JUSTICE AND HOME AFFAIRS COMMITTEE

Wednesday 17 November 1999
(*Morning*)

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JUSTICE AND HOME AFFAIRS COMMITTEE
10th Meeting

CONVENER:

*Roseanna Cunningham (Perth) (SNP)

COMMITTEE MEMBERS:

*Scott Barrie (Dunfermline West) (Lab)
*Phil Gallie (South of Scotland) (Con)
Christine Grahame (South of Scotland) (SNP)
*Gordon Jackson (Glasgow Govan) (Lab)
*Mrs Lyndsay McIntosh (Central Scotland) (Con)
Kate MacLean (Dundee West) (Lab)
*Maureen Macmillan (Highlands and Islands) (Lab)
*Pauline McNeill (Glasgow Kelvin) (Lab)
*Tricia Marwick (Mid Scotland and Fife) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)

*attended

THE FOLLOWING MEMBERS ALSO ATTENDED:

Malcolm Chisholm (Edinburgh North and Leith) (Lab)
Dorothy-Grace Elder (Glasgow) (SNP)
Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
Mary Scanlon (Highlands and Islands) (Con)
Tommy Sheridan (Glasgow) (SSP)
Dr Richard Simpson (Ochil) (Lab)
Mrs Margaret Smith (Edinburgh West) (LD)
Kay Ullrich (West of Scotland) (SNP)
Ben Wallace (North-East Scotland) (Con)

WITNESSES:

Dr Graham Blount (Scottish Land Reform Convention)
Gavin Corbett (Scottish Land Reform Convention)
Mike Dailly (Govan Law Centre)
Mr Rab Hide (British Medical Association)
Rea Johnston (Royal College of Nursing)
Jim Lugton (Scottish Land Reform Convention)
Professor Sheila McLean (University of Glasgow)
Alex McMahon (Royal College of Nursing)
Dr Bill O'Neill (British Medical Association)
Andy Wightman (Scottish Land Reform Convention)
Dr Michael Wilks (British Medical Association)

COMMITTEE CLERK:

Andrew Mylne

SENIOR ASSISTANT CLERK:

Richard Walsh

ASSISTANT CLERK:

Fiona Groves

Scottish Parliament

Justice and Home Affairs Committee

Wednesday 17 November 1999

(*Morning*)

[THE CONVENER *opened the meeting at 09:33*]

The Convener (Roseanna Cunningham): Good morning, everyone. People are still coming in, but I want to press on as quickly as possible because we have a great deal to get through this morning. We will just have to bear with people coming in late.

I have one or two brief comments to make. I have received an apology for the absence of Christine Grahame, who is unwell.

Members of the Justice and Home Affairs Committee will notice that there are extra members of the Scottish Parliament here today. Principally, they are from the Health and Community Care Committee, which wishes to have an input into the Adults with Incapacity (Scotland) Bill. Members of that committee have come along this morning to listen to the evidence of our witnesses and will have the opportunity to ask questions if they wish. I understand that the Health and Community Care Committee will meet immediately afterwards to discuss its input into this bill, so it is important that its members are here.

For those who are not aware of it, this morning a demonstration will be held outside the chamber by prison officers who are concerned by the recent announcement of job losses and prison closures. I understand that about 100 gallery tickets have been given out for today's meeting. I expect that most of them have been given to prison officers, so they will be entering at some point this morning. The massed ranks of prison officers are gathering down the road at 9:30, so I presume that they will be on their way shortly.

I advise the committee that we have managed, with a bit of careful rejigging, to organise next week's agenda to allow Tony Cameron, the chief executive of the Scottish Prison Service, and representatives from the trade union side, to give evidence on the changes to the Prison Service. That meeting will also be held in the chamber.

Because we have asked for extra witnesses this week, we have postponed consideration of the draft report on Scottish prisons that was to form part of our early considerations of Her Majesty's inspector's report. That report, which deals only with the evidence taken on the prison inspector's report and the prison visits that took place in September, will now be postponed until next week. The report will not deal with the current issues facing prisons; it is a different part of the investigation entirely.

Do members of the committee agree that, as we had planned, that part of next week's business should take place in private, as we will be discussing a draft report that, until it is finalised, should not be publicly recorded?

Members *indicated agreement.*

The Convener: Next week we will also consider the stage 1 report on the Adults with Incapacity (Scotland) Bill. Do members agree that, as we will be discussing a draft report, that part of the meeting should also take place in private?

Members *indicated agreement.*

European Document

The Convener: The first item on our agenda is a European document that has been referred to us from the European Committee. European document 291 is a draft council decision on the integration of refugees. I assume that it was referred to us because, technically speaking, this committee has responsibility for home affairs. However, you will see from the clerk's helpful note that it is opportune that members of the Health and Community Care Committee are here today, because the document appears to have more to do with health than with home affairs.

In any event, you will all have read the note, and will realise that the document deals with a reserved matter. As I said, the involvement of Scottish organisations seems to be limited to health matters. From the point of view of this committee, therefore, it may be appropriate simply to note this report. The convener of the Health and Community Care Committee, who is with us today, may want to ask the European Committee why it has not been referred to her as well.

Do members agree simply to note the report today?

Members *indicated agreement.*

Adults with Incapacity (Scotland) Bill: Stage 1

The Convener: We now move on to item 2 on our agenda, evidence on the Adults with Incapacity (Scotland) Bill. We have asked a number of witnesses to come before us today and, despite the short notice, they have agreed to do so.

I ask the witnesses from the British Medical Association to make themselves known, one by

one, to the committee. We have received a helpful written submission from the BMA and I would like us to proceed to a question-and-answer session, rather than hearing lengthy statements. I invite members of the BMA to introduce themselves.

Mr Rab Hide (British Medical Association): Thank you, convener. I am Rab Hide, the vice-chairman of the Scottish council of the British Medical Association. With me are colleagues from south of the border and from Ireland, who will now introduce themselves.

Dr Michael Wilks (British Medical Association): My name is Dr Michael Wilks. I am currently chairman of the BMA's medical ethics committee. I chaired the working party that produced our most recent publication, "Withholding and Withdrawing Life-prolonging Medical Treatment".

Dr Bill O'Neill (British Medical Association): I am Bill O'Neill, a medical member of staff at the British Medical Association. I was previously a consultant in palliative medicine.

Mr Hide: We welcome the opportunity to give evidence on this important issue. We welcome the main thrust of the bill and hope that we can assist the committee in three areas: the initiation and possible withdrawal of treatment in incompetent adults; the question of emergency treatment, where such treatment has to be initiated extremely rapidly; and in the area of research, where we have some concerns that the bill as it stands may cause difficulties in the processing of legitimate medical research in Scotland.

The Convener: Thank you very much. I would also like to thank the two witnesses who have travelled far to be here today. We appreciate that, particularly given the short notice.

We will move straight to the questions.

Tricia Marwick (Mid Scotland and Fife) (SNP): Good morning. Some of the witnesses who have come before us have expressed concern about nutrition and hydration being included in the definition of medical treatment. Does the BMA have a view on that?

Dr Wilks: Our view follows the consequence of the Tony Bland judgment. We believe that artificial nutrition and hydration are part of medical treatment. We used that as a guiding principle in the framework that we produced earlier this year for the withholding of medical treatment.

Reading the deliberations that you have had before, we sense a slight incompatibility in the evidence as it relates to nutrition and hydration. We draw a distinction between artificial nutrition and hydration as part of medical treatment and the giving of oral nutrition and hydration, which we see as part of basic medical care and which we think should never be withdrawn.

We define as artificial nutrition and hydration any method of giving nutrition and hydration that bypasses the swallowing reflex; in other words, any mechanical method. In providing the means to give artificial nutrition and hydration, one is undertaking medical intervention.

Tricia Marwick: Do you accept the concerns of some of our previous witnesses that the inclusion of nutrition and hydration without a clear definition could lead to a withdrawal of that treatment and the hastening of death?

Dr Wilks: Section 44(2)(b) refers to

"ventilation, nutrition and hydration by artificial means".

We assume that that means the provision of nutrition and hydration by some mechanical means. We would not think that that includes oral nutrition and hydration. We are content with the wording of that section.

Phil Gallie (South of Scotland) (Con): Your statement says that, unlike the courts in England and Wales, the Scottish courts have made clear that it is not necessary to apply to them in every case where withdrawal of artificial nutrition and hydration is considered. Do you think that the Scottish way is the better way?

Dr Wilks: The law lords in the Bland case made it clear that each case that you describe should go to court until a body of evidence emerged that might make that unnecessary. I must stress that they were talking about persistent vegetative state, which is a narrower clinical situation than we addressed in our recent document.

In Scotland, it is regarded as unnecessary to take cases of persistent vegetative state to court. We would argue that a sufficient body of evidence has arisen in England and Wales to avoid that need, and our recent document said that we do not think one should have to go to court in most cases in which a decision to withdraw life-sustaining treatment has been made.

We regard the framework that we have set up as being adequate to achieve the right consensus between the doctors and the family and we think that the courts should be involved only where there are significant and irresolvable differences between them. I think that the Scottish way is the better way.

09:45

Mr Hide: As a practising doctor in Scotland who has been involved in this issue, I think that the solution is working very well in Scotland.

Phil Gallie: Your document suggests that, even before the bill is passed, the situation in Scotland

is satisfactory. The doctor can offer or withdraw treatment, depending on his or her interpretation of the situation. Perhaps that suggests that you feel that this bill and these sections are unnecessary.

Mr Hide: Although many areas of the bill address particular problems with much more clarity, we would not like to lose the pragmatic flexibility of the present legal situation in Scotland.

The Convener: Will the bill allow that flexibility to continue?

Mr Hide: We have to be very careful. It is up to the people drafting the bill to ensure that it does.

The Convener: You have presumably read the bill that has been introduced in Parliament, as it provides the basis on which you are giving evidence today. Are you satisfied that nothing in the bill cuts across your present flexibility?

Dr Wilks: The bill admirably addresses the general concept of providing circumstances in which a doctor can initiate treatment for the patient's benefit. However, although the bill does not specifically address the issue of the withdrawal or withholding of treatment, doctors recognise that decisions about treatment might also include decisions that treatment should not be initiated or should be withdrawn. Our guidance about the framework in which such decisions are made is both robust and flexible enough not to require additional comment in the bill.

Mr Hide: Some of our concerns about the bill are not so much related to the wording itself, but to interpretations that have been put on the wording in some submissions and committee reports. I have read that section 44(2)(b) of the bill effectively allows people to withdraw treatment. That does not seem relevant. The present situation could still hold if we stick strictly to the wording of the bill. I understand that section 44(2)(b) talks about the initiation of treatment, not its withdrawal.

Phil Gallie: The bill introduces the power of advocacy and the introduction of a third party. I am talking about the role of the courts. Furthermore, given your comments, I want to explore the wider aspects of the powers of the doctor. I am particularly concerned that, in your submission—

Dr Richard Simpson (Ochil) (Lab): Can I make an intervention on that point?

The Convener: Richard, you are down on the list. If you wait, you will get your turn.

Phil Gallie: I have a slight reservation about the suggestion in your submission that there is room for some experimentation or research without anyone's consent.

Mr Hide: You raise a very important point. However, that is a slightly separate issue that touches more on concerns about research than about active treatment.

As for your first point, we have concerns about the role of the guardian or authority in a situation where such people may be at odds with doctors over medical treatment. As such, if the bill goes through without change, more limitations will apply than under the present legal position.

Tricia Marwick: Can you clarify some points on the subject of nutrition and hydration? You said that the law as it stands allows the withdrawal of nutrition and hydration without petition to the courts.

Mr Hide: Without necessarily petitioning the courts.

Tricia Marwick: Okay.

On 3 November, Lynda Towers, from the Scottish Executive Office of the Solicitor, appeared before this committee and was asked whether hydration and sustenance withdrawal was possible under the bill. She said:

"If somebody seeks to withdraw nutrition and hydration, that will still have to be dealt with by petition to the Court of Session."—[*Official Report*, *Justice and Home Affairs Committee*, 3 November 1999; c 276.]

Do you want to comment on that?

Mr Hide: Before I ask Bill O'Neill to respond, I should say that, if that is the interpretation, the British Medical Association in Scotland would have some concerns. The ideal would be to achieve a truly united response from carers, relatives and the patient, rather than to have to go through the trauma of taking cases to the Court of Session.

Dr O'Neill: We should clarify the important distinction between artificial nutrition and hydration, as specified in section 44(2)(b), and oral nutrition and hydration, to which Dr Wilks has referred. We should also clarify that, to our knowledge, the court judgments have related specifically to patients in a persistent vegetative state. The provision to which Mr Gallie referred relates specifically to such patients.

Tricia Marwick: Your interpretation seems to conflict with the one that we are getting from the solicitors to the Executive. Other witnesses who have appeared before us have their own interpretations of this provision. It is incumbent on the Parliament, and this committee in particular, to ensure that any legislation that we pass is robust and is not open to a series of interpretations. Can you think of a way in which the bill could be tightened up, or does it contain a fundamental flaw?

Dr Wilks: We do not think that the bill as it stands is flawed from a medical perspective. Our

aim is to allow the doctor, the health care team and the relatives to find the best way forward in the interests of the patient. The framework that we have outlined, detailing the processes that should be gone through before a decision is made on whether to withdraw or withhold treatment, is designed to achieve consensus. It is geared towards the benefit of the patient and is intended to make recourse to the courts unnecessary. In Scotland, unlike in England and Wales, it appears that individual cases of PVS do not need to come before the courts. We would hope that, if the general principles of withdrawing and withholding treatment are applied to a wider group of patients who are similarly incapacitated—those defined as having no prospect of recovery—the same flexibility would operate within the health care team and the family.

We have a broader concern about what would happen if a doctor considered that a treatment was to the benefit of the patient and somebody in authority—a proxy or other appointed person—refused that treatment on the patient's behalf. We feel that section 47, in particular, may not contain enough protection for the patient, because the doctor who is deciding whether to respond to a refusal of treatment by a third party has to be satisfied if the proxy indicates that the refusal is based on their understanding that that is of benefit to the patient. We would like the proxy to have to provide more evidence to the doctor that they are acting in what the patient considers to be their best interests. At that time, of course, the patient is incapable of expressing a view.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): The questions and answers so far have already homed in on the two subsections—sections 44(2) and 47(1)—that I wanted to ask about and that seem to be at the centre of the controversy. It is in conjunction, rather than separately, that they are controversial. The first issue is that, as many people have said, section 47(1) appears to give welfare attorneys or guardians the power to refuse ventilation, nutrition and hydration.

Dr Wilks: Yes, we agree that that section could be interpreted in that way.

Malcolm Chisholm: The second issue applies to other forms of treatment. Do you think that the bill needs to be clarified on those issues, which seem almost to be taking over discussion of this legislation? Could not the bill be clarified so that the powers of welfare attorneys and guardians are made clear?

Dr O'Neill: Given the discussion that is taking place across society—let alone in this committee in recent weeks—it is important to classify nutrition and hydration by artificial means as treatment, as the courts have done on both sides of the border. If your question is, "Are we in favour of retaining section 44(2)(b)?" the answer is that we are. It is important to clarify that definition.

Malcolm Chisholm: But section 47(1) seems to say that it is the welfare attorney or guardian who will make decisions about ventilation, nutrition and hydration. Is that the basis of your concern, rather than the fact that someone should be making decisions?

Dr O'Neill: No. A competent patient can refuse any treatment. It seems appropriate that a proxy for a patient could refuse that treatment. As Dr Wilks said, we are concerned that the proxy may not have to make clear the basis on which they are refusing treatment. However, we are happy with the subsequent subsection, which gives doctors the opportunity to apply to the Court of Session to overrule the decision of the proxy.

Malcolm Chisholm: Am I right in saying that you do not think that the cases in which ventilation, nutrition or hydration can be withdrawn need to be written into the bill? A lot of the debate has been about persistent vegetative state, which is a controversial subject, but there are many points across the spectrum. Are you saying that the law is perfectly adequate on this matter? I understand where people are coming from when they criticise this bill, because it appears to open the gateway for a welfare attorney or guardian to make decisions about ventilation, nutrition and hydration outwith cases of PVS.

Dr Wilks: Whether the bill is perfect is debatable, but it is pragmatic and realistic. When we examined the withdrawal and withholding of all forms of treatment—including artificial nutrition and hydration—we realised that there was a vast range of conditions with a degree of incapacity and a degree of what you might call poor quality of life, in which there is no prospect of recovery and in which patients are incapacitated and cannot express their wishes. To draft legislation to cover the different clinical conditions that produce that state of incapacity would be extremely difficult. Moreover, it would probably tie the hands not just of the doctors but of the families and patients. That would not be in patients' interests.

I repeat our concern over the ability of a proxy to refuse all forms of treatment, including artificial nutrition and hydration, on behalf of an incapacitated patient without having to say why. Although we are happy that a doctor has recourse to the courts if there is a conflict over treatment, we would like legislation to reflect the need for the proxy to give good evidence to the doctor that the decision that they are making on the patient's behalf reflects the wishes expressed by the patient when they were competent. Such a requirement is missing from section 47.

The Convener: Dr Wilks, it would help us if you could give us a couple of examples of the kind of evidence that you think should be provided to substantiate a welfare attorney's decision that treatment should not be given.

Dr Wilks: An essential form of evidence would be some form of advance directive that specified the refusal of areas of treatment. As you will be aware, the only type of advance directive that carries any weight in law is one that specifically refuses treatment. It is essential that doctors are bound by those directives, as long as they are confident about two things: first, that the advance directive was made when the patient was competent; and, secondly, that the circumstances in the advance directive apply to the circumstances of the patient.

Other forms of evidence could be statements made to other carers—such as a general practitioner, the family doctor or nursing team—when the patient was competent. That evidence would be important. Statements would not necessarily have to be written. For example, the family doctor could be called to provide confirmation of the patient's wishes.

The Convener: There is a slight difficulty with that, of course, because advance directives have been specifically excluded from the bill, although I think it was originally proposed that they be built into it. Other organisations have submitted written evidence suggesting that, regardless of whether advance directives are given standing in legislation, they will become important in practice because of the way in which decisions will be reached about the ability of people with incapacity to make known their views. It seems that, in a sense, you are now confirming that view. Do you think that, regardless of whether the bill covers them, they will become important?

10:00

Dr Wilks: Yes. We think that a competent advance directive that contains a refusal of treatment is as important as a contemporaneous refusal and should be respected.

Dr Simpson: I have two points, the first of which concerns the proxy. Do you feel that the proxy has a sufficient liability in terms of his or her duty of care? Section 73 limits the liability of guardians, continuing attorneys and welfare attorneys, stating that

"for any breach of any duty of care or fiduciary duty"

they would simply have to have

"acted reasonably and in good faith".

Am I right in saying that you think that section 47 should contain an additional provision requiring the proxy to demonstrate that he or she is either acting on the wishes of the patient or is carrying out some action that is beneficial to the patient after obtaining a second opinion?

Dr Wilks: The framework that we have produced for the withdrawal of artificial nutrition and hydration requires that, in those cases, the doctor obtain a second opinion from someone who is not connected with the case but who has expertise in the area. We feel that that should be a given, because that is the clinical and ethical advice that we are giving doctors.

We are interested in the suggestion that proxies should be subject to a duty of care and should be able to demonstrate their responsibility. The BMA does not have a specific policy on that and has not discussed it, but we would certainly be interested in seeing how the duty of care could be reflected in a requirement on the proxy to demonstrate that he or she was acting in the patient's best interests.

Dr Simpson: We have been discussing very serious cases in which the withdrawal of treatment would result in loss of life. However, there are many other cases in which there may be a dispute between the doctor and the prime carer or proxy. We do not want such cases to go to court, so we must think of some mechanism that will ensure that there is further discussion before those cases reach that point.

We have had evidence from Alzheimer Scotland about the general treatment with drugs of patients with Alzheimer's disease. The Scottish intercollegiate guidelines network has certainly indicated that excessive treatment with neuroleptic drugs is relatively widespread. There may be some dispute about that, and I would like to know how we can promote the good practice that the BMA has talked about to make a resolution between—

The Convener: Could you speed things up a wee bit, Richard? We are struggling for time this morning.

Dr Simpson: I would like to know how a resolution between the care team and the proxy could be established. That balance needs to be struck.

Mr Hide: The BMA in Scotland takes the view that, given the powers that are now in the hands of the proxy, there should be a requirement on that person for some duty of care. You have forgotten to mention ventilation, a matter that has not yet been addressed. There can be acute situations in which artificial ventilation has to be instituted immediately. I hope that that is covered by section 44(6), which states that medical treatment can be given

"for the preservation of the life . . . or the prevention of serious deterioration".

However, I am not confident that it is properly covered, in view of the powers given to the proxy.

Dr Simpson: My other main concern involves the point that has been addressed by our colleagues in the Justice and Home Affairs Committee—the definition of intervention. Many things are defined in the act. Section 76 gives an interpretation of many of the terms and issues. Would you like that section to include an interpretation of intervention, to cover not only positive interventions but omissions and withdrawals? The whole question of intervention would then be more specifically defined.

Dr Wilks: We would accept a definition in which a decision to withdraw was regarded as an intervention as part of the general decision-making process in clinical care. We think that there is an advantage in flexibility; we would have some discomfort about defining an intervention too closely.

Mr Hide: This has to be seen in an international context—we are one of the few countries without a clear definition of a medical act. That is both a blessing and a difficulty. I agree with what Dr Simpson is saying in principle, but it could lead to very complex legislation.

Mrs Margaret Smith (Edinburgh West) (LD): What would the impact of the bill as it stands be on the practical day-to-day work of an intensive care unit? What is the implication for doctors doing their job in emergencies—after road traffic accidents, for example?

Mr Hide: I am often in that situation. It is important that the bill clearly covers that situation in the same way as the principle of necessity in England does. Otherwise, as we have heard, various interpretations will be made; in an acute, life-threatening situation, it must be possible for immediate treatment to be given even if guardians, proxies or relatives are unavailable.

Mrs Lyndsay McIntosh (Central Scotland) (Con): First, what if someone had made an advance directive and advances in medical science are such that the decision that they made in the past has been overtaken by treatment, now readily available, that could perhaps bring them back to a good quality of life? Secondly, how—briefly—would you define a medical act?

Mr Hide: I have debated in several European forums the definition of a medical act; the concept is extremely difficult to define. I will say no more, as I do not want to detain the committee longer than necessary.

Dr Wilks: We share your concern about advance directives, which is why we are not arguing that they should be included in the legislation. As you say, things change and it is difficult to envisage an advance directive that could be sufficiently comprehensive to be always valid. We would argue that any advance directive should be taken into account, however.

Mrs McIntosh: I am thinking of cases in which, in the past, we did not have the same knowledge of drug treatments. Is there any study that could prove conclusively that treatments will be of benefit to patients?

Dr O'Neill: There are numerous examples of treatments having moved on since the person made the advance directive. That may be over a period of three or five years, rather than 10, 20 or more years. For that reason we would not want advance directives to be enshrined in legislation. We must be able to offer an interpretation that the person had made the advance directive at a particular point in time, with a particular understanding and with access to particular treatments, which, as you say, may have changed with time.

Mrs McIntosh: Am I right in thinking that what you are looking for from proxies and attorneys is responsible decision making?

Mr Hide: Yes, very much so. Given the powers that they are being given under the bill, it is very important that they have a duty of care that is enshrined in statute.

The Convener: Will members make their questions as brief as possible?

Tricia Marwick: You say in your submission that section 48 appears to rule out any research that does not directly benefit the incapacitated person. Do you believe that research should be allowed that is not contrary to the interests of the incapacitated person? There is quite a difference there, so could you explain your thinking?

Mr Hide: We have concerns, which have been addressed.

Dr Wilks: As it is currently drafted, we believe that section 48 would inhibit research that is unlikely to produce real and direct benefit to the adult, according to section 48(3)(a). Someone who undertakes a research project that is unlikely to produce real and direct benefit to the adult should perhaps not be doing the research in the first place. However, limiting research to the subject alone restricts research that would help to examine the condition as well as the individual. We are unhappy about that. Such research need not be intrusive; it might be record based or minimally invasive.

We are also unhappy about the final three words in section 48(3)(f), "adult's nearest relative". The concept of involving a close relative is not present in the aspects of the bill that deal with consent or the withdrawal or refusal of treatment. We are

unhappy that an adult's nearest relative is written into the process in some parts of the bill, but not in others. We are not quite sure why relatives are mentioned there.

My third point is about the ethics committee, which is dealt with in section 48(5). We fully support the involvement of local ethics research committees. We assume that the purpose of section 48(5) is to set up a new committee specifically to consider the question of research and incapacitated adults, but we would like clarification on that.

Phil Gallie: You make a presumption that the new bill will allow welfare attorneys to give consent to the use of organs or tissues on behalf of other patients. What did you have in mind?

Mr Hide: Do you mean for transplantation?

Phil Gallie: Yes.

Mr Hide: I would have thought that that would be perfectly appropriate in that situation, but occasionally the time scale can be a problem.

Phil Gallie: In your submission, you say that you presume that such consent will be allowed. Would you like something to be written into the bill that confirms that that is the case?

Mr Hide: Off the cuff, my answer would be yes. That would be helpful for transplantation.

Ben Wallace (North-East Scotland) (Con): Are you concerned by the fact that there is no recognition of partial incapacity or assisted decision making in the bill? The Millan committee aims to redefine what is set out under the Mental Health (Scotland) Act 1984. Are you concerned that we may be left with an all-or-nothing situation if the new definitions do not take account of partial incapacity?

Dr O'Neill: As we said in our written submission, we feel that the bill tends towards a functional definition of incapacity. Incapacity may vary over quite short periods of time for an individual or may vary for particular decisions. Someone may be capable of making a decision on one issue, but not on a more complex issue. We feel that the bill allows for that interpretation.

Mr Hide: There is a slight problem with the bill's failure to clarify the concept of short-term incapacity. Short-term incapacity is very common; it can be seen in accident and emergency departments throughout the country every Saturday night. [*Laughter.*]

Ben Wallace: Richard Simpson brought up the duty of care. I have concerns about the limitation of liability in sections 73 and 74 in part 7 of the bill. There is no onus on the carer or proxy to go beyond the need to be reasonably satisfied that they acted in the best interests of the adult. There is no compulsion or responsibility for individuals to seek advice or to make informed decisions. They must only satisfy themselves that they have acted in accordance with part 1, which obviously is a less stringent level of responsibility than for a clinician. Are you concerned about that? Do you think that we should insert a recommendation that there should be a duty on the carer or proxy to make more of an informed choice?

Dr O'Neill: The only thing that we want to add to what has been said already is that we feel that that section was written with financial and other affairs in mind, rather than issues of medical treatment and welfare.

Mr Hide: Except that it would be perverse if the person making a decision in conflict with that of the medical adviser was working at a lower level of decision making.

10:15

Ben Wallace: That will nearly always be the case, though.

Dr Wilks: They might be on a different level in regard to clinical assessment, but they might have a lot to contribute on an assessment of the patient's wishes because they are close to the patient or are aware of the case. Our point is that that information needs to be offered in evidence to back up the refusal.

Ben Wallace: Do you see trials using placebos being excluded or included by this bill?

Dr O'Neill: As it stands, it is conceivable that they could be excluded. We would like them to be included, after the approval of a research ethics committee, and bearing in mind our interpretation of the clause that refers to a special ethics committee relating to those with mental incapacity.

Dorothy-Grace Elder (Glasgow) (SNP): Earlier, when talking about section 44(2)(b), you mentioned advance directives. At present, how few have those advance directives? Tragically, a large number of young people are brought in with severe head injuries. Young people, quite properly, do not think about the possibility of their dying. Roughly how long does it take someone to die after the withdrawal of artificial hydration and nutrition?

Dr O'Neill: The second question is impossible to answer. It depends on other conditions that the person might have.

Dorothy-Grace Elder: Many of the submissions we have had—and most of the submissions have been about section 44(2)(b)—have mentioned that it might take up to a fortnight for someone to die. Is that correct?

Dr Wilks: That is sometimes the case, but the

implication of the way that the statement is made is that those patients are in some way being abandoned. The doctor might foresee that the withdrawal of nutrition and hydration will result in the patient's death, but that does not mean stopping all palliative care, sedation or the treatment of symptoms. The process of dying is important to the management responsibilities of the doctor, and the nursing team is central to that.

I suspect that the point behind your question is that doctors might make decisions about intentionally killing patients by withdrawing nutrition and hydration. The point that we made in our document, "Withholding and Withdrawing Life-prolonging Medical Treatment", is that a decision might be made that treatment such as artificial hydration is no longer giving a benefit to the patient and should therefore be withdrawn. The primary intention is not to kill the patient, but to withdraw a treatment that is no longer of benefit.

Dorothy-Grace Elder: Yes, but the patient will die, of course.

To return to my first point, how many people come to hospital with any kind of indication that they have made a decision that, if they are in a terminal condition, they want treatment to be withdrawn?

Mr Hide: I am not aware of any direct research into that but, in my experience, it would be extremely unusual for someone to arrive in hospital with an advance directive. In the acute sector, to which you referred, such a thing would be of extremely little practical benefit.

Dorothy-Grace Elder: And in the long-term sector?

Mr Hide: That is different. If it became normal practice to have an advance directive, the practice would expand. At the moment, it is not a major influence.

The Convener: I thank the witnesses for their patience with the questions. If you have the time, you are welcome to stay on and listen to the evidence from the other witnesses. We expect to take evidence until about quarter-past 11.

Will the witnesses from the Royal College of Nursing please introduce themselves? One of the witnesses will give a short opening statement.

Alex McMahon (Royal College of Nursing): I am Alex McMahon and I am the adviser on nursing policy for the RCN in Scotland. My background is as a mental health nurse.

Rea Johnston (Royal College of Nursing): I am Rea Johnston. I am a member of the RCN and a teacher of nurses at Napier University.

Alex McMahon: I will make a brief statement. The RCN supports the overall purpose of the bill and recognises that this is an extremely difficult area that presents legal, clinical and ethical problems to all those involved. We are grateful for this opportunity to explain to the committee the distinctive role that nurses can and should play in caring for those who are incapacitated.

There is a perception that an instruction that is given by a doctor absolves nurses of any responsibility. That is not the case. We suggest that the phrase "medical treatment" be replaced by the phrase "clinical treatment". "Clinical treatment" more accurately reflects the input of each member of a multidisciplinary team. There is a basic standard of nursing care that all patients, regardless of their condition, are entitled to. We oppose any measures that would make it possible for a patient to be denied that level of care.

The Convener: We will go straight on to questions.

Tricia Marwick: I was going to raise those two points with you. Can you expand on your call to change "medical treatment" to "clinical treatment"?

Alex McMahon: "Medical treatment" is an outdated concept. There are many professionals other than doctors who are directly involved in assessment of and delivery of care. The use of the term "clinical treatment" would recognise that. Nurses have a distinctive role to play in assessing and delivering care to every patient.

Tricia Marwick: You mentioned the basic level of care that every patient should receive, regardless of their condition. Your submission indicates that there is concern about the possibility of basic nursing care being withheld. What would you like to see being tightened up to ensure that that cannot happen?

Alex McMahon: There is concern that continued use of the term "medical treatment" will result in nursing care being included in that definition. If a decision was made to withdraw medical care from a patient, nursing care might also be withdrawn. As far as we are concerned, every patient has the right to receive basic nursing care regardless of their condition.

Tricia Marwick: Is that within the terms of your code of professional conduct?

Alex McMahon: Absolutely. At all times every nurse works to the code of conduct that is laid down by the statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Nurses must at all times work for patients' interests.

Tricia Marwick: If the bill stands as it is, is it possible that nurses who were instructed not to carry out that basic nursing care would have to decide between their code of professional conduct and the provisions as laid down in the bill?

Alex McMahon: That is a good question. Nurses must at all times act according to that code and in the interests of patients. You would not find a nurse in the country who will stand back and not deliver the most basic level of nursing care.

Tricia Marwick: Is there the possibility that the bill as it stands might create conflict for nurses between what they are required to do in terms of their own code and the requirements that are set out in the proposed bill?

Alex McMahon: Absolutely. That is why we ask for the phrase "clinical treatment" to be used rather than "medical treatment".

Maureen Macmillan (Highlands and Islands) (Lab): Paragraph 6.1 of your submission seems to indicate that you are worried about the withdrawal of life-sustaining measures. You say that hospital practice does not seem to be following legal principle, which is at odds with what the BMA has said. Can you expand on that comment?

Alex McMahon: Our solicitors in Scotland, Anderson Strathern, have brought to our attention that, at the time of the Law hospital case, a number of patients were in a persistent vegetative state similar to that of Janet Johnston. We are concerned about what action has been taken with those patients following that court decision.

The Convener: Although I do not want to set you at odds with the BMA, do you prefer what has been described as the English practice, in which the court will always be involved in such decisions, instead of the more flexible Scottish practice?

Alex McMahon: In order to act in the interests of patients and to protect professionals involved in the delivery of care, we want to ensure that those professionals are acting within the law and are not liable to prosecution if their actions are detrimental to patient care.

The Convener: So you are more worried about the legal responsibility of nurses than anything else?

Alex McMahon: We are worried about both aspects. Although our job is to ensure that nurses act at all times in the interests of patients, at the same time nurses must protect their own professional status.

The Convener: I appreciate that you have had particular legal advice that suggests that the current practice in Scotland ought not to be happening. However, the issue of legal advice aside, would the RCN prefer to continue with the reality of a flexible approach instead of imposing on the system an insistence that every case must go to court?

Alex McMahon: That is a very good question. Every case should be taken on its own merits and decisions should be based on the patient's needs and on whether we are acting in their best interests at the time.

The Convener: So, although you agree with the BMA, you are concerned about the confused legal position in which nurses find themselves at the moment?

Alex McMahon: Yes.

The Convener: That is a slightly different issue. I am sorry, Maureen—I butted in. Do you want to come back in?

Maureen Macmillan: In paragraph 8.1 of the RCN submission, you say that death should be "peaceful and dignified". Obviously that is in connection with PVS patients. Do you think that you can give people a peaceful and dignified death if artificial means of nutrition and hydration are withdrawn?

Alex McMahon: Yes. Nurses are skilled professionals and their care would ensure that patients' dignity and comfort are maintained. We hope that, in the appropriate circumstances, pain relief would also allow for a pain-free death.

Pauline McNeill (Glasgow Kelvin) (Lab): As many of my questions have already been asked, I will just raise a few brief points. Is there a clear-cut division between a doctor's responsibility and a nurse's responsibility? Are there any grey areas between medical and nursing issues?

Rea Johnston: Nurses are trained to assess patients for nursing interventions and to follow out medical prescriptions. However, they are also responsible for assessing whether to go ahead with medical prescription if a patient's condition calls that into question.

Pauline McNeill: Does that mean that you refer back to the doctor daily?

Rea Johnston: Yes. If any nurse thought that any prescription should not be carried out, they would report that to the doctor for a review.

Pauline McNeill: I heard what you said about the rights of the attorney in respect of the code of conduct. Do you have any suggestions about how to include such principles in the bill?

Alex McMahon: Steps should be taken to ensure that welfare attorneys take sound advice from the professionals who are directly involved in the delivery of care at that time—perhaps from two people rather than one.

Pauline McNeill: What is the status of the professional code of conduct?

Alex McMahon: It is legally binding.

Mary Scanlon (Highlands and Islands) (Con): I would like you to clarify something in your

submission. The word "benefit" is used in the bill, but you suggest that the term "best interests" be reintroduced. What is the difference?

You also suggest that the term "medical treatment" be replaced by "clinical treatment"; What would be gained by that change?

10:30

The Convener: A large group of people have come into the public gallery. I understand that they are prison officers from the demonstration that I mentioned earlier. I remind committee members that at our next meeting we will take evidence from Tony Cameron, the chief executive of the Scottish Prison Service, and from the trade union side on yesterday's announcement. More prison officers may come into the gallery, so members may hear a little noise.

Alex McMahon: Using the term "best interests" would benefit patients where, for example, a confused patient is in a ward with doors to the outside. It may be that a nurse decides to lock the doors. In that situation she is acting in the interests of the patient, who may be so confused as to wander out and harm himself or herself. Obviously, that is not of benefit to the patient, because they are being denied access to the outside, but the nurse is trying to limit any danger that may come to that patient.

Mary Scanlon: Do you feel that retaining the word "benefit" would exclude that form of care?

Alex McMahon: The individual needs of the patient must be considered. At times, acting in the best interests of the patient might not be of benefit to the patient.

The Convener: I want to allow you to put on record your concern that the assessment of incapacity is currently, in effect, being left to doctors. It is your view that there should be nursing input, because in some cases it may be nurses who have had most contact with patients. Also, the BMA has expressed to us its wish to see specific evidence in support of any welfare attorney's decision that treatment should not be given. Can you elaborate on those two points?

Alex McMahon: In our submission to the Millan review of mental health legislation, the Royal College of Nursing asked that nurses be considered for mental health officer status. We did that because nurses deliver 80 per cent of patient care and are in a good position to identify what patients require. Often nurses cannot readily get access to a doctor or social worker; if they had mental health officer status, they could instigate the process of assessment. I do not say that every nurse would fit the criteria—the competency of the nurse would be a factor—but there is scope for that measure.

The Convener: In your written submission you identify with the position of the BMA on the issue of evidence for not applying treatment. Do you have a view about what you would expect to see as evidence in support of such an instruction?

Alex McMahon: We would hope to put in place a mechanism to ensure that anyone acting on the patient's behalf, if outside a professional field, takes soundings from the professionals who are directly involved in the delivery of care, and that that advice is considered in planning any further treatment for the patient.

The Convener: That was not quite the point. You make a specific statement in your submission:

"With the right to withhold consent, the welfare attorney or person authorised to intervene has a power which is not sufficiently counterbalanced."

You are concerned that the bill sets out no criteria for the parties or the court to apply when resolving differences. What, in your view, would make things more balanced?

Alex McMahon: We would like to see direct involvement with the professionals providing the care, but a mechanism should perhaps be in place to ensure that a balance is reached in making the decision.

Mary Scanlon: I would like an answer to my second question, as to why you want "medical treatment" replaced with "clinical treatment".

This next question follows on from Roseanna's point. In paragraph 5.2 of your submission, you say that

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

Are you saying that the welfare attorney would perhaps not be sufficiently knowledgeable on medical treatment to make decisions?

Alex McMahon: Rea could perhaps pick up the first point, on "clinical treatment".

Rea Johnston: We thought that the word "clinical" could be used in section 44 of the bill, so that, as we have stated before, no nursing care is omitted by default. The nurse's accountability would be taken into consideration. Section 47 talks about the welfare attorney. That person would be able to refuse consent for medical treatment. "Clinical" could be used to designate overall care, but if somebody wants to intervene and stop treatment, they would be discontinuing medical treatment, not omitting by default some basic care necessary for patient dignity and a reasonable death.

Mary Scanlon: Are you saying that the attorney

would not have adequate knowledge and would not be able to make such decisions?

Rea Johnston: That is possible, but, in our opinion, our proposal would safeguard the patient.

Mary Scanlon: So you feel that clinical judgment should overrule any decisions that an attorney might wish to make?

Alex McMahon: No. We are saying not that attorneys' decisions should be overruled, but that clinical judgment should be considered if the attorney does not have the expertise.

Dorothy-Grace Elder: If subsection 44(2)(b) was passed with no alterations, do you think that there would be a considerable increase in the number of cases in which artificial feeding or the provision of fluids is removed?

Alex McMahon: I do not think that I could answer that question at this time.

Dorothy-Grace Elder: I gather from your evidence—correct me if I am wrong—that it is the nurses who spend most time with the patients, but who are most excluded from the process. The doctors may not see the patient often, but they have a major decision to make, as do the welfare attorney, relatives and others. Is your main concern that nurses should be involved in the decision?

Alex McMahon: Absolutely. We are calling for parity among professionals on decision making.

Dorothy-Grace Elder: I am also concerned that nurses may feel that they will experience more stress because of such withdrawals of treatment. Is that also one of your concerns for the profession? Some cases must be stressful at the moment.

Alex McMahon: I take your point, but the same thing applies across the professions. Doctors and physiotherapists also experience stress when dealing with patients who are in a persistent vegetative state. We want to ensure that everyone is working in an environment with which they are happy, and that they are not being unnecessarily exposed to stress.

Dorothy-Grace Elder: At the end of the day, it would be the nurses who had to see the patients through the 10 or 14 days—or however long it took them to die—following the withdrawal of fluids and artificial feeding.

Alex McMahon: Yes.

Phil Gallie: We have tended to concentrate on part 5 of the bill, but part 4 would also have a significant effect on nurses. It refers to the management of patients' or residents' finances in residential or nursing homes. You have already indicated the importance of patient-nurse relationships. Do you have any concerns about nurses being caught up in the effects of part 4?

Alex McMahon: For quite a number of years, nurses have been responsible, at ward or nursing home level, for the management of patients' funds. In the case of incapax patients on psychiatric wards, for example, the charge nurse often has the responsibility of ensuring that some of their money is spent in the interests of the patients. That is sometimes, perhaps, an inappropriate burden to place on nurses.

Phil Gallie: Has your organisation considered the implications of part 4, or would you like to come back to us after having considered it further?

Alex McMahon: I think that I will take the opportunity to come back to you at a later date on that one.

Tricia Marwick: Would the RCN be in favour of proxies being given a duty of care, along with the other professionals who are mentioned in the bill?

Alex McMahon: I am sorry, I am not sure. How would that work?

Tricia Marwick: They would have a duty, for example, to seek and to take medical and nursing advice. At the moment, proxies are required only to act in the interests of the patient. If they were given a specific duty of care in the same way that professionals are, would that go some way towards allaying some of the concerns over the withdrawal of basic nursing care, for example?

Rea Johnston: We would like attorneys to take advice from professionals. I might add that in practice, and certainly in my experience, the best decisions are made when relatives—or next of kin—and professionals take decisions together.

The Convener: Thank you very much. That concludes the evidence from the Royal College of Nursing. As a result of some of its evidence, I wonder whether I could ask someone from the British Medical Association to come back in on the issue of nurses' involvement in the decision-making process. The RCN made the point that nurses should perhaps, when decisions are being made on who is ultimately responsible, be given a more explicit role. I saw Dr Wilks nodding his head at one point, so I thought that it would useful to get the BMA's view on record.

Dr Wilks: There have been some unfortunate disagreements that have gone as far as either the General Medical Council or the courts. Part of the background to the disagreements has often included some confusion between doctors and nurses in the health care team. We have made it absolutely explicit that the process leading to, and the decision to withdraw or withhold, treatment, should be consensual among doctors, nurses and the family. We also understand clearly that when a

decision has been made to withdraw or withhold treatment of any type, it is primarily the nurses who have to pick up the consequences of that decision for short-term or long-term nursing.

Once a decision has been made to withdraw or withhold artificial nutrition and hydration and the death of the patient is foreseen, it is important to note that the focus of the care changes from maintaining the patient in their condition to managing, as compassionately as possible, the process of dying. That puts different responsibilities on the nurses which are unique to their profession and do not necessarily involve the doctors to any great degree.

The Convener: So your view is that this is and ought to be a team decision, rather than one person laying down the law?

Dr Wilks: Yes. We would be unhappy with a one-person decision. They tend to be wrong.

The Convener: Thank you for coming back before the committee.

Our next witness is Professor Sheila McLean from the University of Glasgow. I see her sitting at the end of the row, which may not be the best place for her to sit while giving evidence. Perhaps she could move forward.

Thank you for coming, Professor McLean. You have been listening with interest to the evidence that we have heard so far. I hope that you have also had an opportunity to examine some of the evidence that has already been submitted to us in respect of the bill. From that, you will know which aspects of the bill have given witnesses and members of the committee cause for concern. We want to hear from you because it seemed appropriate that, in your capacity as a professor of ethics, you should be given an opportunity to comment on some of the difficult subjects that are being discussed. Perhaps you would like to take two minutes to make a short statement, before we go to questions.

10:45

Professor Sheila McLean (University of Glasgow): Thank you. I am actually professor of law and ethics in medicine, which is a pretty cumbersome title. I mention that because my background is in law—I am not a health care provider or purely an ethicist.

I had not intended to make anything approaching an opening statement, but perhaps I can give you the lawyers' view on the current position in Scotland in respect of the withdrawal of nutrition and hydration. I sat through the Janet Johnston case and was present for the final judgment. My understanding is that individual cases do not need to be brought before the Scottish courts—in other words, that the decision can be left to the clinicians. On the other hand, immediately after the Law hospital decision, the Lord Advocate said that he would guarantee not to prosecute doctors who were involved in removing nutrition and hydration only if the Court of Session had authorised them to do that. That is slightly different position from the one that people had assumed.

My interest in the bill has been spiced by what I have heard this morning, and I wonder whether I may ask a question. It is my presumption that the main intention of the bill is to close a legal loophole that left nobody authorised to consent to treatment on behalf of an incapacitated adult. If that is the case, it seems to me that a number of the points of difficulty that have been raised are not relevant. This is a bill that confers positive powers. If section 47 is read in the light of the conclusion of section 44(1), which refers to the

"authority to do what is reasonable in the circumstances to safeguard or promote the physical or mental health of that adult",

some of the concerns that have been expressed in the media and outside this chamber should be assuaged.

The Convener: That is the view that most of us held prior to taking evidence. Our difficulty is with what one might call the law of unintended consequences. We all know of pieces of legislation that have become subject to interpretations that are at odds with what was originally intended by them. We have heard a number of witnesses express concern about the possibility that that might happen with this bill. I know that this is rather like crystal ball gazing, but that is why we go through the process of taking evidence.

From the evidence that you have seen, you will know that certain organisations have raised specific concerns relating to omissions as opposed to acts. Members of both the Justice and Home Affairs Committee and the Health and Community Care Committee would find it useful if you could comment on any potential unintended consequences of the bill. From the text of the bill—leaving aside its stated intention—and from the evidence that we have been given, do you believe that those concerns are justified?

Professor McLean: My impression from the evidence that I have seen so far, and from the bill, is that it is remarkably clear. When the Scottish Law Commission report was produced I had hoped that the Scottish Parliament would be enabled to look at advanced directives and at the distinction between acts and omissions, which, in my view, is a distinction without a difference in legal terms. The bill is clearer than it might have been because those issues were excluded from it.

That allows people to focus on what the bill does, which is to supplement common law capacities with a statutory basis.

Pauline McNeill: Several witnesses have encouraged us to look at introducing a duty of care for the proxy or welfare attorney. What do you think about that?

Professor McLean: I understand why that is being suggested and the intention is good, but it would create legal difficulties. We have no tradition of a duty of care between individuals and the community, as opposed to between the individual and those with a professional responsibility to them. For example, we have no duty to rescue; it is against the law to commit an assault but not to fail to prevent an assault from being committed. To impose on an individual, non-professional person an equivalent to the duty of care expected from professionals would be to create something novel. It could be difficult to impose because it turns our legal tradition on its head. It would be extremely difficult to enforce—what would you do if the person failed? With groups that have a duty of care, such as doctors and nurses, there are sanctions available if they fail in that duty, either through litigation or through their professional associations. I do not know who would implement or deal with a breach of a duty of care in an individual.

Pauline McNeill: Apart from it being an onerous duty to take on the power of attorney, particularly if we introduced an additional duty of care, are you saying that there are legal consequences for that person? Could it mean they would be open to litigation by other parties who felt that they had made a negligent decision?

Professor McLean: I am not sure on what basis you could challenge them because a proxy decision maker could always say that they had acted in good faith. All the evidence is that proxy decision makers get it wrong more often than they get it right, but that they do so in good faith. To give a duty of care to an individual would make significant inroads into an established legal process for little gain. Those who believe that a duty of care is important might decide that they would rather not act in that capacity. Equally, there may be those who think that it does not matter because all they have to do is say that they acted in good faith—how would you prove that they had not? That is especially difficult since they are not in a professional role.

Pauline McNeill: Where should a final decision about medical treatment lie: with the medical professionals or with the proxy?

Professor McLean: If there is a dispute between the proxy and the health care professionals, the courts should be involved. I would say that about any decision that makes an avoidable death unavoidable—for example, by withdrawing nutrition and hydration. We should not be hesitant about taking such a decision to court because it is much more than medical; it is a matter of human rights.

Phil Gallie: We have been concentrating on the medical and care aspects of the bill. My original understanding of the bill was that it was to look at the life management of individuals and to move away from the costs of curators bonis to give individuals the right to manage an incapable adult's affairs. If you have had a chance to look at the other parts of the bill, do you feel that it achieves its original aims and have you any concerns?

Professor McLean: I have not been able to consider the rest of the bill in much depth. I had a look at some of the stuff on guardianship and wardship. It seemed to me—and I am not an expert in this area, so I am reluctant to say anything—that the bill tackled fairly head-on the problems that the Scottish Law Commission, among others, identified. Those problems concerned the lack of accessibility to certain kinds of protection, through either cost or time delay. In the little that I saw—and speaking as a non-expert—the bill seemed to me to deal with those fairly clearly and well.

Phil Gallie: So, you have not really analysed the detail of other parts?

Professor McLean: No.

Malcolm Chisholm: All the examples that have been given today have been based on the scenario in which a doctor wants to give medical treatment but the welfare attorney or guardian does not want that treatment to be given. What is the situation if the reverse happens—if a doctor wants to withhold treatment and the relative, or whoever it is, wants it to be given? That would include decisions about hydration, nutrition and ventilation. Do you think that the bill will alter the situation, in those circumstances?

Professor McLean: My understanding of the current legal position is that no doctor or other health care provider can be obliged by anyone else to provide treatment if doing so is against his or her professional judgment. The existence of another person with some kind of authority would be insufficient to override the clinical decisions of the health care providers.

The paradox is that, if the reverse happens and the doctor wants to give the treatment but the other proxy person—a spouse or another relative—does not want it to be given, the doctor's views would, in most circumstances, override the other's. One of the things that concerns me is the extent to which the bill appears to be trying to give

considerable powers to relatives. I have two concerns about that. First, this is a novel situation in law, as that is the kind of problem that is being tackled. Secondly, people have traditionally misunderstood the role of relatives in the provision or refusal of consent. Unless we spell that out clearly, that kind of misunderstanding might be perpetuated.

Organ donation is the clearest example. Although the legal position is that somebody has said in advance that they want their organs to be removed or there is no reason to believe that they would have objected to it, it is still practice to invite relatives to comment on whether organs should be removed. That is perhaps a humane thing to do, but it is the result of a fundamental misunderstanding of what the law requires. We must clarify exactly what powers we are handing over to relatives. There might be confidential information that clinicians would otherwise not want a relative to know, which they might have to disclose if that person has a significant power.

Your second question was about the extent to which the bill, if enacted, would change current practice. My suspicion is that its terms fit quite clearly into what doctors and nurses already think of as good practice. Practice may not change dramatically, but the bill might provide health care workers with the reassurance that what they are doing is lawful as well as good practice. That is something that people have felt has been missing for some time. I do not imagine that there will be radical changes in practice, but I would like to think that health care providers will feel more comfortable, and that they will be working within a framework that they understand.

Malcolm Chisholm: I would like you to clarify the position. We are all agreed that, in the bill, the welfare attorney or guardian will have a significant power in the withholding of treatment. Are you saying that they will have no powers in demanding treatment, including hydration, nutrition and ventilation?

Professor McLean: Yes. The only case law that I know of concerns a couple of English cases, in which the Court of Appeal moved as far away as it could from saying that anybody could force doctors or nurses to treat individual patients. I have every reason to think that the Scottish courts would take precisely the same attitude.

The answer is yes, you may give somebody powers to make less than life-threatening decisions, and you may give them powers to agree in circumstances in which no one else could. However, unless the common law is breached, you are not passing on to the guardian or welfare attorney the power to compel clinicians to treat.

Gordon Jackson (Glasgow Govan) (Lab): I have two questions. You pointed out to Pauline McNeill the difference, in some situations, between doing something and doing nothing—if one assaults someone, it is a crime, but if one stands by and does nothing, it is not. In the context of omissions, in particular, and of withholding treatment, you said that, as far as you were concerned, there was no distinction between an act and an omission. Could you explain that concept further?

11:00

Professor McLean: Certainly. It goes back to the example that I gave. The relationship between individual members of the community is such that there is a clear distinction between an act and an omission. That is the legal order—one is not obliged to go to someone's aid, but one is obliged not to harm them. The difference with a professional relationship is that the nature of that relationship establishes a duty of care, the core content of which is that one is as responsible for one's omissions as for one's acts. Out on the street, there is a difference between acts and omissions, whereas in the peculiar nature of the professional's duty of care to the client or patient, an omission is as culpable as an act. That has been the legal position for a long time.

Gordon Jackson: So a doctor is no more entitled not to do something as he is to treat wrongly.

Professor McLean: Absolutely. If the doctor—or nurse—failed to provide treatment in circumstances that were subsequently challenged, their omission to provide the treatment would be just as culpable, if it were negligent, as an act would be.

Gordon Jackson: My other question, which may be personal only to me, relates to what one of the doctors said earlier. He said that as a person could refuse treatment—which is right—it would be reasonable for a proxy to refuse treatment. I instinctively drew in my breath at that, as I was not entirely at ease with that statement. Obviously, I can refuse treatment, as I am an awkward, bolshie human being. Regardless of whether it is in my interests to do so, I might just say, "Who cares?" That is my right—as the play says, "It's my life." However, the idea that a proxy would have that power and that one could equate the two positions left me feeling uncomfortable. Do you have any views on that?

Professor McLean: Yes, I share your view. The proxy, in any event, is not being asked the same question. You would ask yourself, "Do I want this treatment?" You might not, because you might want to go to a party tomorrow night and the

treatment would get in the way. The proxy is not asked that question—the proxy is always asked to act in the best interests of, or for the benefit of, the third party. It is not the same decision. You are entitled to deny your best interests and no other person can be given that power. You can say, "I know it's in my best interests to avoid this party and get this treatment, but I do not choose to do that." No other person can be given that power over your life and treatment.

Gordon Jackson: That brings us back to the definition of the proxy's duty of care, which is what I find difficult.

Professor McLean: As I said, I understand that the proxy—or whatever that person is called—will fill the gap that existed in law, which was that no one could make a decision for an incapacitated adult. The proxy is being offered a limited range of decisions—inevitably, as there are some issues that they could not decide—or a limited opportunity to act in the best interests of the incapacitated adult. Almost certainly, that decision would almost always be to accept recommended medical treatment. The bill puts the health care provider in a safer position legally, because they will know that the proxy has some authority. It also allows the person who is incapacitated to receive treatment that otherwise they may not have been able to get. I see that part of the bill as a positive provision of authority rather than a negative removal of treatment.

Ben Wallace: Professor, you will have heard my question to the BMA on the limitation of liability in section 73 of the bill. I want to return to the point about duty of care. Would you be satisfied that that limited liability puts enough pressure for the person responsible to be informed, to their satisfaction, about the benefit to their charge of any intervention, as under section 1(2)?

Professor McLean: Again, I have sympathy with the concept but, pragmatically, I cannot see how any more of an imposition could be made on people's good faith, which is what one has to rely on in institutionalising proxy decision making.

I do not see how we could create an additional duty of care. Oddly enough, the best safeguard is to ensure that only some people are entitled to be proxies. Some problems could be screened out before people are given authority. I am not clear on how much more could be done.

Ben Wallace: Could one ask for a second opinion?

Professor McLean: One could certainly ask for a second opinion.

A relevant question that we have not touched on is who decides that a person is incapable. People have quietly accepted—the bill certainly seems to accept it—that the decision on whether somebody is incapable for these purposes is made by the clinician. I suggest—this relates to the issue of a second opinion—that there are fine decisions to be taken about incapacity. Some decisions are obvious—for example, when the patient is unconscious. Other patients, as my colleague from the Royal College of Nursing mentioned, may have capacity in some areas but not in others. Radically, I think that lawyers and not doctors should decide on capacity in grey areas, as incapacity is a legal, not a medical, concept. It might be that, to ensure that a decision is properly reached, one would want to take a second opinion from somebody who did not come from the health care professions.

Ben Wallace: Are you saying that there is no way of putting a safeguard on the actions of a proxy?

Professor McLean: I cannot think of any way that would do more than allow us to make the presumption that the person is acting in good faith. If the doctors or nursing staff who are in charge of the patient felt that a decision was manifestly being taken in bad faith, or directly in contradiction of the patient's best interests, they could pursue the matter through current common law—a decision could be challenged.

Ben Wallace: That could be a lengthy and impractical option.

Professor McLean: Yes, it could be.

Dr Simpson: On that issue, would it be sufficient in the guidance to require the proxy to seek further advice or to demonstrate evidence to back their decision? We have to find some midway course. I think that I accept that a duty of care would not be appropriate, but we have to find some way of putting a greater onus on the attorney than is allowed under the bill at present.

Professor McLean: I understand the intention, but I find it difficult to imagine how that could be done. A lot of these issues are heavily dependent on good faith. I know of no test to discover in advance whether someone is likely to act in good faith.

We know that proxy decision makers are pretty inaccurate. Most of the research on this subject has been done in the United States. If the person who has appointed the proxy is asked what they would want their proxy to say, and then the proxy is asked what they think that the person would want them to do, the evidence is that there is very little congruence between the two views. Some surveys suggest that the incidence of congruence is no greater than chance. The same often applies to what the doctor thinks that the patient would want and what the patient would actually want, so we are scuppered there.

Other legislation has the notion of good faith built in—abortion legislation requires people to testify in good faith that, for example, they have a conscientious objection. Even in such cases, however, the law requires only a statement on oath that a decision is made in good faith. I cannot see how the law could be made any more rigorous for a proxy decision maker, although I understand why you might want it to be.

Dr Simpson: You have certainly increased rather than reduced my anxiety.

Do you have any comments about research in relation to the European Convention on Human Rights and Biomedicine, to which, I suspect, we will sign up? Do you think that it should be incorporated?

Professor McLean: I rather like the way in which the section on research is phrased. However, my medical colleagues have some difficulties with it, because they believe that it will limit research. The section is much closer to the Nuremberg code—the initial international agreement about the use of human subjects in research—than it is to the Helsinki declaration, which is the principal ethical guidance nowadays and which permits proxy consent for research. I think that I am right in saying that the Helsinki declaration does not even outlaw non-therapeutic research. The Nuremberg code, however, makes it clear that someone can be involved in research only if they can give free and informed consent. The partial move towards allowing research in circumstances in which the individual is unable to do that is a reasonably satisfactory compromise between the absolute position and the need to find ways of improving diagnosis and treatment.

Dr Simpson: Do you feel that that would allow, for example, genetic research with minimally invasive procedures and randomised, controlled trials with a placebo?

Professor McLean: Only, I would have thought, if that was justified in the circumstances or if the person had been capable of giving consent. The genetic issue is more complicated, because for the moment—as you are almost certainly aware—it seems that people are being extraordinarily cautious before allowing any kind of genetic research to be done. I would have thought that the sensitivities of genetic information were such that the terminology in the bill would not necessarily permit it. It would depend what is meant by risk or minimal risk. If risk is the disclosure of confidential or private information, for example, through genetic information, that would not be a minimal risk in anybody's terms. I know that the language in the bill has been chosen fairly carefully, but I am sure that there will be difficulties down the line in interpreting what is meant by minimal risk.

Tricia Marwick: My first point is on research. Section 48 appears to rule out any research that does not directly benefit the person with incapacity. The British Medical Association said that it would prefer the section to say that the research would not be contrary to the interests of the incapacitated person. There is a clear difference. Would you come down on the side of the bill, which says that research must be of direct benefit to the person with incapacity?

Professor McLean: Yes, I would. The concept that the BMA favours is becoming popular, for good reasons. In the context of research, however, I would still err on the side of caution. The bill should at least contribute to minimising the number of incapable people who are involved as research subjects, even though I understand why research needs to be done and the benefits for patient care that it may lead to. The provision represents something close to a balance—it will satisfy neither the extreme human rights view nor the clinical view, but it is somewhere reasonably in the middle.

Tricia Marwick: Thank you. I have one other point of clarification. You threw in at one point your view that you would like a decision on incapacity taken not by the doctors and clinicians but by somebody independent—a lawyer, for example. We have not had ample opportunity to explore that. You probably heard the evidence from the Royal College of Nursing, which would like the involvement of one person who is independent from the hospital institution or the day-to-day care team. Would you see that as a compromise? Would it satisfy you that an independent person would be involved as well as the clinician, or do you hold to your view that the decision should be taken out of the hands of the medical profession completely?

11:15

Professor McLean: As I said, in some circumstances it is quite clear that there is an incapacity, because it is temporal—it is about loss of consciousness. The biggest problems arise when the decision about capacity or its absence is taken in respect of somebody who is conscious. This is going to sound very cynical, but the question of somebody's capacity to accept—or refuse—medical treatment will arise only when the person does not want to accept the medical recommendation. The same is true with children. That is the point at which health care providers start to say whether a person is competent.

Given that human beings, especially adults, are given the absolute right to make decisions that are completely irrational and that do not necessarily follow medical recommendations, I am concerned that there might be a temptation to over-use the

notion of incapacity. I am not suggesting that there is a conspiracy, but if there is an intransigent patient and the health care provider knows that medical treatment can help them, there would be some benign temptation. That is the rationale for having someone independent from the care team—which has an interest in doing the best for the patient, in clinical terms—to make such judgments. Ideally, that person would be a lawyer, because incapacity is a concept with clear legal overtones, not medical ones.

The Convener: Thank you, Professor McLean, for coming at relatively short notice.

Abolition of Poindings and Warrant Sales Bill: Stage 1

The Convener: The committee must now move on to a different inquiry, the Abolition of Poindings and Warrant Sales Bill. Tommy Sheridan MSP and Mike Dailly from Govan law centre are with us today.

Tommy Sheridan (Glasgow) (SSP): Mike will speak first.

The Convener: I see that there is a third person with you.

Tommy Sheridan: That is Mike's assistant. She is not going to speak to the committee.

The Convener: Fine. I welcome you all to the committee. You have asked to make brief opening statements, which I must ask you to keep fairly tight, as we are running about 10 minutes behind schedule. We will then move on to questions.

Mike Dailly (Govan Law Centre): Thank you, convener. It may be helpful for me to give a brief introduction to my background and to set out my legal perspective. I am the principal solicitor of Govan law centre, which is a community-controlled legal resource. For the past five and a half years, I have specialised in social welfare law in Scotland.

The client base at Govan law centre consists of people with varying degrees of multiple debt. Typically, they are threatened with eviction actions, actions of payment and poindings and warrant sales. Many of our clients live in inadequate housing conditions—with damp, disrepair and overcrowding—and the majority live in poverty. That is my background.

I understand that the Scottish Executive has asked the Scottish Law Commission to reconsider whether its 1985 conclusions on to why poindings and warrant sales should not be abolished remain valid. I will briefly address those conclusions.

The Scottish Law Commission's main conclusion was that, rather than abolish poindings and warrant sales, it would be better to make this form of diligence more humane. In essence, that is what the Debtors (Scotland) Act 1987 attempts to do by creating categories of exempted goods that cannot be poinded in certain circumstances. However, in my experience, that act often provides no protection for people in respect of poindings and warrant sales, because of the way in which such actions operate in practice.

At present, many sheriff officers use poindings and warrant sales as a sword of Damocles to extract lump sums from people on low incomes. I will give members an example that I dealt with last week at Govan law centre. A young disabled woman had arrears of £255 in council tax and she offered to pay back £5 per week. Sheriff officers rejected that offer and said that she must pay £75 up front. The woman was living on incapacity benefit of £80 per week. The value of the goods that were poinded in her house was only £77. It was impossible for her to pay that lump sum.

That example illustrates how the Debtors (Scotland) Act 1987 can provide no protection in certain circumstances. It also illustrates one of the ironies of warrant sales. Those people who would block Mr Sheridan's bill say that the abolition of poindings and warrant sales would result in a return to unscrupulous debt collection and money lending. In my experience, many people would have to go to a moneylender to get the lump sum to prevent a warrant sale. Money lending is alive and well in Scotland. It flourishes in those communities where poverty is rife.

It is important to recognise that unscrupulous forms of debt collection are commonplace in Scotland. We have circulated to committee members an article by the Scottish Legal Action Group describing an investigation into doorstep debt collecting in Scotland. People go to people's doors, intimidating and humiliating them and coercing them into handing over money. That happens all the time.

I also want to highlight the fact that some councils, such as Glasgow City Council, have unofficial, or secret, policies of no warrant sales. I would ask: is it humane to intimidate poor people into paying lump sums, when there is no intention of carrying out the warrant sale in the first place? In any other situation, we would call that fraud.

Another important conclusion that the Scottish Law Commission reached in 1985 was that the abolition of warrant sales would tempt debtors to convert funds into moveable goods. I find that assertion naive and offensive to my client base. The conclusion proceeds on the basis that, if poor people get the chance, they will cheat. That is simply untrue. In my experience, the majority of people are good citizens who want to pay their debts; the problem is that they do not have the

money to do so. The minority of people who are unscrupulous will escape the threat of poinding or warrant sale because they will hide or dispose of their goods. Such people are not affected by the current legal position, because they are devious anyway.

The Scottish Law Commission took the view that it was a fundamental principle that people who could pay their debts should be required to do so by law. That assertion proceeds on the basis that people who can pay will not pay. Again, in my experience at Govan law centre, that is not the case. It is instructive to consider the findings of the Scottish Executive, which are set out in the financial memorandum to Mr Sheridan's bill and which support that point.

If the bill was to become law, the reform would be self-contained, although many further reforms would be needed in the area of debt and diligence. Other forms of diligence would be effective: one can have deductions from income support or arrestments can be taken from people's wages. In West Dunbartonshire, the council, which operates a policy of no warrant sales, maximises people's income. That is very effective.

Last year, there were 23,000 poindings, only 6,000 of which were non-summary warrant poindings. That means that 17,000 people could not get a time-to-pay order, because that would not be competent and could not recall the warrant sale if it was unduly harsh.

It is right for me to flag up the fact that, when the Human Rights Act 1998 comes into force in, I think, October next year, Govan law centre and other law centres will seek to challenge the competence of the summary warrant procedure under article 6 of the convention.

I would like to thank the convener for giving me the chance to address the committee.

The Convener: Tommy, we will hear from you before we go to questions.

Tommy Sheridan: Thank you, Roseanna. I will try to be brief and not dwell on some of the cogent points that Mike Dailly has raised.

The fundamental objection that the sponsors of the bill—and Mike, as the draftsperson of the bill—have to warrant sales and poindings is a moral one. We are morally opposed to the use of poindings and warrant sales as a form of debt recovery in a modern society. In my opinion, there are powerful and cogent arguments that illustrate the ineffectiveness of poindings and warrant sales and their incompatibility with the European convention on human rights.

Those arguments deserve to be heard; but I want to concentrate more on the fundamental inspiration that has led me, John McAllion and Alex Neil to sponsor this bill. We believe that warrant sales and poindings are immoral and outdated. The committee will be aware that those practices dates back to the 16th century, and that dear old Rabbie Burns himself, in the 18th century, had occasion to criticise their use—which is ironic, given that he was a tax collector. In the early part of this century, Labour and trade union organisations were often founded on a clear commitment to abolish poindings and warrant sales. Our collective hope is that the new Scottish Parliament—assisted by recommendations from this committee—will have the vision and the political courage to take us into a new century without this 16th-century practice.

Poindings and warrant sales are about fear and intimidation. They are used almost exclusively against the poor. Multiple debt is a serious problem in Scotland. It is a problem that this bill will not, in itself, address. However, our argument is that poindings and warrant sales do not, in any way, ease the problem of multiple debt—rather, they accentuate it. For many creditors, poindings and warrant sales are seen as reasonable and satisfactory arrangements; we argue that the consequence is often a massive increase in multiple debt problems for people who are already living in poverty.

Some argue that we need poindings and warrant sales because some people simply refuse to pay their debts. I hope that the committee will accept that poindings and warrant sales are as ineffective as a chocolate teapot for some people—people who, for want of a better term, I will call Johnny-fly-by-nights. Those people know how to avoid poindings and warrant sales. They know the rules and provisions and which goods are exempted.

If one uses the sanction of poindings and warrant sales against a person from Newton Mearns who refuses to pay debts and who has two big cars in the driveway—which is the example that I often hear when speaking to the Law Society of Scotland and others—and if one believes that that person does not know the rules and provisions under the Debtors (Scotland) Act 1987, one is suspending reality. Poindings and warrant sales are not about Johnny-fly-by-nights—they are about the poor.

I appeal to the committee to keep its eye on the ball. I repeat, poindings and warrant sales are about fear and intimidation. They are about forcing people who are already in debt to accumulate even more debt. I am glad that Mike Dailly brought the example of Mary Ritchie to the committee's attention, because it is important that we deal with reality. Mary faced a warrant sale last Wednesday. If it had proceeded, I and a number of others from Glasgow—including, perhaps, MSPs—would have been outside her door hoping to prevent the

warrant sale from taking place.

The point is that the woman was trying to survive on £80 of income—incapacity benefit—a week, and the sheriff officers refused a £5 per week repayment schedule. They insisted on a £75 lump sum payment. That is the type of settlement that forces people into the hands of money lenders. It happens day in, day out. The committee must bear in mind the fact that, in the case of a £255 debt, the value of the poinded items was £77. I hope that we are clear that poindings are not about recovering debt; they are about fear and intimidation.

I plead with the committee not to be dazzled by legal jargon and establishment arguments. The poor, in our opinion, are daily being intimidated and harassed by sheriff officers wielding the threat of poindings and warrant sales. I do not offer this as a scientific argument, but it is worth noting the recent Glasgow *Evening Times* opinion poll, which asked whether people supported the abolition of poindings and warrant sales. I might be accused of not using scientific evidence—so be it—but, incredibly, 95 per cent of respondents called for their urgent abolition. I draw attention to the weight of that opinion and I applaud the editorial position of that newspaper, which supports abolition.

11:30

Many have argued that an alternative is required, and that it is not enough just to abolish poindings and warrant sales. I am not going to argue—neither will John McAllion, Mike Dailly or Alex Neil—that the bill is a rounded-out solution to debt and credit problems in Scotland; there is obviously a need for an overhaul and review. Alternatives exist in the form of wage arrestments, benefit and bank account arrestments, ordinary decree for inhibition of property and sequestration orders. The idea that the whole debt recovery system in Scotland will collapse if the diligence of poindings and warrant sales is removed is patent nonsense. I hope that the committee will accept that. There are other more humane and often more effective methods of debt recovery.

I mentioned legal jargon and establishment arguments. The evidence of the Law Society of Scotland comes to mind. According to its written evidence—forgive me if I over-egg the pudding—there would be a disaster in Scotland if poindings and warrant sales were abolished. The Law Society predicts dire consequences—it even claims that the poor will suffer because they may be less likely to gain credit. That seems a perverse and unsubstantiated argument. One of the arguments that it missed was that the weather would get worse, although I am sure that that argument will come in time.

One point from the Law Society's evidence that must be taken up is—

The Convener: Can you move on a bit, Tommy? The Law Society will be giving evidence and you will, of course, be entitled to question their representatives.

Tommy Sheridan: I am sorry, Roseanna. I will finish on this point. I accused people of being out of touch with reality. The Law Society has said that current legislation on poindings and warrant sales offers enough protection for the poor. In its evidence, it said that only people who had luxury goods such as a car, valuable antiques, stock and the like needed to be worried by poindings and warrant sales. I ask the committee to consider the facts: it is televisions, hi-fis, videos, coffee tables and display cabinets that are getting poinded daily, not luxury items. That shows how out of touch the Law Society's argument is.

West Dunbartonshire Council has taken a courageous and innovative decision. It has banned poindings and warrant sales and put in place other effective forms of debt recovery. In the space of six months, it has collected £300,000 by visiting debtors and by trying to make more humane and compassionate arrangements. It is also running another project to maximise benefits—in the same six-month period, it has enabled £1.1 million of unclaimed benefits to be claimed, which has reduced debt problems in its area. I offer that as the way forward for this Parliament.

I conclude by asking the committee to recommend to the Parliament to support the bill so that we march into the 21st century, leaving behind the medieval and antiquated method of debt recovery of the 16th century. Further reforms may come in the future, but this bill stands on its own two feet and is worthy of support in and of itself.

The Convener: Mike, you made a point about the European convention on human rights. Money Advice Scotland has made the same point. Given current interest in the matter, could you expand a bit on the effect of the ECHR on Scots law and, in particular, on your view that you could not make a challenge now? I am not clear why you think that. It would be useful to have on record why you think that a challenge under the ECHR would end up with warrant sales going.

Mike Dailly: In the Mary Ritchie case to which Tommy referred we lodged an application in court. The only thing that can be done with a summary warrant is to say that it is invalid, which is what we tried to say. However, we managed to negotiate the case with Glasgow City Council. We are trying to use the convention now but, to be honest, I think that we will be unsuccessful because of recent cases—in Scotland it was the case of T,

Petitioner. The courts can have regard to the convention, but it is not directly applicable. Once it comes into force, it will be possible to found challenges directly on the convention.

The Convener: That is what I do not understand. The convention is currently in force in Scotland in regard to devolved matters under the Scotland Act 1998. Perhaps there is an issue there that needs to be explored. My understanding was that the ECHR was in force in Scotland in regard to devolved matters and that it is applicable in Scots law.

Mike Dailly: You are quite correct about the Scotland Act 1998. However, that is only applicable for things that the Scottish Parliament, the Scottish Executive and the Lord Advocate do; only the acts of those institutions must be compliant with the convention under the Scotland Act 1998. Local authorities, for example, do not fall under the Scotland Act 1998 in that regard. We must therefore wait until the Human Rights Act 1998 comes into force for the rest of the United Kingdom before it can be used.

We have looked into the matter. Whatever happens, come next year, article 6 of the convention, which says that every citizen has the right to a fair and impartial determination of their civil rights, will apply. One thing that worries me about summary warrant procedure, which is a powerful procedure, is that, effectively, a bundle of debts for various people throughout the country can all be passed to the sheriff court and essentially just rubber-stamped. Once there is a summary warrant and a poinding takes place, it is not necessary to ask the sheriff's permission to do a warrant sale.

The problem in the case last week was that there was no way to challenge that other than to say that the whole summary warrant procedure was invalid. The whole procedure will, I am sure, be challenged. Given that we know that the vast majority of poindings are carried out on the back of summary warrants, the bill would go some way towards helping the Scottish Parliament to comply with its obligations under the convention.

The Convener: Money Advice Scotland refers to article 8 of the convention, which gives individuals the right to protection of their property. Are you saying that there is another article under which challenges could be made?

Mike Dailly: Absolutely. Article 8 gives the right to respect for family life. One could use that to argue that a warrant sale was in breach of the convention.

Gordon Jackson: I am still interested in what would replace warrant sales. I am working on the assumption that warrant sales are blunt instruments that do not achieve anything and that have no place in how we deal with matters. No lawyer likes them in that sense. However, I am still a little worried about what would replace them. You say that there are other options, for example, arrestments, but I imagine that, by and large, warrant sales are not the first option for people who are owed money.

Most creditors would arrest wages, if they could, rather than initiate a poinding and warrant sale. The warrant sale is a fallback position, a course of last resort for someone who is owed money. Tommy Sheridan is right to say that it is used as a threat. The reason that it does not happen in Newton Mearns is that there the threat works. People are told that the Mercedes in their driveway will be poinded, and they make other arrangements.

Linked to that in my mind is the slight fear, which Tommy dismisses, that, unless the fallback position of a warrant sale is there, many ordinary folk who would be able to pay their way will not get credit. What would Tommy have as a last resort? How, for example, would he feel about attaching benefit? He made the point that people are not allowed to pay off a small amount of their debt, say £5, each week. I agree that that is a nonsense. If someone says that they are prepared to pay a fiver a week, it is ludicrous to poind their property rather than permit them to do that. However, if benefits are the only source of such payments, how would Tommy feel about a small proportion of them being set aside, by agreement, for the repayment of debt?

Tommy Sheridan: If I may answer the last part of Gordon's question first, what he has described is already a reality. Tens of thousands of benefit attachments have already been made in Glasgow, for both council tax and residual poll tax arrears. The only advantage of benefit arrestments is that they are limited, the current maximum being about £2.50 a week. That is why the offer that Mary Ritchie was making was so attractive. She was offering double what could have been obtained legally via a benefit arrestment.

Gordon made the point that warrant sales are a last resort, but my argument is that other measures already exist. If he is saying that the abolition of poindings and warrant sales would lead many more people to refuse to pay their debts, that implies that many people do not want to pay their debts. However, all the evidence, including even that of the Law Commission, shows that the overwhelming majority of people in Scotland pay their dues regularly. It is not a case of people deliberately avoiding paying their debts; something like 95 per cent of the debt that is being pursued is owed by people who want to pay but are unable to do so because of poverty.

I accept that the bill does not address the

problems of credit control. However, if a credit agency were unwilling to give credit to someone with a low income because it was worried that it would not get its money back without the sanction of a poinding and warrant sale, I would question the ethics of that agency. I do not think that it would be a bad thing to restrict the type of crazy-jobs credit facility that is the bane of the lives of many poor communities, offering televisions for a pound that cost £300 in the long run. I ask Gordon and other members to consider whether credit and debt recovery would collapse in Scotland if poindings and warrant sales were no longer available from tomorrow. I do not think so. There will be marginal problems. We must accept that any change to the law will have consequences. However, the change that I am asking for in this bill has more advantages than disadvantages.

Gordon Jackson: I was not making an argument; I was asking a question. I am seriously trying to clarify this matter.

Phil Gallie: None of us can disagree with the arguments that Tommy Sheridan has made in the cases that he described today. It is a nonsense to take property away from people who have virtually nothing. However, my impression is that warrants go further than that. Use is made of them in the business community. Last week, I stopped a warrant sale proceeding in a case where a businessman who had been pursued by the Inland Revenue for a long time had adamantly refused to pay. Under the threat of the warrant, he came up with a satisfactory payment formula. It seems that the public sector—the Inland Revenue, Customs and Excise, the councils—uses warrant sales frequently.

11:45

Tommy Sheridan: That is right. The figures that Mike Dailly gave earlier indicate that. Some 16,000 of the 23,000 poindings last year were under summary warrant, which means that they were carried out by a local authority, the Department of Social Security or the Inland Revenue. That is interesting because it shows that small businesses or individuals are not using them. There is evidence that the business community does not think that they are necessary. The fundamental question is whether the Inland Revenue could use other diligence. I do not see why, in the case that you mentioned and others like it, ordinary decrees are not used instead of summary warrants. Perhaps the problem is that summary warrants are convenient for public bodies.

Mike Dailly: Something like 5,000 of the 23,000 poindings were carried out by the Inland Revenue, Customs and Excise and the Department of Social Security. In their submissions, those bodies concede that poindings and warrant sales are a small part of the diligences that they use. At present, money that is owed can be deducted only from income support. It would be helpful if it were possible to deduct it from any benefit.

Phil Gallie: The individual that I referred to was not involved in the benefit stream. He has a business and he has some cash flow. He refused to pay but is now paying.

Mike Dailly: If warrant sales were to be applied to some people but not to others, there would be a debate about how to define the categories and, doubtless, inequalities would result.

Phil Gallie: Perhaps the categories of those against whom warrant sales could be carried out and those against whom they could not be carried out could be based on debt levels and value of property. Those things are already taken into account, to a degree.

Mike Dailly: If the bill proceeds, some people will win and some will lose. A political judgment must be made about what is acceptable. Does Parliament want to proceed with the bill as a matter of principle?

Tommy Sheridan: The point that I was trying to make was that, if the Inland Revenue did not have the opportunity to carry out a warrant sale, it would have been possible for it to recover the money by other means, although it might have taken longer and might have involved more court appearances.

Phil Gallie: We should perhaps call representatives of the Inland Revenue before us.

Glasgow City Council has written in support of your bill. However, Castlemilk Law Centre's submission shows that councils are perhaps most at fault in this area, as you have already acknowledged. Is not it a bit hypocritical of Glasgow City Council to support your bill when it is carrying out poindings and warrant sales?

Tommy Sheridan: I do not know whether Glasgow City Council is giving evidence—I hope so. I would argue that the council is being honest; it feels compelled to use those mechanisms because they exist. In Glasgow, it is a secret—probably one of those secrets that everyone knows about—that the council does not carry out warrant sales. However, the council will not tell people that; an auditor might look unkindly on the end-year report because the council has not used all the diligences available to recover debt.

That is why the West Dunbartonshire Council decision is so forward-looking. The council has taken legal advice to the effect that poindings and warrant sales do not recover debt and in fact cost more than other methods of debt recovery. I believe that Glasgow City Council's position is consistent. Although it is forced to use those

methods because they are on the statute book, the council would like them removed from the statute book.

Tricia Marwick: The Glasgow City Council submission that Phil mentioned was actually from the consumer and trading standards division, which also makes the point that poindings are invariably used to frighten debtors who are mostly already stressed about other outstanding debts. There are other descriptions of the distress caused by poindings and warrant sales. Many of us have seen such distress. However, is not that the point?

Last year, according to the Scottish Executive justice department, there were 23,067 poindings, of which only 513 proceeded to warrant sales. I agree that poindings have little effect on gathering debt, but instead humiliate people into trying to get some money from moneylenders or whomever. Like you, I am looking forward to the Law Society's visit to the committee because it claims that poindings and warrant sales represent

"a sanction which lies at the heart of our whole system of diligence".

Will you comment on that?

Tommy Sheridan: I hope that Gordon did not take it personally when I talked about legal jargon. I was not having a go at his or other committee members' legal background. I have spoken to the Law Society, the Writers to the Signet and other representatives of the legal establishment, and I have become increasingly disheartened by the gap between their understanding of reality and reality itself. That reality is the debt that people face and the problems that they are trying to grapple with. Evidence that talks about luxury items such as antiques, stocks and cars and forgets about things such as coffee tables and display cabinets displays a breathtaking arrogance and a lack of a grasp of reality.

Poindings and warrant sales should not be at the heart of the system of diligence, and I hope that the Justice and Home Affairs Committee will recommend to the Parliament that, at the start of a new century, such baggage should be removed. By all means, ask the Scottish Law Commission and the Executive to suggest other reforms or to re-examine the summary warrant procedure and the availability of credit. However, that should not delay what is effectively a stand-alone measure.

It would prove a symbolic gesture across Scotland if the Parliament were to pass this bill. I think that it would show a lot of people in Scotland that the Parliament was willing to get to the heart of the things that affect people's lives.

Tricia Marwick: If, out of 23,000 poindings, only 513 proceed to warrant sales, that is not an efficient method of gathering debt, leaving aside the fact that they are humiliating and all the rest of it. If the method not efficient for the local authorities, what purpose does it serve, and how on earth can it be at the heart of the system?

Tommy Sheridan: If I were the Law Society, I would probably turn the argument on its head and say that that is evidence of how effective it is. When I have spoken to people from the Law Society, they argue, "Yes, we have 23,000 poindings, but only 513 warrant sales, and that is because people have paid up once they have been poinded—so it is effective." In its submission to the committee, the Law Society talks about "suitable arrangements" being arrived at. I have questioned what is meant by suitable arrangements, and been told that it means suitable to the creditor.

The problem with the Mary Ritchie case and the others is that people who are faced with a poinding will put off some other payment, to pay off the poinding. They will not, all of a sudden, find money under the mattress; they will get themselves into multiple debt. We, as a Parliament, should take measures, even small ones, to prevent that. Abolishing poindings and warrant sales could help.

Pauline McNeill: I support the principles in the bill, and I agree that the evidence suggests that poindings and warrant sales are more a punishment than an effective method of collecting debt. I would like to ask some questions arising from the numerous submissions that we have had on the bill. I have not read all of them, but I have a flavour of the three points of view—in favour, opposed and neutral.

Citizens Advice Scotland feels that, if poindings and warrant sales were abolished, there might be a stronger emphasis on other means of enforcement, and it is especially concerned about the banks. I would like to press you on that, Tommy. For the reasons that you have just outlined, Citizens Advice Scotland is suggesting a debt arrangement scheme. Often, when there is a warrant sale, the person involved might have more than one debt, and will pay the most aggressive creditor. It might therefore be sensible to examine closely procedures that could run in tandem with the abolition of warrant sales, and to think about how we could put in place a scheme that would allow people to manage their debt more effectively. I believe—as you do, Tommy—that it is not that people do not want to pay; it is just that they have so many people on their backs that they do not know what to do.

Tommy Sheridan: I agree with you 100 per cent. That is why I keep emphasising that this is not the final chapter on credit or debt management in Scotland. I spoke at the Money Advice Scotland

conference a few weeks ago, where there were people from citizens advice bureaux and other money advice centres who are working in that area. I asked them to make suggestions—either to the Social Inclusion, Housing and Voluntary Sector Committee for a bill, or to an individual MSP who could promote a member's bill. I agree that other reforms are needed, although you will understand that I am keen that this reform should go through, because the removal of poindings and warrant sales in itself is a worthwhile reform. It is not the final chapter, but it is a worthwhile reform.

Your specific point about bank accounts must be addressed. The problem with a bank account freeze is that it takes no account whatever of outgoings. A person's mortgage, furniture loan—

Pauline McNeill: I wanted to ask you about that, because—as far as I understand it—the Debtors (Scotland) Act 1987 left the banks with carte blanche to be first in the queue, and put no upper limit on what they could take. There is a concern that, on the day that warrant sales are abolished, creditors will look for other methods of enforcement. The power of the banks especially concerns me. In cases where people have bank accounts, banks are first in the queue to recover debt; and if a bank account is frozen, there is no upper limit on what the bank can take.

12:00

Tommy Sheridan: Mike Dailly wants to come in on that. An upper limit is usually applied and a sheriff officer will usually serve an action of furthcoming in which he will ask for around £1,500 or £2,000 to be arrested. Sometimes there is much more than that in an account, and sometimes there is less. That is the input in a suspense account. Money going in the next day or the day after is not affected; only the money that is in the account on the day when the bank account freeze takes place will be affected.

However, most organisations that are serving actions on bank accounts, particularly local authorities, tend to serve them at the end of a month, hoping to catch wage payments going into accounts. That is the problem that citizens advice bureaux are flagging up to us. Bank account arrestments, as they currently operate, take no cognisance of a person's outgoings, whereas a wage arrestment is strictly regulated and is based on the amount that is earned.

Pauline McNeill: Do you think that, if we abolish warrant sales, there will be a greater emphasis on bank accounts being frozen?

Tommy Sheridan: I do not foresee that at all. As I emphasised earlier, there are exceptions to every rule. In general, however, poindings and warrant sales are being used against the poor, and the poor tend not to have bank accounts or, if they have bank accounts, there is not much in them. For that reason, I do not think that the abolition of warrant sales will lead to a massive increase in bank account seizures. That is not to say that I do not think that that procedure needs to be reformed; it needs to be reformed for those who are subject to that diligence.

Pauline McNeill: This may be more of a question for Mike, but feel free to answer it if you want to, Tommy. What are the main types of debts to which you are referring—hire purchase debts or other types of debt?

Mike Dailly: It is mostly council tax and poll tax debts. The vast majority of people who come into the Govan law centre and other law centres and advice agencies are being chased up by the council.

Pauline McNeill: Are there any other types of debt besides those?

Mike Dailly: People can get into all sorts of debts by taking out loans. It has been said that, if the bill were to go ahead, people would not be able to get credit. It is important to remember that people who are on low incomes do not get good credit because they have probably been blacklisted. They will therefore end up going to agencies that charge over-the-top annual percentage rates, or to the dodgy characters who would send round doorstep debt collectors. People who need to buy clothes for their kids to wear to school may take out a loan from one of those outfits and default on it. They will end up being taken to court and the decree will pass. That is the kind of thing that we are talking about.

Tommy Sheridan: Coming from Pollok, I know that there is a lot of catalogue debt, especially at this time of year, when many families get into debt to pay for the kids' toys and clothes at Christmas. They can spend the rest of the year trying to pay back that money, and sometimes they default on their payments because of an illness in the family or for other reasons. That leads to the use, not often of poindings and warrant sales, but often of other collecting agencies, some of which are better than others.

Pauline McNeill: I have two final questions. A number of organisations have said that there is simply not enough use of time orders, which are contained in the Consumer Credit Act 1974. Have you anything to say about that?

Tommy Sheridan: Mike covered that point, but it is worth emphasising it. Time-to-pay orders can be granted only under ordinary decree. In other words, they are not available under summary warrant procedure. Of last year's 23,000 poindings, 16,000 were done by public bodies when time-to-pay orders were not available to the

debtor. That is because the procedure introduced by the Debtors (Scotland) Act 1987 did not allow time-to-pay orders under the summary warrant procedures. That is the type of consideration that should be included in any wider reforming bill. Time-to-pay orders can often be effective but, as the evidence shows, they are not used enough.

Pauline McNeill: My final question addresses a different subject. Are you concerned about commercial debt? At the moment, there is no distinction between commercial and consumer debt. Are you saying that there should not be?

Tommy Sheridan: Making that sort of distinction would create more problems than it solved. I have spoken to the Federation of Small Businesses—which, as the committee knows, has submitted evidence—and to other, not-so-small businesses. They say that they do not use poindings and warrant sales because they are not an effective means of recovering debt of a commercial character. My bill would not fundamentally or significantly affect commercial debt.

Euan Robson (Roxburgh and Berwickshire) (LD): Earlier you spoke about creating different classes of debtors, but the bill seeks abolition of poindings and warrant sales for all debtors. There may be an argument for restricting that to what may be described as domestic debtors and retaining the threat of poindings and warrant sales for commercial debtors. Can you say why you chose to make the bill broader in scope?

The Debtors (Scotland) Act 1987 outlined other measures, apart from time-to-pay orders, to protect the debtor. I think that I know what your answer to the question that I am about to ask will be, but why do you think that those measures were ignored, underused or not used as they were intended?

Tommy Sheridan: It would have been fundamentally inconsistent of me to come before the committee and argue against the principle of poindings and warrant sales, while saying that it was okay to retain them for commercial debt. I think that they are wrong full stop. They are a medieval practice, dating back to before the 16th century. It would also be incredibly difficult to differentiate between commercial and domestic debts. It is best to take a holistic approach and to abolish poindings and warrant sales completely. As I said earlier, that will not affect the ability of commercial traders to pursue commercial debt. The commercial sector has not presented us with a plethora of evidence that the bill would be a disaster. In fact, the people who are saying that are from the legal profession.

Euan Robson's second point related to the reforms contained in the Debtors (Scotland) Act 1987. It is important to bear in mind that protection is effective only if people know that they have it. That is why I made a distinction between the Johnny-fly-by-nights and the overwhelming majority of people, who do not know what is exempt and are unaware of their rights under the law. I have dealt with many cases in which people have had three-piece suites pointed because they did not know that those were exempt. Often such people do not come to us until months later, having missed the two-week deadline for taking the matter to court. The lack of information is legion.

Euan Robson: Lack of information and advice has thwarted some of the intentions of the 1987 act. From my experience in the energy industry, it is perfectly clear to me that one can never provide people with too much advice and information. I would favour incorporating into your bill some extension of advice and assistance to people, if possible, as that would represent a marked improvement on the current situation. Do you agree that at the moment the provision of advice can be haphazard?

Mike Dailly: I agree that advice can make a difference. There are a tremendous number of high-quality advice agencies throughout Scotland.

It should be emphasised that the protections contained in the 1987 act do not apply in the vast bulk of cases, because they are handled under summary warrant.

I want to cut to the chase regarding the purpose of warrant sales and poindings. They are not just about getting people to pay their debts, but about creating a preferential claim. They are a sledgehammer to crack a nut. Poindings and warrant sales are being used to get lump sums out of people, rather than small amounts. Is it not an anomaly that local authorities and businesses agree that they will not carry out warrant sales, but are happy to fraudulently misrepresent them to demand lump sums? That cannot be the way to run a system of diligence in Scotland.

The Convener: That concludes questions for the moment. I emphasise to everybody that three committees, the Social Inclusion, Housing and the Voluntary Sector Committee, the Local Government Committee, and this committee, are taking evidence for the bill. The division of responsibility will be communicated to everybody, including to you, Tommy Sheridan, so that you understand clearly what evidence is being heard by which committee and will be able to give your input where you feel that it is most appropriate. We will advise everybody once we have the dates for the meetings at which the other committees will hear evidence. This is simply the start of the process.

The committee still has one remaining item on the agenda. We are running seriously behind time, so we will press on, but I make the point that some of our business this morning was put on the agenda at the request of members of the committee. It is difficult to find time to take extra evidence if members do not exercise a little restraint over the length of questions. Some questions have been more like personal statements than questions. That can create difficulties when we have rejigged agendas to include as much as possible.

We are now 20 minutes behind schedule. This meeting is supposed to close at 12.30 pm. We can run over by 10 minutes, but that is the maximum.

Abolition of Feudal Tenure etc (Scotland) Bill: Stage 1

The Convener: I welcome the witnesses who are here to give evidence for the Abolition of Feudal Tenure etc (Scotland) Bill. I understand that, for unavoidable reasons, there is a change to the witnesses who are named on the agenda. The Scottish Land Reform Convention is an umbrella group, which comprises a number of smaller groups. I will ask somebody to give a brief explanation of how that works. We were supposed to have Alison Elliot of Action of Churches Together in Scotland, but I understand that Graham Blount is here instead, because she is stuck in Brussels. We have Gavin Corbett from Shelter, and Jim Lugton from the Scottish Council of Voluntary Organisations. Andy Wightman, who gave evidence on an earlier occasion, is here too.

Could you give a brief explanation of how the Scottish Land Reform Convention works, given that each witness represents a slightly different organisation? We will then go straight to questions. Thank you for your written submission. That will help to focus our attention.

Dr Graham Blount (Scottish Land Reform Convention): The Scottish Land Reform Convention was set up to stimulate and conduct debate in civic society about land reform generally. The convention comprises Action of Churches Together in Scotland, the Scottish Trades Union Congress, the SCVO, and a number of other organisations, which are primarily from the voluntary sector. It encourages debate not only on the two bills that Parliament is considering but on the on-going land reform agenda.

Andy Wightman is an adviser to the convention.

Maureen Macmillan: I want to ask about the matter of abolishing the ultimate superiority of the Crown, on which we had evidence last week, from Robin Callander and Professor Rennie. I was rather taken back by Professor Rennie's total dismissal of the idea; he thought that there was no practical use for it. Does Andy Wightman have any response to that?

12:15

Andy Wightman (Scottish Land Reform Convention): There is some confusion about that topic. To be blunt, the whole constitutional position of the Crown and its role in the feudal tenure system has not been subject to adequate analysis and debate in the past.

The Abolition of Feudal Tenure etc (Scotland) Bill and the proceedings leading up to it have been dominated by the conveyancing profession to such an extent that, at times, the conveyancing profession regards land tenure as a subset of conveyancing. However, conveyancing is a very, very small subset of land tenure. With respect to those who have been involved, there has been a tendency to view the arguments from a narrow, legalistic point of view, rather than on a wider basis of public policy and constitution.

We should perhaps put to one side the debate about the role of the Crown. What was being argued last week was the case for a simple, technical redrafting of section 56 that would allay the fears of those who think that there would be major implications of abolishing the role of the Crown, but would not affect the interests of those, such as Professor Rennie, who think that the Crown has no role to play. At a later stage of the bill, perhaps we could propose a reworded section 56 to address those concerns, without getting bogged down at this stage in the policy debate, which is still unresolved.

Gordon Jackson: I asked about the role of the Crown last week, but I am happy to leave that matter until a later stage, as Andy Wightman suggests.

The Convener: Members seem to be uncharacteristically silent.

Maureen Macmillan: We are all exhausted.

Gordon Jackson: Does the Scottish Land Reform Convention foresee any other difficulties? Are there any other problems with the bill that you would like to highlight?

Dr Blount: Our primary concern has been to assert that there is a public interest in land and that it is unrealistic to separate land tenure as a legal issue from the impact of land use, management and ownership on people and communities.

We think that there might be some difficulties with the consultation process. For example, the idea of conservation burdens has been introduced fairly late in the process, without any opportunity

for people other than those who proposed it to respond to it and consider its implications in greater detail.

Jim Lugton (Scottish Land Reform Convention): Allow me to develop that argument a little further. We are particularly concerned that some of the content of the bill on burdens may lead to difficulties for organisations such as the Corstorphine Trust in Edinburgh, which owns a substantial area of land in the Corstorphine area. That sort of body has not been involved in the process as yet, and may not appreciate the consequences of this type of reform. There are considerable numbers of similar smaller trusts in towns and villages scattered throughout Scotland. We feel that engagement in the consultation process by such bodies is a vital part of the relationship between civic society and the Parliament and that, in the preparation of the legislation, greater thought and consideration should have been given to it.

Another aspect is important. If there are no specific safeguards for those bodies, there is a real danger that proceeding too rapidly on wholesale abolition will merely close the door on the public policy interest in land. The Scottish Council for Voluntary Organisations, as a gathering of civic societies, would like that public policy interest to be retained.

Gordon Jackson: Could you spell out exactly what you mean by the adverse consequences for such bodies as the Corstorphine Trust?

Jim Lugton: I would choose the words "potential adverse consequences", because, until the specific content of the bill has been examined by those bodies, neither they nor we will be in a position to assess what the consequences might be. To date, they have been excluded from the consultation exercise and, in some cases and from the information that we have received, they might not even be aware that the debate is taking place.

Andy Wightman: I wish to add to Jim Lugton's comments. The categories of burdens that have been retained are maritime, neighbour, common facilities and conservation. I do not think that anyone has problems with the categories of neighbour and common facilities, as they are sensible. The category of maritime is in direct response to the interests of the Crown Estate commissioners, but I do not want to get into a debate about that.

However, I understand that the category of conservation has been introduced only because the National Trust for Scotland was concerned that it would lose its ability to control the fate of property that it had bought and restored—under the small houses scheme, for example. Therefore, the bill contains a series of burdens that have been developed, principally in response to the individual interests of those who originally responded way back in 1991. We argue that the consultation process has been flawed, as the Law Commission's report was published in February, a letter went out in June inviting people to comment on that report by August and then the bill was published in October this year. The people who were invited to comment in June could do so only if they could afford £22.50 to buy the Law Commission's report. In addition, the detail of feudal tenure is so complex that most people simply cannot get a handle on the issues.

In a range of circumstances across Scotland, it could be deemed to be in the public interest for burdens to be retained. It could be argued that conservation is one such circumstance, although that has big implications, which should be explored further. Just because the National Trust for Scotland wants conservation to be retained does not mean that other interests in society will be happy that their land could be saddled with burdens from bodies such as Scottish Natural Heritage, which are to be approved by the First Minister. There will be a big debate about that.

There are other interests, such as the Corstorphine Trust, which has been mentioned already and which I understand is a democratically elected body that owns the superiority of the village of Corstorphine, and housing interests—perhaps Gavin Corbett could address that issue. In other words, there are interests in society that own superiorities or that would be able to use the mechanisms of superiorities to advance not their own individual interests but an interest on behalf of the community. Those people have not had an adequate opportunity to explore the implications of the bill for their interests. They might wake up in a couple of years' time to realise that the functions that they fulfilled in the past—preserving the amenity of Corstorphine, providing for social housing, or whatever—are no longer available to them.

Gordon Jackson: So, you do not think that the way to advance or safeguard the civic interest is through what you call a democratically elected body such as the Corstorphine Trust. Rather, you think that that should be done through democratically elected bodies, such as the Scottish Parliament or City of Edinburgh Council, which have a civic interest in how land is dealt with.

Andy Wightman: Yes, but it is a matter of concern if superiority interests might no longer be available to a body that owns them, although they are not held to benefit the body individually for profit but are held for the benefit of the community as a whole. It would be of particular concern if the body were democratically elected. The matter

goes to the substance of the bill, not the wider issues about protection from the Parliament. The Parliament will have to ensure that the implications of burdens that are being conserved—and, possibly, those that are not being conserved—are fully explored. Our argument is that they have not been fully explored, as the consultation process has been inadequate.

Jim Lugton: I wish to echo what Andy said in respect of one aspect of the bill. A confusing series of statements and information has been released on the consequences of the bill for the udal system of landholding in parts of Shetland.

The Deputy First Minister was inconsistent when he said, in reply to a question from Mike Watson:

"The proposed legislation will also abolish some other archaic forms of land tenure and types of payment. It will not, however, abolish udal tenure, which is already non-feudal."—[*Official Report, Written Answers,* 30 June 1999; Vol 1, p 29.]

Subsequently, in paragraph 211 of the memorandum to the bill, which deals with section 70 on interpretation, we were told:

"The definition expressly includes land which was not actually held on feudal tenure but which because of its nature might have been (for example, ground owned under udal law)."

Despite those two statements, we find in part 1 of schedule 11 to the bill, that the Udal Tenure Act 1690—

The Convener: Mr Lugton, please could you give more specific references? You talked about a previous statement by Jim Wallace, for example.

Jim Lugton: I can provide that.

The Convener: That would be useful.

Jim Lugton: In part 1 of schedule 11 to the bill, on general repeals, we find the proposal to repeal the Udal Tenure Act 1690. Those three statements are not consistent.

Tricia Marwick: Can I take up Andy Wightman's invitation to bring in Gavin Corbett of Shelter? Perhaps Gavin can outline Shelter's concern and interest in the bill.

Gavin Corbett (Scottish Land Reform Convention): We have some questions about the process. Our organisation was not one of those that received a letter from the Executive about the bill, and that puzzled me.

Andy Wightman referred to burdens. It is unclear why the bill specifically includes conservation burdens, when there has been a lively debate in the past 15 years—particularly in rural areas—about ensuring that much-needed affordable housing is maintained as a public asset. I am talking not about adverse consequences, but about the potential of the land tenure system. There is a distinction between housing in an open market and housing for social need. I would have hoped that we could talk about that as part of this process. We might consider a burden related to social housing. That is not adequately covered by the current planning and financial systems. That potential has not been fully explored, and I am not clear when it will be.

Tricia Marwick: Do you think that part of the problem was the admission that the convener managed to extract at the previous meeting, that there is a series of bills: one is the Abolition of Feudal Tenure etc (Scotland) Bill and the other is a bill on title conditions, which is yet to come? Professor Rennie advised us that it would have been more beneficial for the committee to consider the two bills together. Perhaps some of the concerns of Shelter and other organisations will be addressed when we consider the second bill.

Gavin Corbett: I do not envy the committee's task in considering real burdens reform, tenement law reform—another aspect of this subject—and a complicated set of proposals. It has not been the easiest process with which to engage. That is in marked contrast to the consultation process on the land reform white paper, which I know the committee will be considering later. There has been a thorough engagement with that matter.

I do not want to suggest that everything that the committee is considering is wrong—the bill is thorough and much research has gone into it. However, some areas need to be considered more thoroughly, and feudal burdens are an example of that.

The Convener: That is one of the points which I wanted you to address in more detail. The concern expressed by members of the committee last week was that we were doing one part of a much larger jigsaw. The extent to which each of the subsequent pieces of legislation will impact on this one had not been fully appreciated by any of us. Considering the bill will be difficult. Without knowing what future legislation will contain, we cannot be certain that we are using our time effectively. We might be wasting time in being concerned about things that will be fixed. We are struggling with how to deal with that.

We have had a fairly detailed second submission from Land Reform Scotland as a result of the evidence that was heard at the committee meeting last week. Do you have any comments on that? I appreciate that it is not your evidence. You will know that we heard from Professor Rennie last week, and that he said that there is no public interest under the feudal system.

12:30

The issue that has been at the core of some of

the submissions—including the one from Shelter—is that we should explicitly retain a reference to the public interest, in a way that is most appropriate. Professor Rennie was clearly of the view that that was an interesting idea, but that the feudal system itself was not about the public interest. Land Reform Scotland has indicated that other authorities counter Professor Rennie's opinion. Unfortunately, in its submission, it does not tell us who those other authorities are.

This question is probably best addressed to Andy Wightman. Are you aware of other authorities? I am a lawyer and, to me, other authorities means something specific. Land Reform Scotland may be using a different context. Will Andy comment on what Land Reform Scotland is saying about Professor Rennie's opinion that there is no public interest under feudal tenure?

Andy Wightman: The professor's statement was a matter of opinion. As I hinted earlier, I have problems with the conveyancing profession.

The Convener: Don't we all.

Andy Wightman: I have problems with the conveyancing profession commenting on matters that are much wider than conveyancing. That is not to criticise Professor Rennie's obvious professional competence in the area. I am not legally trained either, so I do not presume that I have any specialist knowledge on the topic. However, Robin Callander, who gave evidence to the committee last week, has spent the past four or five years doing detailed research into the nature of the public interest in land and has published a book on the topic. It sets out a number of arguments, which have not been countered by anybody in the legal profession, and which highlight that for decades—perhaps centuries—the system of land tenure has not been subject to scrutiny beyond a narrow class of those involved in conveyancing property within that system and covered by it. The debate about the nature of the public interest in land has been dead for a long time.

Dr Blount: Within the convention, we have spoken about the possibility of getting a QC's opinion or a similar legal basis for the case. We feel that it is not an appropriate role for us in the process to get legal opinion on one side of the debate, or the other. What we are saying is that the public interest must be safeguarded. It does not appear that anybody from the Executive can tell us what is being abolished in terms of the Crown's role as paramount superior. It therefore seems to be illogical to be so enthusiastic about having it abolished.

The Convener: It is worth emphasising that at this stage of the bill we are, as a committee, required to draft a report on its principles. That will go to the Parliament and will inform the stage 1 debate. The bill will come back to us for a lengthy and detailed line-by-line process, which is where specific amendments will be debated.

We are saying to all witnesses that, whatever you feel your remit might be at the moment, if it becomes necessary in your view to propose specific amendments, they can be introduced via sympathetic MSPs, whose name will have to be added in support of them. It is open to you for weeks, if not months, to consider the more specific issues. Our report must be on the principles. It has sometimes proven difficult to remember that, because members want to dive into a specific discussion about a potential amendment, which is not what we should be doing at this stage.

Do any members have further questions that they wish to ask of these witnesses at the moment?

Members: No.

The Convener: I thank the witnesses for coming. You are free to do what Land Reform Scotland has done and give us another written submission on the basis of the evidence so far. We are reading those submissions and absorbing the various points.

Thank you for coming; you will no doubt follow the issue with interest.

I have already indicated what will happen next week. We have rejigged the agenda and will have further discussions on the prisons issue as we have found space for that.

In the next few days, I hope that members will get a copy of the first draft report on the Adults with Incapacity (Scotland) Bill. The input of the Health and Community Care Committee is yet to come, but by next week members will have a draft report before them. We will work through that as well.

Meeting closed at 12:35.

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