HEALTH COMMITTEE

Tuesday 25 October 2005

Session 2

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CONTENTS

Tuesday 25 October 2005

HEALTH COMMITTEE
25th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

Helen Eadie (Dunfermline East) (Lab)
Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Paul Martin (Glasgow Springburn) (Lab)
*Mr Kenneth Macintosh (Eastwood) (Lab)
Mary Scanlon (Highlands and Islands) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE:

The Solicitor General for Scotland (Mrs Elish Angiolini)
Joanna Keating (Scottish Executive Legal and Parliamentary Services)
Dawn Kemp (Royal College of Surgeons of Edinburgh)
Dr Andrew Kitchener (Human Remains in Scottish Museums Working Group)
Lewis Macdonald (Deputy Minister for Health and Community Care)
Professor Anthony Payne (University of Glasgow)
Will Scott (Scottish Executive Health Department)

CLERKS TO THE COMMITTEE

Lynn Tullis
Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERKS

Merrin Thompson
Roz Wheeler

LOCATION

Committee Room 4

Scottish Parliament

Health Committee

Tuesday 25 October 2005

[THE CONVENER *opened the meeting at 14:00*]

Item in Private

The Convener (Roseanna Cunningham): I welcome everyone to the first meeting back after the October recess. I ask Kenneth Macintosh to confirm that he is attending the meeting in place of Helen Eadie, who has had to send her apologies because once again there is a clash in the timing of the meetings of the Edinburgh Tram (Line One) Bill Committee and the Health Committee. Are you here in your capacity as a Labour Party committee substitute?

Mr Kenneth Macintosh (Eastwood) (Lab): I am.

The Convener: I have also received late apologies from Kate Maclean, who is unwell.

Item 1 is to ask the committee whether it agrees to take in private item 5, so that we can consider our draft budget report. That is now fairly standard procedure. Is that agreed?

Members *indicated agreement.*

Subordinate Legislation

Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2005 (SSI 2005/443)

Mental Health (Care and Treatment) (Scotland) Act 2003 (Transitional and Savings Provisions) Order 2005 (SSI 2005/452)

Food Labelling Amendment (No 2) (Scotland) Regulations 2005 (SSI 2005/456)

Bovine Products (Restriction on Placing on the Market) (Scotland) Regulations 2005 (SSI 2005/470)

14:01

The Convener: Item 2 is consideration of subordinate legislation. Four instruments that are subject to the negative procedure are listed on the agenda. The Subordinate Legislation Committee had comments to make on two of them—SSI 2005/443 and SSI 2005/452—which are reproduced in an accompanying paper. I have received no comments from members of the committee and no motions to annul any of the instruments have been lodged. Are we agreed that we do not wish to make any recommendation on SSI 2005/443, SSI 2005/452, SSI 2005/456 or SSI 2005/470?

Members *indicated agreement.*

Human Tissue (Scotland) Bill: Stage 1

14:02

The Convener: Item 3 on the agenda is continued consideration of the Human Tissue (Scotland) Bill. Today is our final evidence session. We have two panels of witnesses. The first panel, the members of which have taken their places, comprises representatives of a range of organisations that have interests in the revisions that the bill seeks to make to the Anatomy Act 1984, particularly those that are connected to control of display of anatomical specimens and body parts.

I welcome Dr Andrew Kitchener, who is from the human remains in Scottish museums working group, Dawn Kemp, who is from the Royal College of Surgeons of Edinburgh and Professor Anthony Payne, who is from the University of Glasgow. The Health Committee does not normally take opening statements, but I want the witnesses to state their specific interests in the bill and to comment briefly on it, indicating whether they support its provisions. We will start with Dr Kitchener.

Dr Andrew Kitchener (Human Remains in Scottish Museums Working Group): I thank the committee for its invitation. Although I am the principal curator of mammals and birds at the National Museums of Scotland, I am representing the wider community of registered Scottish museums as a member of the working group.

There are human remains in a number of museums in Scotland, which are held for research and education and to assist the public's understanding not only of medicine and health, but of evolution and cultural history. It is only right that human remains in museums are held, used and treated appropriately. The Scottish museums working group is drawing up guidelines on display and care of, and access to, human remains in museums.

During the course of our work, we became aware that the Human Tissue (Scotland) Bill could restrict significantly the basis on which museums in Scotland may hold, display and use human remains and we do not believe that such a restriction would be in the public interest. We have three specific concerns, which I can go into now or bring up in later discussions.

The Convener: I invite you to flag up those concerns very briefly. You are not meant to be giving a statement, but an indication of where your particular interest lies. That will help the committee to focus its questions.

Dr Kitchener: We are concerned that the bill will prevent us from using collections of human remains for public education and some kinds of research because it is highly specific about how such collections can be used. In addition, it will impose severe restrictions on the purpose and nature of public displays of bodies and body parts. We are also concerned because some implications of the licensing arrangements for museums require clarification.

Dawn Kemp (Royal College of Surgeons of Edinburgh): Thank you for inviting me. I am director of heritage at the Royal College of Surgeons of Edinburgh and am responsible for the care of the college's collections, including its pathology and anatomical specimens, and their use for public educational purposes. I am also a member of the Scottish Museums Council's working group on human remains and a part-time doctoral research student at the University of St Andrews studying public access to pathology and anatomy museums in Scotland during the first half of the 19th century.

We welcome the amendments to the Anatomy Act 1984 that concern professional medical surgical practice and we fully endorse and understand the need to safeguard public confidence in the care and display of human remains. It is right that that is an area of great public sensitivity. Our main concern is that without greater definition of the licensing criteria for public display, human remains that are less than 100 years old may be presumed to be too sensitive to show, regardless of the public educational benefit.

From informal conversations and more structured research, we believe that public opinion is largely in favour of display of human remains if it is done in a respectful context. The introduction of overly restricted public access may inadvertently fuel public concerns instead of alleviating them. We are also concerned that any restriction on display of photographic images of most specimens would deprive the public of an extremely valuable educational resource.

The Convener: I know that you want to make some wider comments, Professor Payne. I ask you to keep them as brief as possible.

Professor Anthony Payne (University of Glasgow): Good afternoon. I am the professor of anatomy at the University of Glasgow. First, our everyday operations come not under the Human Tissue Act 2004 but the Anatomy Act 1984. My colleagues and I welcome the bill, particularly the changes to the purposes for which bequeathed cadavers can be used; namely, for training as well as teaching. We are heavily involved in continuing professional development for surgeons and we welcome the fact that the bill will rule out that anomaly.

Our one concern relates to public display of anatomical material. The Hunterian anatomy museum in Glasgow has customarily been open to the public. That has been the case for a number of reasons, the first of which is that the museum was built by public subscription. Secondly, in the so-called Scottish codicil to his will, Dr William Hunter made it clear that his collections should be seen by the public.

Thirdly, in common with all modern museums, we believe that we have an educational duty to allow the public to see things that interest them. We prefer the public to do so in a sober and academic environment and not through the kind of sensational show that has appeared on television in recent years. We have urgent concerns on that subject. Our museum, and the Hunterian museum more generally, is about to mount special exhibitions. One will deal with Hunter, his life and collections; another will deal with the role of Glasgow in the development of medicine over the years. The exhibitions are being funded by the Wolfson Foundation, the Wellcome Trust and the Heritage Lottery Fund.

We need to sort out how public display will be legislated for under the bill—whether by licensing, as the bill suggests, or by exemptions, as people in the Executive have suggested. We need to be clear whether that will be put in place before the bill becomes law or before its regulations or codes of practice come into force.

The Convener: Thank you. We move to questions from the committee.

Mrs Nanette Milne (North East Scotland) (Con): In their submissions to the committee, several interested parties sought clarification on what would happen to existing holdings, given that it may not be possible to say where those holdings originated. How are museum holdings regulated at present—if at all? What are your concerns about the provisions that relate to existing holdings?

Dawn Kemp: The Royal College of Surgeons of Edinburgh has a full-time anatomical conservator who looks after the collections. We have a storage area and properly looked-after areas in which that work takes place. Any disposals that we make are done following all necessary legal requirements and in the respectful way that human remains deserve to be treated.

Dr Kitchener: Obviously, I can speak only for the National Museums of Scotland. All specimens are registered as part of the formal collections and are fully accounted for in public terms. They are cared for in specialist areas.

Mrs Milne: Is that a legal requirement?

Dr Kitchener: No, it is not.

Professor Payne: We operate in the same way under the Anatomy Act 1984. My answer to the question of the legal requirement is the same as the other witnesses'.

Dawn Kemp: Museums have their own ethical guidelines for the care of collections in general and, more specifically, for the care of human remains.

Mrs Milne: Are those guidelines drawn up by individual museums?

Dawn Kemp: They are agreed with the Museums Association. In order to be a registered museum, we have to show that we have processes in place that meet the minimum standard. We asked for an exemption for registered museums in Scotland. The standards are already affirmed through our membership of the Museums Association.

Mrs Milne: Do you have concerns about the provisions of the bill?

Dawn Kemp: It would be a great shame if we lost the educational resource. People view human remains differently from any image or representation of the human body. They are fundamental to people being given the broadest chance to understand themselves—there is the classical aphorism, "Know thyself". We are truly all Jock Tamson's bairns. No collection shows that better than ours.

Mrs Milne: What concerns does the bill raise in connection with the definition of public display?

Professor Payne: Perhaps we should not have any concerns. However, the bill rules that there may be no public display unless there is an approved licensing system. We need to ask you, as much as you need to ask us, quite what the Scottish Executive's intention is in this case. We hope very much that it does not intend to take away existing customary rights of access by the public to museum displays, which is a possibility under the current wording of the bill.

Mrs Milne: What features would you expect to be included in a licensing scheme? Do you think that the nature of the scheme should be defined on the face of the bill?

Dr Kitchener: We in the wider museum community—non-medical museums—would like an exemption for our existing collections, which are mainly historic. In many cases, we cannot be certain when the person who contributed the remains died. The bill might impact negatively on our current practice.

Dawn Kemp: We recommend that any licence for existing material be issued on the presumption that, as long as donor confidentiality is not compromised, most specimens are suitable for public display. There is extremely sensitive material in anatomy and pathology collections and we believe that it is undoubtedly inappropriate to display some specimens. However, we hope that the vast majority of specimens for which there is no documentation of donor intentions but for which anonymity is assured may continue to be used to inform and educate the public. That has been the case in Scotland, as distinct from England and Wales, for 200 years. The situation here is still distinct from that in England and Wales.

Mrs Milne: What provisions would you like to see on the face of the bill?

Dawn Kemp: Licensing should presume that most material should be allowed to be on public display, rather than decide which few specimens can be on display.

The Convener: You want licensing to be inclusive, rather than exclusive—those are the modern buzzwords that you are supposed to use. All of us are schooled in modern buzzwords and would understand what you mean.

Dawn Kemp: It comes from working in an 1830s building.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): My question relates to the concern that was expressed by Professor Sue Black about the fact that a child of 12 or over could give written authorisation for the use of their body for anatomical examination after death. Professor Payne was concerned that a requirement for formal written authorisation might deter people from donating.

Professor Payne: Quite the reverse—we are keen on written authorisation. It is very difficult to donate one's body because the donor must seek us out. We provide a variety of types of advice—I will not use the word counselling—to people who are contemplating being donors. It might surprise the committee to learn that at the moment there are about 6,000 living potential donors in the west of Scotland. It is quite a trade, but people have to seek us out in the first place. We would not normally take anything from a child.

The Convener: The issue is how we define a child. The legislation would allow a child of 12 or over to give authorisation, but you are saying that you would not be happy about that.

14:15

Professor Payne: Do you mean under the amendment to the Anatomy Act 1984? I think that that provision is in the Human Tissue Act 2004.

Dr Turner: The bill would allow a child aged 12 to choose for the purposes of organ donation and hospital post mortem—

The Convener: Professor Payne, you have no interest in the use of an anatomical examination after death.

Professor Payne: Not at all. I defer to the people who are interested in the Human Tissue Act 2004.

Dr Turner: But you would be concerned about taking—

The Convener: I think that Professor Payne has just said that he will not take a position because the subject is not in his remit of interest. Do either of the other two witnesses have a view?

Dawn Kemp: There is a slight possibility of interest in making additions to a surgical pathology collection in the future. For example, it might be that part of a person aged 12 or over has undergone an operation. Say that in five years we can get eye transplants and that that person has the first eye transplant to take place in Scotland. With their authorisation, that organ could be kept. There might be some such cases, but we do not show foetal or child material anyway.

The Convener: How do you define "child"? The issue is about setting the age of the child.

Dawn Kemp: We do not have an age definition in that respect, but perhaps we should for our own guidelines.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Can a 12-year-old child give medical consent?

Professor Payne: I do not believe so; they would look for their parents to give consent.

The Convener: Age has been a consistent question throughout our consideration. We have to have a statement from the minister about why the Executive is thinking what it is thinking. I am not getting any sense from this panel that the witnesses have a huge issue with the idea of a fixed age limit's being included in the bill. We have heard from other witnesses who have said that regardless of what the future act said, they would not be happy to accept consent from children under a certain age. However, the current witnesses are not really in that position and have no fixed view. That is fair enough.

Dawn Kemp: I have one point about authorisation. To give clarity of donors' intentions in future, we would recommend that a specific category be included in the bill on authorisation forms for the use of human tissue for the purposes of public education through display and photographic or other forms of representation. That would clarify any future material that might come into the collections.

Dr Turner: You said that about 6,000 people have said that they will donate their bodies. What is their knowledge of what will happen to their bodies after they have said, “I would like to donate my body”? Do they have to fill in a specific form?

Professor Payne: Yes. There is lots of paperwork and they know that they are leaving their bodies for the purpose of medical education and, if the bill is passed, for medical training in the future. They also have to fill in boxes positively if we are to be allowed to retain any of their parts for permanent teaching purposes. What has just been said about using parts for display purposes could well be the subject of an additional box that they would have to actively fill in.

Dr Turner: So it would be quite clear to a person what they were doing.

The Convener: Are sufficient numbers of people currently donating their bodies for those purposes to fulfil existing need?

Professor Payne: Just about. You must remember, however, that of those 6,000 people some will emigrate, some will move to other parts of the country, some will change their minds and in some cases the paperwork will get lost and the families will not know about it. There is always natural wastage.

We do not take every bequest. In order to protect our staff, we would not take someone with hepatitis or MRSA.

The Convener: So at present, you are just about breaking even—there are enough donors.

Do you share a concern that the committee has heard that accepting only formal written authorisation might deter some people? You mentioned the lengthy bureaucratic process that people have to go through at the moment. Given that, would you be happier if it were enough for people to say in their will that they were prepared to make a donation rather than go through that whole rigmarole?

Professor Payne: What I have described with our written consent forms is best practice. However, there might be cases in which one would accept an arrangement such as you suggest. The further away we get from a prior written agreement that might have been given 20 or 30 years before a person dies, the more uncertain we become about the original intention. That is particularly true of elderly people who are demented or confused.

The Convener: Therefore, a clause in a will would not necessarily satisfy you unless the will had been written relatively close to the death of the donor.

Professor Payne: No—it would satisfy us.

The Convener: It would?

Professor Payne: It would.

The Convener: At present, it would not be enough, but in the future it may be.

Professor Payne: We have not had to call upon that until now, but I can see no reason why it should not be legal and useful in the future.

The Convener: You said that at the moment the supply of people who are willing to leave their bodies to you is about right. That may mean that you do not have concerns about making people more aware about the possibility of making such an authorisation. You say that people have to make a determined effort to seek you out. Most of us have heard friends and relatives say that they would not mind donating their bodies, but they do not follow through. Are people deterred by the lengthy process?

Professor Payne: I have no way of evaluating that. People usually come to us after speaking to their general practitioner, another medical attendant, their lawyer or the matron of a nursing home.

The Convener: I do not detect a great deal of concern about the authorisation of post-mortem donations. I appreciate that your evidence is about your concerns that you would like us to put to the minister. He will be next to give evidence, so we will raise your concerns with him.

Mr Macintosh: I get the impression that there is quite a robust system in place regarding the public display of human remains. I am trying to get a feel for how often issues of taste or decency come up. One of the best pieces of written evidence that we have received in a long time comes from Dawn Kemp. It states:

> “There has never been any disturbance in the Museum … Visitors of the lower classes, mechanics, sailors and soldiers have uniformly been quiet, careful and most orderly.”

That is from a letter by the conservator of the museum of the Royal College of Surgeons of Edinburgh in 1837. Is that still the case? Professor Payne mentioned anatomical shows on the television, and I believe that there are artistic displays of human remains. How much of a problem is public display of human remains?

Dawn Kemp: People have a great deal of respect for human remains; they view them with awe and they engage with what they see. The word “voyeurism” is bandied about when the talk is about human remains, but if you were to stand for an hour in our museum you would see that that is not what is on the faces of the people who are looking at those wondrous things.

We had some concern about paragraph 71 of the “Policy Objectives” in the policy memorandum to the bill, because it mentions "exhibitions under the guise of education or art."

Art and anatomy have always been inextricably linked. It sometimes takes an artist's eye to show a surgeon or medical professional things that they might otherwise miss. Just last month, a cardiac surgeon in England claimed to have had a eureka moment on looking at a da Vinci drawing of the heart, whereby he understood a new and more effective way to repair a mitral valve. Our bodies are part of our cultural experience and there is no harm in having body parts beside cultural artefacts of the body and representations of it, but the context must be considered and understood. Such practices should not be cast aside outright.

The Convener: The concern is about sensationalism, in which none of you is involved.

Professor Payne: I agree entirely with what has been said. My impression is that we have some members of the public in our museum every day. Mr Macintosh read that interesting quotation—I know that members of the armed forces have visited us. I have never experienced a disturbance in more than 30 years at our museum and no one has ever complained to me about what they have seen. If anyone came to us looking for a gore-fest—if I may put it that way—they would be sadly disappointed.

The Convener: I thank the three witnesses for appearing; I hope that it was not too stressful. We will take a minute or two to change name plates for the second panel.

I welcome to the committee the second panel of witnesses, in particular the Deputy Minister for Health and Community Care, Lewis Macdonald, and Elish Angiolini, who is the Solicitor General for Scotland. A variety of officials accompany them, but I will not try to name all the officials.

I will cut to the chase and invite the deputy minister to give a brief introduction. We want to get cracking with questions.

The Deputy Minister for Health and Community Care (Lewis Macdonald): In that spirit, I will desist from introducing each accompanying official. The committee can take it that they cover the policies in question.

I remind committee members of the fundamental principle that underlies the bill, which is that the wishes that a person expresses in life should be respected after their death. The bill embraces that principle by introducing the concept of authorisation rather than consent for transplantation and post-mortem purposes.

The act that currently controls those activities is the Human Tissue Act 1961. The bill addresses several problems with the current legislation. For example, in the current legislation the role of a surviving spouse or relatives is not always clear, the final decision lies with the person who is lawfully in possession of the body and the 1961 act is couched in terms of establishing a lack of objection rather than a positive authorisation.

14:30

Above all, the fundamental problem is that the 1961 act applies in exactly the same way to transplantation and to post-mortem examinations, which are different activities with different histories and different public perceptions that require different approaches. We have formed the view—our expert advisory bodies have reinforced it—that transplantation and post-mortem examination should be subject to separate legislative provisions. It was determined that the most efficient and effective way to do that was to update the legislation and to do that in one bill—the Human Tissue (Scotland) Bill—but to provide clearly and separately for different activities in different parts of the bill. That is why we have also made specific authorisation arrangements that are tailored to the needs of each of the categories. That has been done deliberately. A positive choice was made and it is a positive feature of the bill.

The new legislation seeks to reflect the new principle of authorisation through its constituent parts. Part 1 of the bill regulates organ donation and transplantation by setting out the arrangements for authorising the use of parts of the body for those purposes. Part 2 deals with hospital post-mortem examinations by establishing standardised arrangements for authorising those examinations. Part 3 deals with procurator fiscal post mortems by setting out arrangements for authorising the use of tissues and organs from such post-mortem examinations once those are no longer required for the procurator fiscal's purposes. Part 4 makes supplementary provisions in respect of parts 1 to 3.

The existing legislation that covers transplantation and hospital post mortems is, as I have said, more than 40 years old. I think that there is wide acceptance—I hope that the committee's evidence taking has reflected that—among professionals and the general public that the legislation needs to be updated. We believe that the bill will meet those expectations and that our bill, while being specific to Scottish circumstances and Scottish legislative requirements, is consistent with the fundamental principle that underlies the act that has been passed for England and Wales, which is that people's wishes should be respected. We have therefore introduced a bill that strengthens existing opt-in arrangements for transplantation and builds on the public's very positive perception of and attitude towards organ donations, but which also draws the lessons from the past about hospital post-mortem examinations and seeks to ensure that there is absolute clarity as to why an examination is needed and what exactly has been authorised.

Finally, part 5 of the bill will amend the Anatomy Act 1984 by introducing changes to controls on the use and display of bodies that are donated under that act.

The Convener: Thank you. I think that the Solicitor General for Scotland's interest in the matter is more narrow. Do you want to make any comments at the outset?

The Solicitor General for Scotland (Mrs Elish Angiolini): I have no introductory comments.

The Convener: We will go straight to questions.

Shona Robison (Dundee East) (SNP): The deputy minister referred to the concept of authorisation. The issue of whether a definition of authorisation should be included in the bill has been raised on a number of occasions by Professor Sheila McLean and by the British Medical Association. I look for a response to the suggestion from the deputy minister and perhaps from the Solicitor General for Scotland. Having heard what the BMA and Professor Sheila McLean have said, are you persuaded that a definition of authorisation should be included in the bill to provide greater clarity and ensure that there is no misunderstanding?

Lewis Macdonald: I indicated in my opening remarks that I was keen that it was understood that the authorisations in question were for different purposes and therefore set different standards for post mortem and for transplantation. It follows from that that the means of authorisation vary according to whether the provision is in part 1 on transplantation or in part 2 on post-mortem examinations. Does that address your point?

Shona Robison: It probably leads to the next set of questions, which are about the differences between and the confusion that could be caused by those authorisation processes. Would it not be possible, even taking into account the different processes, to provide a definition of authorisation? You say that because of the different application of authorisation it would be difficult to provide a definition in the bill that could encompass all those processes.

Lewis Macdonald: There is a well-understood meaning for the phrase "to authorise", in legal terms as well as in general English: it means to give legal force to and legal authority for. The existence of that understood meaning is adequate in the context where the bill sets out in detail the means of authorisation, which are not the same for each part of the bill. All that we are proposing rests on the understanding of the meaning of the phrase "to authorise", which is to give legal authority and to enable; the bill does not seek to narrow that down or to apply it in exactly the same way to each of the processes involved.

The Solicitor General for Scotland: I support what Lewis Macdonald said. Authorisation is a generic, uniform concept, but it is subject to a variety of different tests in the legal context, some of which are more robust than others. It is a policy issue whether the tests that are applied in a particular category are subject, for instance, to witnesses or to subscription or to a variety of other tests. It has to be a matter of what works in individual circumstances and what is practicable and desirable.

Janis Hughes (Glasgow Rutherglen) (Lab): I accept the minister's comment that there are different processes in different parts of the bill for specific reasons, but a number of issues have arisen during evidence taking that need clarification. For example, the bill states that an adult can provide verbal authorisation for organ donation and transplantation, but a mature child cannot. Do you want to respond on each of the issues individually?

Lewis Macdonald: Yes. You asked why there is a difference between the provisions for adults and those for 12-year-olds. Children between the ages of 12 and 16 often have the capacity to understand the issues involved, and therefore to give consent, but we recognise that their ability to do that might be a little bit more subject to other views and influences than would be the case with an adult. The bill provides extra protection—an extra guarantee, if you like—that in giving his or her consent, a child does so in an informed way.

Janis Hughes: Why was the age of 12 chosen in the definition of a mature child? Perhaps the Solicitor General could comment as well.

Lewis Macdonald: The Age of Legal Capacity (Scotland) Act 1991 lays down that 12 is an appropriate age for children to make a number of decisions, for example, to make their own will, to consent to an adoption order or to consent to medical treatment under certain circumstances. Allowing consent to be given in relation to transplantation is consistent with that. It is an appropriate age at which a child has the ability to understand the issues raised. For example, on transplantation, the judgment is that, consistent with understanding the consequences of medical treatment to themselves, children in the 12 to 16 age group are capable of understanding the concept and effect of organ transplantation after their death.

Janis Hughes: The bill states that adult verbal authorisation for organ donation must be withdrawn in writing, but adult verbal authorisation for hospital post mortems can be withdrawn verbally. Can you give a reason for that discrepancy?

Lewis Macdonald: The position in relation to transplantation is that withdrawal of authorisation must be done in writing. That is because the circumstances that apply to a transplantation situation are somewhat different, in that once authorisation has been given, we want to avoid any confusion or lack of clarity about the intention of the adult in question. The adult gives their authorisation in advance. We want to ensure that the clinician is protected from any ambiguity about withdrawal of authorisation.

The Solicitor General may want to say something about that aspect, because it is clearly of interest from her perspective. The bill creates the criminal offence of conducting transplantation after authority has been withdrawn. For the protection of the clinician, it has to be absolutely clear when consent has been withdrawn.

The Solicitor General for Scotland: I agree. Given the scope and the conditions in which the action would take place, there is a time imperative, which would not be the case with regard to the other issue. Where there are criminal consequences of a failure to comply with the wishes of the next of kin, we would be looking for corroborative evidence to suggest that there was an intention to fail to comply. The bill provides a safeguard for clinicians in those circumstances and clarity for the prosecutor about what evidence they would have to rely on in proceeding to prosecution.

Janis Hughes: What would happen if there was a dispute between people in the hierarchical structure for giving consent? For example, what would happen in the case of a child where, in the first tier, one parent was the primary carer and the other was an absent parent and there was a dispute between them? We heard various views on that in evidence. The main clinical view was that in such situations a post mortem would not take place. That raised concerns among members. What are your views on that?

Lewis Macdonald: We understand that that issue is difficult. It is difficult to anticipate in legislation all the circumstances that can arise in relation to the hierarchical structure. The bill allows intervention to go ahead on the basis of authorisation by one parent. That is consistent with the general provisions of the Children (Scotland) Act 1995, in relation to parental consent for medical treatment. That act provides that in similar circumstances, in which one parent consents to intervention, that is sufficient authority for it to go ahead. It is also consistent with the Human Tissue Act 2004, which makes the same provision south of the border. Under the 1995 act, where two or more people have a parental right, each of them has the power to exercise that right without the consent of the other.

The bill needs to state the clear, unambiguous legal position. It is fair to say that practice might not reflect that position. I suspect that most clinicians, when faced with a position in which two parents took different views, might well take the safer option of not proceeding. The legal position is that, under the bill, they would have the right to proceed. That gives them the flexibility to act.

Janis Hughes: What would be the legal position? Would one parent have more of a right than the other to give consent?

Lewis Macdonald: Not as the bill is drafted. The bill simply provides that a person with parental authority may authorise an intervention.

Janis Hughes: So both parents would have equal rights, but if one of them consented and one dissented it would be up to the clinicians to make the decision.

Lewis Macdonald: No; the consent has legal force.

Janis Hughes: Okay.

The Convener: Shona Robison had a question about withdrawal of consent, which she might want to ask at this stage.

Shona Robison: The bill allows authorisation that is granted by a relative to be withdrawn. We have heard evidence, particularly from the Scottish Transplant Co-ordinators Network, that the bill should be clearer on how long before transplantation occurs authorisation can be withdrawn. We can envisage a situation in which withdrawal could endanger the life of the recipient if they were prepared for surgery. At what stage would it be possible for authorisation to be withdrawn and how will that be stipulated? Will it be included in guidance?

Lewis Macdonald: Guidance could well be used in that respect. There is the option to amend the bill to address that issue, which we certainly recognise is difficult.

The principle that was advanced in evidence to the committee was that, once an authorisation is in place and a person is being prepared to receive a transplanted organ, that person’s interests should take priority from the clinicians’ point of view. That is a pretty sound approach that would command general support. I would be prepared to consider how best to enforce it, either through amendment to the bill to clarify the position or through guidance on completion of the statutory process.

14:45

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): If we have gone to the trouble of getting authorisation from the nearest relative of a deceased adult and donation has been agreed and authorised, why does there need to be provision for withdrawal? Not having such provision would resolve the issue of what happens once authorisation has been given.

Lewis Macdonald: You are absolutely right. The alternative approach is simply to say that, once the nearest relative has given authorisation, intervention should proceed and that should be the end of the story. That is not how the bill is drafted. However, I recognise that there is an issue that needs to be resolved. We have not reached a fixed view on how that is best done.

Mr Macintosh: There is an element of presumed consent in the Executive's approach to the bill, but we have heard evidence from the BMA and others that, if we take presumed consent as the approach to organ donation and transplantation, the benefits to patients needing an organ are clear for all to see. I share that view. In the policy memorandum, you note that an estimated 90 per cent of the public support organ transplantation. What level of consideration did the Executive give to the issue of presumed consent? Why did it not pursue that approach in the bill?

Lewis Macdonald: These are difficult judgments. We take the view that to go ahead on the basis of presumed consent would be a tenable position only if there were clear and overwhelming expressions of both public and professional support for it. As you know, there are divided opinions among the relevant professions.

You raise the issue of public opinion and the public appreciation or perception of the issue. Although at the beginning I was keen to emphasise the distinction to be drawn between the provisions that we are making in relation to transplantation and those relating to post-mortem examination, we would be unwise not to learn the lessons of situations in which there was presumed consent for post-mortem examination. Parents of the deceased children concerned were horrified to discover that their consent had been presumed, and we have seen the consequences of that. The post-mortem elements of the bill are driven largely by the failure of presumed consent to reflect the opinions and wishes of the families in the cases to which I refer. Although transplantation is a separate issue, we would be wary of presuming consent to transplantation and then discovering that the families of some of those affected did not wish their consent to be presumed.

Mr Macintosh: At the moment people can register to donate organs, but they cannot register to voice objections to the donation of their organs. Did the Executive explore that issue? Even under the current system, it would give extra comfort to professionals working in the area if they knew that there was a register that they could consult that allowed people who had strong objections to their organs being subject to post mortem or being used for transplantation to raise those objections in advance. That would be very reassuring.

Lewis Macdonald: You make a fair point. I will ask Will Scott to say something about what consideration was given to the proposal prior to this stage. It is directly relevant to the issue of how we judge consent for transplantation. The situation as it stands—and as it will stand if the bill is agreed to in its current form—is that there is no absolute, fail-safe way in which to register non-consent or non-authorisation.

Clearly, if a person has strong views about their organs or body parts or tissue not being used for any purposes after their death, they can convey their wishes to their close family members, notify their general practitioner to enter a note on their medical records and put a statement about the matter in their will. Clearly, those methods will not be relevant for situations in which an urgent decision is required, but they allow a person to seek to ensure that their body parts are not used after their death. However, given that the issue often arises in an emergency situation, I recognise that none of those methods is failsafe as such.

Perhaps Will Scott can comment on the earlier consideration around those options.

Will Scott (Scottish Executive Health Department): The minister has covered the issue very well. The bill builds on the positive attitudes towards organ donation that are held by 90 per cent of the population, but there are methods of recording objections to such transplantation. Under the bill, even if a person who had a strong objection to the use of their organs for transplantation after their death had not written down the objection formally, their nearest relative would not be able to authorise such usage if they knew that the person objected. By covering the positive aspects of the issue, we feel that we have dealt by default with the objections.

The Convener: Mike Rumbles and Janis Hughes have questions on the organ donor register.

Mike Rumbles: Bearing in mind the minister's opening remarks in which he said that one of the bill's main purposes is to ensure that the wishes that are expressed by a person in life are respected in death, I suggest that the electronic NHS organ donor register should, as many of those who have given evidence have recommended, be referred to in the bill. I know that it is argued that the bill should not mention the register because the register might change in the future, but the evidence that we have received is clear about the need for the bill to refer to the register. There is a feeling that people who have already expressed their view will need to do so again or will face some other additional hurdle.

Lewis Macdonald: I know that the issue has been raised at previous meetings. On the one hand, we recognise that most people who authorise the use of their body parts for transplantation will do so by carrying a card or by registering with the national organ donor register. The case that has been made is that the bill should provide the framework within which authorisation should take place. At the moment and for the foreseeable future, authorisation is usually made in one of the ways that I have mentioned. However, over time, the way in which people make their wishes known might change either because of technology or for some other reason.

To reassure you and to ensure that people will not need to repeat the process of making their views known, we will issue guidance to all those who will be responsible for implementing the bill and its consequences. That guidance will make it clear that the current organ donor register and the donor card that people carry will count as authorisation. We will issue that guidance under the bill to remove any ambiguity.

Mike Rumbles: Let me follow that up. It is important that any such guidance is accepted by lawyers. Given that disputes arise over all sorts of things, if the bill states that authorisation must be given “in writing”, we need to ensure that an entry in the electronic register counts as authorisation. If the bill is passed, which will have precedence—the guidance or what is written down in the bill? Do you see what I mean?

Lewis Macdonald: I think that I follow your point. I think that the bill is not unclear about whether an electronic authorisation will count as written authorisation under the bill. Perhaps Joanna Keating from our legal side can respond to the point that Mike Rumbles has raised.

Joanna Keating (Scottish Executive Legal and Parliamentary Services): The provisions for existing written requests can be found in section 8. At the moment, the bill requires that requests for parts of the body to be used after death are to be

> “in writing signed by the adult”.

Issues have been raised recently about the organ donation register. I do not want to give any definite undertaking today, but we will have to consider whether the register itself counts under the terms of section 8. It might be that we have to look again at that section or to consult with policy colleagues who are instructing us on how best to proceed. We will obviously listen to what the committee says on the matter.

Lewis Macdonald: We will take on board the committee’s views, but our intention must be clear. Signing up electronically by registering with the organ donation register should have effect. We will consider before stage 2 whether the provision requires amendment. Our initial view is that it probably does not need to be amended but, if it does, such an amendment will be lodged. In any case, we will issue guidance to ensure that people recognise that registering with the organ donation register has that effect.

The Convener: I know that Mike Rumbles wants to ask about living donations, but Janis Hughes has a follow-up question about organ donation.

Janis Hughes: Section 7 says that the nearest relative may not give authorisation if they know that the adult is unwilling for the part of the body in question to be used for transplantation. In the absence of a register that allows people to opt out—for example, if the nearest relative has not seen the person in question for some time and is not aware of changes in their beliefs—how does one prove that the nearest relative knows about the adult’s non-consent for their body parts to be used and that they are therefore giving consent contrary to the adult’s wishes?

Lewis Macdonald: That very good point brings us back to Ken Macintosh’s question about how one demonstrates consent or non-consent. My answer is broadly the same: people can make their views known in a variety of ways. For example, they could make their views known to their nearest family members, wherever they might sit in the hierarchy outlined in the bill; to their GP; or in their will after their death. All those mechanisms allow the adult’s views to be made known, but, as I said in response to Ken Macintosh, there is no absolute fail-safe in that respect.

Janis Hughes: If someone made it clear verbally that they did not want any part of their body to be used but the nearest relative, who might not have been around for some time, said, “Take any part you want”, how could it be proved that they knew that their relative did not want to give any organs?

Lewis Macdonald: I will return to your direct question, but part of the answer is that, because the bill contains no criminal sanctions in relation to nearest family members, the standard of proof is somewhat different to the standard that applies to a clinician who takes action in defiance, for example, of a withdrawal of authorisation. There are no such sanctions because the issue of bad communication between family members is difficult to prove and difficult for the law to enter.

Janis Hughes: So the provisions hold no legal weight.

Lewis Macdonald: There is no legal force behind them.

The Solicitor General for Scotland: If one could prove that the nearest family member had such knowledge, any consent would be invalid. Proof in any civil or criminal forensic situation can be established in a variety of ways, including the use of circumstantial evidence. That means that, although the family member in question might not have written knowledge of the adult's non-consent, other family members might be aware that the nearest family member was aware of the adult's views. Hearsay evidence is admissible in civil matters.

I am trying to think of a practical situation in which such an issue might arise. I suppose that there might be a dispute between family members. If one branch of the family wished to interdict the nearest family member from giving such consent, the civil test would have to be applied. That would allow the submission of oral and hearsay evidence which, as Lewis Macdonald pointed out, represents an entirely different standard to that which pertains in criminal proceedings. It is not impossible or impractical to establish such proof; indeed, contract law is very often based on oral or verbal contracts. Having written evidence makes matters easier to prove in many cases, but it is not unusual in law to rely on verbal evidence.

15:00

Mike Rumbles: In its original submission to the committee, the BMA stated that it agreed with the provisions in the bill that under-16s should be precluded from the live donation of whole organs but General Medical Council Scotland's submission to the committee states that there could be situations in which using organs, or parts of organs, from children might be necessary, such as when a child is the only suitable donor for a sibling. It believes that there should be provision in the bill for such situations. Will you comment on that?

Lewis Macdonald: The bill broadly provides that there should not be a donation of tissue other than regenerative tissue. That exception is important because it allows a young person to donate bone marrow, for example, to a family member.

Other donations are not provided for so that we can provide protection and ensure that a child's long-term health interests are not compromised by a decision that is made while their body is still developing. That is broadly the current position in the bill.

The Convener: We move on to hospital post-mortem examinations and Dr Jean Turner's concerns about definitions.

Dr Turner: The Parkinson's Disease Society raised a point about the definition of post-mortem examination in the bill. It argued that the definition should be tightened so that relatives are clear about the purposes for which they might be asked to authorise a hospital post mortem. [*Interruption.*] I am talking about section 19, "Meaning of post-mortem examination for purposes of Act". What might be clear to some of us might not be so clear to the relatives of a patient. That follows on from the points about the definition of tissue raised by the Parkinson's Disease Society and others. What is an organ and what is tissue? That comes into the question as well. Part of it is—

The Convener: Could you get to a question that the minister can answer?

Dr Turner: I have asked him whether he thinks that those definitions need to be tightened up; I thought that he was trying to find the right part of the bill. What might be clear to us—it seems relatively clear to me—might not be clear to relatives.

Lewis Macdonald: I understand your point but the definition is pretty comprehensive and should meet the needs of the bill. It should be clear that the definition of a post-mortem examination covers all the circumstances in which a post-mortem examination might take place.

Dr Turner: Will the forms that will have to be completed clarify that?

Lewis Macdonald: The forms will certainly be comprehensive in what they cover. We hope to make the post-mortem authorisation forms available to the committee before the stage 1 debate in Parliament. Will Scott might have something to say about the content of the forms in relation to the definition of a post mortem.

Will Scott: There is no definition of a post-mortem examination in the existing legislation so we thought that including a definition in the bill would be a big step forward. The terms of the definition were the subject of very wide consultation with the health service to ensure that it would be fully comprehensive and would not inadvertently omit something that should be included. The authorisation forms will be accompanied by information leaflets that will make very clear what a post-mortem examination is and the purposes for which an examination should be carried out. The leaflets will be offered to families in every case so that they will have the chance to find out exactly what is involved.

Dr Turner: So there will be every chance of a relative being able to understand the legislation.

Lewis Macdonald: Yes. It is important not to overdefine in primary legislation, and a helpful definition is provided.

Dr Turner: I understand that.

What about the use of the words "tissue" and "organ"?

Lewis Macdonald: I would give the same response. Overdefinition would not necessarily be helpful. The understood meanings of the words are adequate for the purposes of the bill. We have taken advice from the Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation, which has a long name and an important remit, and it is clear that it is almost impossible to get universal agreement on definitions. Therefore, as I said, the understood meanings are adequate for the purposes of the bill.

Dr Turner: You would not need to have agreement to take blood from people to be used anonymously in blood banks. Tissues are sometimes retained as blood.

Lewis Macdonald: Blood banks are not covered in the bill.

Dr Turner: Blood banks may not take blood and retain the specimens, but hospital departments may do so. Is that included in the bill? I mean, of course, ante-mortem samples.

Will Scott: The definition of the body parts that can be removed and retained at post-mortem examination is set out in section 23(5). That makes it clear that blood or material derived from blood is included. However, ante-mortem samples, whether of blood or tissue, are not covered by the bill at all. The bill looks only at transplantation or post-mortem examinations; it does not look at the taking of surplus tissue from the living.

That said, we intend to issue guidance in the form of a Health Department letter dealing with surplus tissue. It will contain guidance on whether the samples are to be anonymised and on the procedures governing authorisation from a living person.

The Convener: Nanette Milne had questions about authorisation, but one of them has already been answered.

Mrs Milne: Both of them have been answered.

The Convener: We have heard that the committee will have sight of the draft forms and therefore will have some clue about how clear they will be.

Lewis Macdonald: The draft form of authorisation for post-mortem examination should be with you when it is ready.

Mrs Milne: We spoke about withdrawal of consent. However, we did not discuss whether there should be a central register of people who are willing to offer their body for post-mortem examination. We dealt with the matter when we discussed organ donation but not with regard to post mortem. Should there be such a register?

Lewis Macdonald: That is an interesting suggestion. I am happy to consider it, as there is a clear logic in going down that road.

There is wide public perception of the benefits of making organs available for transplantation. However, it would be fair to say that there is not the same public perception of the benefits of making organs and tissues available for post-mortem examination. The suggestion is certainly worth considering, and we would be happy to come back on that.

The Convener: Thank you. You might not be aware that we have had a petition on post-mortem examinations where the deceased has no surviving relatives. We wrapped consideration of the petition into this discussion, because it is part and parcel of the debate.

Shona Robison: Margaret Doig's petition expressed a preference that the deceased's executor be contacted to ascertain the deceased's view, including the express wish that no post mortem be carried out. The bill provides that an individual can nominate someone to give authorisation for a hospital post mortem in the event of their death.

I would like clarification on two points. First, can the individual's wish not to grant authorisation for a hospital post mortem be stated through a nominee? Secondly, can an express view, issued to a nominee, not to have a hospital post mortem override the view of those in the nearest relative hierarchy?

Lewis Macdonald: The answer to the first question is yes, one can use a nominee. However, I am not sure off the top of my head about the second point. The principle is that the wishes of the person in question, expressed in whatever way, should take precedence, and I assume that that principle would apply in the case that you mention.

Will Scott: I will need to check the details, but the thrust of the bill is about trying to find who was closest to the person when they were alive and is therefore most likely to know what the person's views were. The purpose behind having a nominated person or persons would be to make absolutely sure that the deceased person's views were known and acted on, and that would apply whether there were views in favour of carrying out a post mortem or—as in Ms Doig's case—against doing so. We have made provision to protect Ms Doig's position and to address her concerns.

Lewis Macdonald: The nominee would have to demonstrate that what they say reflects the wishes of the person in question rather than their own views.

Will Scott: Yes. Essentially, the nominee would need to have been given clear instructions by the deceased about what they should say if the circumstances should arise.

The Convener: In case she thought that she was getting off scot-free, I have a question for the Solicitor General. In taking evidence on the bill, we have heard from a number of parents, and the issue of the Crown Office and Procurator Fiscal Service's position has arisen. What steps are being taken within your remit to address parents' concerns? Obviously, the question arises from historical concerns, but there are on-going concerns, too.

The Solicitor General for Scotland: Clear steps were taken to address difficulties when information and evidence were uncovered about what was happening to body parts that had been originally retained for procurator fiscal post mortems and were subsequently retained in medical establishments without the knowledge of the procurator fiscal or the parents. Indeed, the Crown Office and Procurator Fiscal Service participated in Professor McLean's committee, and there were major changes to practice by and guidance to procurators fiscal following the phase 3 report to ensure that the policy that is envisaged by the bill is in place and that the appropriate information is given in practice.

The bill provides a clear premise for the future and the clarity that it provides will require further amendment to the guidance, which is imminent. Indeed, the comprehensive review will result in further training throughout the Procurator Fiscal Service to ensure that the bill's provisions and the further changes that have been made are understood in the policy department and at the coalface.

The Convener: That probably exhausts members' questions about organ donation and transplantation and hospital post-mortem examinations. However, we have still to deal with the part of the bill that relates to the Anatomy Act 1984. Questions have arisen from the evidence that we have taken on that part of the bill. Jean Turner is concerned about public displays.

Dr Turner: The clear evidence from people who work in museums is that they are terribly concerned about historical exhibitions and material that has been acquired within the past 100 years. The situation in Scotland is different to that in England, and they would still like to have public displays. What arrangements do you propose for the public display of bodies?

Lewis Macdonald: As you know, the bill includes a requirement for the licensing of public displays of anatomical human remains. That is a response to perfectly legitimate and reasonable concerns that have arisen and which need to be addressed. There is no intention to prevent bona fide museums from having bona fide exhibitions, but an inadvertent consequence of the bill as drafted is that there would be an imposition on such museums requiring them to go through the licensing process, although there is no real or clear need for them to do so. We intend to amend the bill at stage 2 to make specific provision for bona fide museums that are appropriately registered to exempt them from such a licensing requirement.

Dr Turner: So they will not need to be licensed.

Lewis Macdonald: Bona fide museums will not require a licence.

15:15

The Convener: That will be greeted with a collective sigh of relief, I suspect, by those organisations. Therefore, existing artefacts will not be in any way—

Lewis Macdonald: There will be no requirement to license items that are more than 100 years old.

The Convener: That is fine.

Mike Rumbles wants to ask one final question about 12 being an acceptable age for a child to authorise a post-mortem examination. There is a very specific issue about this aspect of the bill. The answer may be the same, but we should still make sure that we ask the question.

Mike Rumbles: The bill proposes to allow a child of 12 or more to authorise the use of their body in anatomical examination. That has caused some of our witnesses concern. Can you comment on that concern?

Lewis Macdonald: The convener was right to predict that the answer is one with which the committee will be familiar. The age of 12 is in the bill because it is consistent with the provisions of the Age of Legal Capacity (Scotland) Act 1991. However, we want to make sure that provisions for 12 to 16-year-olds are clear and consistent, and we are happy to look at that in detail.

Mike Rumbles: I would like to ask you about a comment that you made earlier on the issue. I did not realise that a 12-year-old could give authorisation for medical treatment. Is that a general authorisation or were you referring to specifics?

Lewis Macdonald: There is a very specific provision. Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 states:

> "A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

That is slightly different from the provision on adoption or the making of a will, for example, where simply being of that age is in itself adequate. In the case of medical treatment, there is a requirement that the clinician is content that the child understands the position. In relation to an anatomical or post-mortem examination, the presence of a witness to the child's consent is also required.

Mrs Milne: Some concern was expressed to the committee that the nature and detail of an anatomical examination were perhaps beyond the comprehension of one so young.

Lewis Macdonald: I hope that the provision requiring the presence of a witness to support a written authorisation would address such concerns. My view, which is reflected in the bill, is that children in that age group who are seriously ill are aware of the nature of their illness and often have a very good understanding of what their illness entails for them and the value that they can add in one way or another to research into the illness from which they suffer. It is a positive provision that allows children in such situations, with the back-up of a witness who supports their consent, to give that authorisation.

The Convener: There are a couple of sweeping-up questions: one is very narrow; the other is very broad. The narrow one is about evidence that we heard from Professor Sue Black. In discussing the Anatomy Act 1984 and the amendments to it, she pointed out that the definition of anatomical examination as a

> "macroscopic examination of a body for the purposes of teaching or studying"

might narrow considerably the potential for teaching and studying. She suggested to the committee that the definition should include the word "microscopic" as well. That is a very narrow point, but it is worth putting to you, as you may want to consider it. She was concerned that the provision as drafted would perhaps leave a loophole about microscopic examination.

Lewis Macdonald: I am happy to consider that.

The Convener: The much more general question is that we know that there was a late decision by the Executive to undertake a more detailed consultation on adults with incapacity, which I do not think is finished yet. As we have a little bit of time in hand, could you take a couple of minutes to tell us what main themes and issues have arisen from that consultation, so that we may be aware of them when we produce our report?

Lewis Macdonald: The consultation finishes next week. We have received one very comprehensive response, which covers a number of the key issues on which we asked questions. I ask Will Scott to summarise the content of that one response.

Will Scott: On the question of what should happen after the death of adults with incapacity, the response was very much in favour of treating them in exactly the same way as any other adult. If someone had indicated what they would like to happen after their death while they still had the capacity to do so but then went on to lose capacity, the wishes that they had expressed while they still had capacity should be respected. In cases in which people never had any capacity and therefore were not able to express any wishes, the response suggests that it should be possible for the nearest relative to provide authorisation.

On organ donation by living adults with incapacity, the consultation paper is cast such that only the donation of regenerative tissue, such as bone marrow, would be permitted. The response suggests that that approach is too narrow and that it should be possible for an adult with incapacity, while alive, to donate organs, parts of organs or non-regenerative tissue. We need to take that into account in our considerations. It is hard to tell whether that is the majority position or not.

The Convener: Do you anticipate more submissions coming in during this final week?

Lewis Macdonald: I believe that a number of people have expressed concerns to the committee. Clearly, that is a useful short cut. We would take into account any submissions that come directly to us and any submissions made to the committee that it cares to share with us.

The Convener: We would appreciate as much of a heads-up as possible before we complete our stage 1 report.

Lewis Macdonald: Certainly.

The Convener: That concludes the questions from the committee. Thank you very much for coming along. No doubt, you will await our stage 1 report with some interest.

Lewis Macdonald: Absolutely. Thank you very much.

Regulatory Framework Inquiry

15:23

The Convener: For item 4, I draw members' attention to the draft paper that has been circulated, the aim of which is to put forward the Health Committee's response to the Subordinate Legislation Committee's inquiry into the regulatory framework in Scotland. The paper incorporates various points that were raised by members on 27 September. It also contains one or two points on the way in which the National Assembly for Wales handles subordinate legislation, which, in my view, is considerably better than ours. Its straightforward approach to explanations should be incorporated by the Scottish Executive forthwith. I invite comments from members on our draft paper. If members wish to propose any substantial changes, now is the time to do so, although I would argue that the paper gives a good summation of our views.

Mike Rumbles: I do not propose any changes. I fully support the contents of the paper, which addresses some important matters. One of our big bugbears with subordinate legislation over the past six years has been the inability of committees to amend it. If that can happen in the National Assembly for Wales, there is no reason why it cannot happen in the Scottish Parliament.

Mr Macintosh: I wonder whether there are any more examples. The Welsh example is very good with respect to timing and amendments. On the quality of information, are there any examples to which attention could be drawn, rather than—

The Convener: On the quality of information, you will find an attachment, which—

Mr Macintosh: Is the attachment not all about the Welsh system?

The Convener: Are you talking about poor quality of information?

Mr Macintosh: Yes. I am looking at what we have said in the draft paper. To be honest, it does not matter—the Subordinate Legislation Committee will know of lots of examples. I was just wondering whether there was a particular—

Janis Hughes:—model of obfuscation.

Mr Macintosh: Things are put quite aggressively in the paper, and I was wondering whether there is any example of—

The Convener: It would indeed be useful if we could find a model of obfuscation, as Janis Hughes put it. We could append that as a counterpoint to the crystal clear explanatory memoranda that the Welsh Assembly's Health and Social Services Committee receives. That point is taken on board.

I invite the committee to agree our submission for presentation to the Subordinate Legislation Committee, and to agree that any oral evidence that I give should be on the basis of that submission.

Members *indicated agreement.*

15:26

Meeting continued in private until 15:41.

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