report drew attention to the various Glasgow constituencies.

The facts are undisputed; what is in dispute is the precise mechanisms or pathways by which social and health inequalities are generated and maintained. There are many different theories, some of which are complementary rather than contradictory—I am not sure members want me to go into that now. I think that we have decided that the sub-group will survey the literature on that, and that we will try to contact certain individuals in Scotland—many of the key academics on the subject are in Scotland, including Professor Hanlon, the professor of public health at the University of Glasgow.

The second major question is what effective actions can be taken to deal with the situation. There is reading to be done, but that is also where we can make our main contacts. We discussed going to talk to various organisations and individuals who are trying to address matters locally. We have done a lot of preparatory work and we are now prepared to meet people and organisations.

I do not know whether members want me to cover all the territory. Probably not, considering the time. In general, though, this is a key subject for this committee, so our investigation will just have to go on for a long period of time. If we can crack this, we will have made the biggest breakthrough on health policy.

I always thought that poverty was the biggest challenge to the Parliament. One of the fundamental questions is about the extent to which we can tackle it through health policy. The reality is that we can do only a bit through health policy.

The Acheson report, produced by the Department of Health in England, was one of the most interesting things that I have read. Sir Donald

Acheson, the chief medical officer at the time, said:

"We consider that without a shift of resources to the less well off . . . little will be accomplished in terms of reduction in health inequalities by interventions addressing particular 'downstream' influences".

That is a very radical challenge from a pillar of the establishment in England. It does not mean that we give up on all the health policies and interventions, but it does provide some context.

Two people whose work has interested me are Wilkinson and Barker. Wilkinson's basic point is that income inequalities are most closely correlated with health inequalities—that is controversial and has great political implications. In our meeting with Scottish Executive officials, we learned about the great deal of work that is being done on the influence of low birth weight on later life. That puts another perspective on the matter. The theories about accumulated effect have enormous practical implications for health policy, but they do not contradict other theories.

We have not given up on this—we are trying to tackle this enormous challenge.

The Convener: Your main issue is probably what to focus on in tackling it.

Malcolm Chisholm: I return to what I was saying about seeing how individuals are trying to address poverty, using a community development approach to tackle it at a grass-roots level. Many such projects are under way. The question is—it was asked when we considered the Arbuthnott report—how health boards spend their money and the extent to which they focus on poverty.

I cannot claim that the sub-group has come to any conclusions, but we are more familiar with the territory—I am; Irene is already an expert, so she did not have to do so much preparatory work.

The Convener: Shall we go to the expert, then, or are you happy with what Malcolm has said, Irene?

Irene Oldfather: I think that Malcolm summarised the situation very will.

The Convener: Are there any other comments for the poverty sub-group? If not, we will move on to the next one, on access.

Mary Scanlon: We have decided to meet in the very near future. We have not so far agreed on a time when we are all together, but we have briefly discussed a possible framework of reference and a structure for this enormous subject, and a structure under which we will pursue our investigation.

Our report is therefore not very long.

The Convener: Are there any suggestions or comments for the access sub-group?

I would like to move to the timetable for the sub-groups' work. We are all well aware of everyone else's work load, and I appreciate that our own was particularly great in the first few months. Some of us may be getting more to grips with it now. I do not think that there is anything to be gained, in any of the three subjects, by rushing to conclusions. I think that it is much better to allow things to develop. It is obvious just from the three reports that we have heard now that members are at different stages.

I suggest that we give this another three months and ask sub-group members to return in three months' time with further progress reports. We will decide then whether to put forward the timetable for the finalisation of reports or whatever we want to do with the work that sub-group members have done up to that point.

Dorothy-Grace Elder: The access group members were wondering whether it would be appropriate for us to consider social inclusion partnerships in greater detail. We wondered whether that would fit in with access.

The Convener: I would not have a problem with that. It is in the hands of sub-group members.

Dorothy-Grace Elder: Damp housing was another thing that we discussed.

The Convener: There are overlaps.

Malcolm Chisholm: Social inclusion partnerships is something for us to consider.

The Convener: If members want to make visits or do anything else that they think would be helpful in progressing their work, they should make the clerks and me aware of it, and we will do what we can to facilitate anything that would be useful or helpful, apart from going to California—unless the convener can come too.

Meeting closed at 12:09.

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