JUSTICE AND HOME AFFAIRS COMMITTEE

Tuesday 29 February 2000
(*Morning*)

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JUSTICE AND HOME AFFAIRS COMMITTEE

8th Meeting 2000, Session 1

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Gordon Jackson (Glasgow Govan) (Lab)

COMMITTEE MEMBERS

*Scott Barrie (Dunfermline West) (Lab)
*Phil Gallie (South of Scotland) (Con)
*Christine Grahame (South of Scotland) (SNP)
*Mrs Lyndsay McIntosh (Central Scotland) (Con)
*Kate MacLean (Dundee West) (Lab)
*Maureen Macmillan (Highlands and Islands) (Lab)
*Pauline McNeill (Glasgow Kelvin) (Lab)
*Michael Matheson (Central Scotland) (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)
Iain Gray (Deputy Minister for Community Care)
Angus MacKay (Deputy Minister for Justice)
Dr Richard Simpson (Ochil) (Lab)
Mrs Margaret Smith (Edinburgh West) (LD)

CLERK TEAM LEADER

Andrew Mylne

SENIOR ASSISTANT CLERK

Shelagh McKinlay

ASSISTANT CLERK

Fiona Groves

LOCATION

The Chamber

Scottish Parliament

Justice and Home Affairs Committee

Tuesday 29 February 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:31*]

Adults with Incapacity (Scotland) Bill: Stage 2

The Convener (Roseanna Cunningham): Good morning, everybody. I see that today, everybody really means everybody. I welcome the Executive team and the ministers. The ministers are clearly anticipating—

The Deputy Minister for Justice (Angus MacKay): We have brought our big brothers with us today.

The Convener: So I see. [*Laughter.*]

I also welcome to the meeting Margaret Smith, Dorothy-Grace Elder, Dr Richard Simpson and Malcolm Chisholm from the Health and Community Care Committee. The members of that committee will be able to speak if I call them, but will be unable to vote. I hope that they will not stick their hands up at inappropriate moments.

I wish to make one or two comments before we start this morning's proceedings. We are all aware that a certain amount of controversy has arisen in connection with this part of the bill. Along with many other members, I have read some fairly alarmist pieces in various newspapers.

I say, on behalf of committee members, that every single one of them knows perfectly well what the arguments and the issues are, and what people's concerns are. Indeed, all of us have been deluged with letters and with proposed amendments from a variety of individuals and organisations, which are basically trying to argue to the same end but from wholly contradictory positions. That does not make the job of members any easier.

Whatever decisions are arrived at this morning in respect of individual amendments, I know that, on the basis of all the information that they have, committee members will have given careful thought to what their position is. I hope that this morning's debates are dealt with as calmly and as rationally as possible, and that the subsequent reporting is as calm and as rational as possible.

These are not easy issues. The arguments that are being put to committee members, although quite contradictory, claim to try to achieve the same ends. That makes the individual positions of those members very difficult indeed.

I exclude the article in *The Herald* yesterday by my deputy convener, Gordon Jackson, from my comments about the reporting of this issue. Gordon has set out fairly the difficulties that face the members of this committee and which will, ultimately, face all MSPs, who are having to deal with issues that are not particularly easy and that are being argued from entirely contradictory points of view.

Section 44—Authority of persons responsible for medical treatment

The Convener: I call amendment 309, which is an Executive amendment. If it is agreed to, a number of other amendments—118, 156, 157 and 158—will not be called, because it will pre-empt them. Amendment 309 is grouped with amendment 118 in the name of Phil Gallie and Executive amendments 313, 315, 316, 328, 329, 330, 320 and 321.

The Deputy Minister for Community Care (Iain Gray): Thank you for your helpful introduction to this morning's work, convener.

This group of amendments makes significant improvements to section 44 of the bill as introduced. The whole bill is about helping people who, for one reason or another, cannot participate in decision making about their own affairs. The general authority to give medical treatment lies at the core of part 5 of the bill. For the first time, it clarifies the legal position concerning consent to treatment for adults with incapacity and all those who care for them, including doctors, nurses and other health staff.

As the convener said, we all know that there are those who have fears about this bill. One fear is that the bill opens the way to what has been called passive euthanasia. In fact, nothing could be further from the truth. The Scottish Executive has no plans to change the law in respect of euthanasia. An act of euthanasia—that is, where the injuries were not self-inflicted—would be regarded as the deliberate killing of another and would be dealt with in Scots law under the criminal law of homicide. Doctors and nurses are bound both by the law and by their professional ethics not to harm patients under their care.

Those who disagree with the proposals in the bill have suggested that the general authority to treat may lead doctors to refuse life-supporting measures to patients, where they believe that this will not benefit them. However, to suggest that is to confuse the general provisions of the bill, which are about helping and healing adults with incapacity, and common law—two entirely different matters.

Three salient features about the general authority to treat have to be clearly understood. I refer to section 44 as amended, in particular by amendment 309. The first is that the general authority brings clarity about the consent arrangements concerning medical treatment for adults with incapacity for the first time—that is, to whom and how the consent confers the authority.

The second feature is that treatment must be under the authority of the medical practitioner primarily responsible, who must ensure that it conforms to the general principles of the bill. That means that it must benefit the patient, that it must be the least restrictive option available and that the views of those close to the patient must be taken into account.

The third important feature is that the treatment must be designed to safeguard or promote the physical or mental health of the adult. Let me dwell on that for a moment. Amendment 309 quite specifically says that the medical practitioner is authorised

“to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult.”

That is the extent of the authority conferred. There is absolutely nothing in this section that gives authority to do anything that would deprive the adult of life.

Let me go further. The amendment expressly states, in subsection (1A), that the authority given by section 44 is

“without prejudice to any authority conferred by any other enactment or rule of law.”

The practical effect of this is that the common law position relating to patients in a persistent vegetative state, established in the judgment in the Law hospital case, stands and is not superseded by this bill. The bill is about helping, not harming, adults with incapacity. I hope that the committee will be reassured by what I have said.

Amendment 309 improves the drafting of the bill in ways that emphasise those features. It requires the person responsible for treatment to be a medical practitioner and it extends the authority to treat only to those acting under the instructions of, or with the approval or agreement of, that practitioner. It makes clear, as I have said, that the bill does not cut across other statutes or indeed the common law. The amendment also brings the definition of incapacity into line with the definition used in other parts of the bill that have already been considered.

I believe that part 5 as a whole brings major benefits to adults with incapacity in Scotland. I hope that the committee will approve this amendment, which improves the way in which part 5 works.

Phil Gallie’s amendment 118 provides that the person who assesses and certifies incapacity for the purpose of authorising medical treatment must be a medical practitioner. I hope that Mr Gallie will accept that amendment 309 achieves the result that he wants and that he will therefore agree to withdraw his amendment.

Splitting the former section 44(1) into three, as amendment 309 does, will require consequential technical amendments to references to section 44(1). Those are Executive amendments 313, 315, 316, 328, 329 and 330. Amendment 320 makes a change to section 46 consequent on amendment 309. It replaces the phrase, in section 46,

“the person responsible for the medical treatment of the adult”,

with the phrase introduced by amendment 309,

“the medical practitioner primarily responsible for the medical treatment of the adult”.

Amendment 321 clarifies and makes explicit the fact that the bill does not affect the common law authority to treat a patient in an emergency. That authority remains in place, even if the emergency occurs while there is a court application for a relevant intervention or guardianship order pending, when the general authority is otherwise disapplied.

I hope that the committee will agree that the bill is improved by including an explicit statement that the terms of the bill do not override the common law.

I move amendment 309.

Phil Gallie (South of Scotland) (Con): I thank the minister for his comments with respect to adding the term “medical practitioner”. That meets the needs of my amendment. However, without intending to nit-pick, I ask him to define medical practitioner.

Iain Gray: My understanding of medical practitioner is that it usually includes nurses and so on, but not dental practitioners.

Phil Gallie: Thank you.

Christine Grahame (South of Scotland) (SNP): In general, I welcome this amendment. However, I wish to draw the minister’s attention to something from the Law Society of Scotland, which I am sure that he has seen. It relates to the amendment in section 44 regarding the issuing of certificates. Have I jumped the gun here?

Iain Gray: Yes.

Christine Grahame: I am sorry. I have jumped the gun. We are coming to that in the next bit. It is an easy mistake to make.

The Convener: Nobody else has indicated that they wish to speak on this amendment. Phil Gallie has not indicated what he wishes to do with his amendment.

Phil Gallie: I will not move amendment 118.

Amendment 309 agreed to.

The Convener: Amendment 118 falls and we go straight to amendment 310, which has already been debated with amendment 156. This is where it will get confusing.

I now call the minister to speak to Executive amendment 310, which is grouped with amendments 159, 311, 119, 160, 161, 162, 164 to 169, 171 to 178.

09:45

Iain Gray: Am I to understand that amendments 156, 157 and 158 fall because amendment 309 has been agreed to?

The Convener: Yes. Those amendments all fall, so we jump straight to amendment 310. We shall have to work our way through this quite carefully.

Iain Gray: Do amendments 159, 160, 161, 162, 164, 165, 166, 167, 168 and 169 still stand?

The Convener: Yes. They are grouped with amendment 310.

Dr Richard Simpson (Ochil) (Lab): Why was amendment 156 not grouped with amendment 309? It has now fallen and, although I do not intend to move it, I wanted to make a point.

The Convener: It was grouped with amendment 309. I mentioned that it would be pre-empted when we discussed that group.

Dr Simpson: It did not appear with amendment 309 on the grouping list published this morning.

The Convener: Amendment 156 is pre-empted by the fact that 309 has been agreed to, and will therefore not be called.

We move straight to amendment 310. Have you caught up with me, minister?

Iain Gray: I think so, convener. The Executive appreciates the concern that underlies those of Dr Simpson's amendments that are still part of the group that we are discussing, which seek to recognise the importance of the parts played by all the members of the team in caring for the adult with incapacity. However, we believe that the proposed distinction between "medical" and "clinical" will not now be necessary.

Under Executive amendment 311, the existing definition of medical treatment will be considerably simplified to cover

"any procedure or treatment designed to safeguard or promote physical or mental health".

That will cover procedures or treatment carried out by any or all of the members of the health care team under the authority of the medical practitioner primarily responsible for treatment. It implies full consultation and discussion among all members of the health care team prior to decisions being taken. Given that assurance, I hope that Dr Simpson will accept that input from all members of the team will be needed, and will on that basis decide not to move his amendments.

Amendment 311 gives effect to the undertaking that the Executive gave at stage 1 to revise the definition of "medical treatment" to omit any reference to nutrition and hydration by artificial means. Instead, the definition is now given a much more positive ring by characterising medical treatment as

"any procedure or treatment designed to safeguard or promote physical or mental health".

We believe that the amendment will help to underline the fact that the bill is designed to help rather than to harm adults with incapacity.

I hope that the committee will agree to amendment 311. If it is agreed to, Mr Gallie's amendment 119 would not be required, as the specific reference in the definition of medical treatment to

"ventilation, nutrition and hydration by artificial means"

will have been removed. I hope that Mr Gallie will therefore agree not to move amendment 119.

Executive amendment 310 applies that revised definition of medical treatment to the whole of part 5. We believe that the present drafting of the bill is confusing, and the amendment is designed to ensure that the phrase "medical treatment" applies consistently throughout part 5.

I move amendment 310.

Dr Simpson: My amendments substituting "clinical" for "medical"—a change originally suggested by the Royal College of Nursing—sought to change the emphasis from a purely medical one to a clinical one. I lodged those amendments based on subsection (2) as originally drafted, which endeavoured to make a number of definitions that—with the possible exception of paragraph (c)—were not all-embracing. I welcome the Executive's proposed changes, as they broaden the definition substantially. I am therefore happy to withdraw my amendments, or to let them fall or be cancelled out as the convener decides.

Phil Gallie: I welcome the minister's comments. Everyone has speculated about the removal of ventilation, nutrition and hydration. Executive amendment 311 removes the emotive element, and I am therefore happy not to move amendment 119.

The Convener: Amendments 171, 172, 173, 174, 175, 176, 177 and 178 in this group are in the name of Dr Simpson. Do you want to speak to them?

Dr Simpson: No.

The Convener: Amendments 160, 161, 162, 164, 165, 166, 167, 168 and 169 are also in your name.

Dr Simpson: They all substitute "clinical" for "medical" and are therefore consequential. I shall therefore not speak to them.

Amendment 310 agreed to.

Amendment 159 not moved.

The Convener: If amendment 311 is agreed to, amendment 119 cannot be called.

Phil Gallie: I do not intend to press amendment 119 in any case.

The Convener: That is right. I would like to make it quite clear that this business of pre-emption will happen throughout part 5.

Amendment 311 moved—[Iain Gray]—and agreed to.

The Convener: Amendment 180 is in the name of Margaret Smith and supported by Dr Simpson.

Mrs Margaret Smith (Edinburgh West) (LD): This amendment picks up on the fact that, in the bill as originally drafted, the duration for a certificate is only a month. Members of the Health and Community Care Committee felt that that was not sufficient time for situations of degenerative illness and chronic incapacity. Other groups, such as Alzheimer Scotland—Action on Dementia and the Mental Welfare Commission, also raised the issue. Those members of the health committee who are here this morning are happy not to move amendment 180 in the light of Executive amendment 312, which we think is an improvement on the original draft.

Amendment 180 not moved.

Angus MacKay: Amendment 312 seeks to bring greater flexibility to the process of certifying incapacity. As introduced, the bill allowed for certificates of incapacity to be valid for up to one month. The Executive has listened to representations from doctors whose task it will be to issue such certificates. We now agree that it would be unduly cumbersome for doctors to have to issue a new certificate every month in the case of patients with long-term incapacity. The amendment gives doctors greater discretion in the duration of certificates, which it allows to be valid for up to a year. That change is intended to minimise the time spent filling in forms and to maximise the time available for treating patients.

I would like to say a word or two about the point that I think Christine Grahame was trying to address earlier. Although amendment 312 increases the period of certificates from one month to one year, it also, in subsection (3A), allows a doctor to revoke a certificate and to

> "issue a new certificate specifying such period not exceeding one year from the date of revocation of the old certificate as he considers appropriate to the new condition or circumstances of the adult."

The Executive intends that the issue of any new certificate would require a fresh assessment of the patient, just as revocation would. I assure members that we would make that clear in the codes of practice that are to be issued under the bill. We will also ensure that it is a requirement in regulations.

We think that it would be unduly onerous for doctors to have to apply to the court in every case in which the total duration of the certificates would exceed one year. The new appeal provision, which we will attempt to introduce through amendment 333 later this morning, will allow anyone with an interest in the adult to appeal to the sheriff if they have concerns that a certificate is of too long a duration or have any other concerns connected with certificates.

I move amendment 312.

Christine Grahame: I am not quite clear how a fresh assessment is to be made. As you know, the Law Society felt that, if there was to be an extension for a further year by the practitioner, there should be an application to the court to show why the circumstances had changed. Perhaps you could clarify that.

The Law Society also suggested that section 44(3A) should state that a certificate should be issued only for as long as is necessary in the circumstances. I think that that observation has some merit, and would welcome your comments.

Angus MacKay: Where reasonable, we would seek to avoid recourse to the court by doctors if at all possible. Under the amendment that we are proposing, the requirement to re-examine at the point of extension or renewal of certificates addresses that point.

What was your second point?

Christine Grahame: My second suggestion was that the legislation should state that the certificate should last for only as long as is necessary in the circumstances, rather than for a year.

Angus MacKay: We regard that point as redundant, given that the certificate would be predicated upon a medical examination, which would of itself dictate what was required.

Christine Grahame: You say that there would have to be a further assessment, but who would monitor that assessment?

Angus MacKay: The amendment and the recommendations would make it a matter for the medical practitioner concerned to carry out the evaluation or assessment of the patient. That is open to challenge at any time. Under amendment 333, there is a power to challenge issues of this sort at any time. If there is any uncertainty or concern about a second, third or subsequent evaluation, it is open to challenge.

Christine Grahame: When will we see draft regulations?

Angus MacKay: They will be published in the summer.

Amendment 312 agreed to.

Amendment 313 moved—[Angus MacKay]—and agreed to.

The Convener: I call Margaret Smith to speak to amendment 181, which is grouped with amendment 182 and Executive amendment 314.

Mrs Smith: Our amendments are straightforward. The Health and Community Care Committee feels that it is necessary to add further safeguards by adding "reasonable" and to set some boundaries to the use of force by including—as amendment 182 proposes:

"to avoid serious harm to the adult or to others".

We are picking up on comments made by the secretary to the Millan committee and by the Mental Welfare Commission. Our proposed changes would strengthen safeguards and protect the human rights of the adult involved.

Angus MacKay: The Executive understands that amendment 181 attempts to restrict the degree of force that can be used in caring for or treating and adult with incapacity. However, we do not consider the amendment to be necessary in practice.

Section 44(4) limits the use of force to only that which is necessary in the circumstances. In addition, the general principles in section 1 provide that any intervention in the affairs of an adult should be the least restrictive necessary to achieve the desired purpose and for the adult's benefit. They apply equally to any physical intervention under section 44(4) and would govern any proposed use of force or detention, such as administering necessary treatment to an adult. Those principles, as applied to that type of intervention, would ensure that only the minimum force necessary could be used, and that any restraint or detention would be the least necessary in the circumstances.

10:00

Amendment 182 seeks to restrict section 44(4)(a) by introducing two new elements: first, that force or detention may be used only when it is necessary to prevent the adult seriously harming themselves or, secondly, to prevent serious harm to others.

The Executive's view is that doctors must be able to use some force or restraint when a patient resists necessary treatment. The general principles make clear that any intervention must be for the adult's benefit and that it must be the least restrictive possible. On that basis, it is clear that force or restraint can be used only when it is absolutely necessary and when no other intervention can be used.

The test of serious harm that would be introduced by amendment 182 is therefore unnecessary and arguably would erode the principles set out in section 1, which the committee has already approved.

It is worth stressing that the whole point of the bill is to provide protection for the adult with incapacity. When there is likely to be a risk of harm to others, we believe that it might be appropriate to use other powers, such as the Mental Health (Scotland) Act 1984, formally to detain the adult. Introducing the concept of preventing harm to others would significantly extend the purpose of the bill.

I hope that the committee will be reassured by that explanation and that Mrs Smith will feel able not to press her amendments.

The Convener: Nobody else has indicated that they wish to speak. Margaret, do you wish to move your amendment?

Mrs Smith: I think that I have a lack of consensus in my committee's group.

We will let our amendments ride, if that is okay with you, convener.

The Convener: Are you insisting on your amendment?

Mrs Smith: Yes.

Amendment 181—[Mrs Smith]—moved.

The Convener: The question is, that amendment 181 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Euan Robson (Roxburgh and Berwickshire) (LD)

AGAINST

Scott Barrie (Dunfermline West) (Lab)
Roseanna Cunningham (Perth) (SNP)
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)
Michael Matheson (Central Scotland) (SNP)

The Convener: The result of the division is: For 1, Against 10, Abstentions 0.

Amendment 181 disagreed to.

Amendment 182—[Mrs Smith]—moved.

The Convener: The question is, that amendment 182 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

AGAINST

Scott Barrie (Dunfermline West) (Lab)
Roseanna Cunningham (Perth) (SNP)
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)
Michael Matheson (Central Scotland) (SNP)
Euan Robson (Roxburgh and Berwickshire) (LD)

The Convener: The result of the division is: For 0, Against 11, Abstentions 0.

Amendment 182 disagreed to.

The Convener: Amendment 314 has already been debated with amendment 181.

Amendment 314 moved—[Angus MacKay]—and agreed to.

The Convener: Amendment 315 has already been debated with amendment 309.

Amendment 315 moved—[Angus MacKay]—and agreed to.

Amendments 160 and 161 not moved.

Amendment 316 moved—[Angus MacKay]—and agreed to.

The Convener: We now move to amendment 317, in the name of Jim Wallace, which is grouped with amendment 318, also in the name of Jim Wallace, and amendments 163, 170 and 179, which are in the name of Dr Richard Simpson.

Iain Gray: Amendment 317 recognises that the simple reference to "the Sheriff" in section 44(6) in the initial draft is not sufficiently wide. It would unnecessarily circumscribe the range of safeguards for the treatments to be excepted from the general authority under section 44, which will be set out in regulations under section 45. The regulations may provide for decisions on particular treatments to be determined by the Court of Session. The amendment would give the desired flexibility. Amendment 318 is largely technical and makes explicit that the bill does not, in these instances, affect the common law authority to treat the patient in an emergency.

Dr Richard Simpson's amendments 163 and 170 seem to be based on a reasonable concern that, when it is necessary to give emergency treatment, such treatment must be given. In fact, a doctor has a professional duty of care obliging him to provide treatment to a patient when necessary. As nothing in the bill alters that, the Executive believes that the two amendments are unnecessary. I believe that Dr Simpson's third amendment, amendment 179, is covered by subsection 7 of Executive amendment 322, which will be debated later with the group headed "Medical treatment where guardian etc has been appointed".

In the light of my comments, I hope that it will be possible for Dr Simpson to withdraw his amendments.

I move amendment 317.

Dr Simpson: Although I accept the minister's point, I see no reason why it should not be reinforced by changing the word "may" to "shall". Many witnesses who gave evidence raised concerns about whether the practitioner will act. Although I agree that the practitioner should act, the word "may" is permissive, whereas I propose that the practitioner "shall" act. That does not override part 1, which stipulates that doctors must act in a manner that does not harm the adult with incapacity. My amendment would require the doctor to act; it does not give him the option to do so, unless it is harmful to the adult. As a result, the balance of such a decision is moved closer to those who have considerable concerns about delays in action which cause deterioration.

Gordon Jackson (Glasgow Govan) (Lab): Although I appreciate the point behind Richard Simpson's amendment, it tries to achieve something different from the aims behind the bill. There might be a place for a bill that tells doctors what they should do, but this bill authorises certain actions in respect of incapable adults and authorises doctors to do what they would normally do—make a decision about whether treatment is appropriate and act on it. If we put a compulsitor on the doctor, we move into a totally different area of medical ethics and law, which is not the aim of the bill.

Dr Simpson: In most circumstances, I would accept Gordon's point, but we are dealing with a very precise situation in which the treatment is not designed for the long-term management of the patient, but specifically for the preservation of the adult's life and the prevention of serious deterioration in his or her medical condition while a decision is being made and other parts of the act are coming into being. Although I would not normally wish to instruct doctors, I think that such instruction is required in these circumstances.

Euan Robson (Roxburgh and Berwickshire) (LD): My concern is that "may" introduces an element of doubt. Perhaps the Executive could expand on that point.

The Convener: Can you expand on that, Euan, so that everyone else understands your point?

Euan Robson: I might have got this wrong, but my point is that "may" instead of "shall" gives the appearance of some discretion, yet there is a compulsitor—to use Gordon's word—in common law. Does not that suggest a difference between the two forms of legislation? Could not that lead to some confusion? That is the point I am trying to make—perhaps somewhat inarticulately.

Dr Simpson: It is a very valid point.

Iain Gray: The arguments have been well made and the intention behind them is certainly sincere. Although Euan Robson's point is important, it argues against his own case. We believe that changing "may" to "shall" would impinge on the common law position, which we have tried to avoid. The combination of the common law requirement and the professional duty of care already exists, and obliges doctors to undertake emergency treatment to preserve life. That is done in a way that preserves professional judgment. We should be clear that such provisions apply in these circumstances, and go no further by changing the extant general position.

Dorothy-Grace Elder (Glasgow) (SNP): Can I just make a comment, convener?

The Convener: Please indicate that you want to speak, Dorothy, before you start speaking.

Dorothy-Grace Elder: The word "shall"—

The Convener: I will call you to speak, Dorothy, if you indicate that you wish to do so by raising your hand. Can you do that in the first place, please?

Dorothy-Grace Elder: I will raise my little hand, convener.

The word "may" is an unclear word, Mr Gray, and "shall" is absolutely clear. When we consider the type of patient with which we are dealing, the public would feel more secure with the use of a stronger word.

Maureen Macmillan (Highlands and Islands) (Lab): I think that we are getting into semantics here. The word "may" gives the doctor permission to give treatment, even though court proceedings are in progress, and does not refer to whether the doctor might treat the patient. The doctor might have questioned whether he could give treatment if it was subject to court proceedings.

Gordon Jackson: I agree with Maureen Macmillan. The word "may" is not inexact when it confers the authority to act on doctors, which is what the bill is doing; it does not prescribe the treatment that adults should receive. I do not think that changing "may" to "shall" helps in this respect.

The Convener: No other members have indicated the wish to speak on this subject. Richard, do you wish to come back on any comments before we formally deal with the amendment?

Dr Simpson: The arguments before the committee are clear. The word "may" confers authority; the word "shall" places a requirement on the doctor, subject to the usual tenets of not harming the person, which is already dealt with by part 1. I feel that the stronger term is more appropriate in this case.

Amendment 317 agreed to.

Amendment 162 not moved.

10:15

The Convener: We move now to Executive amendment 318. I point out that if amendment 318 is agreed to, amendments 163 and 164 will be pre-empted and will not be called. They will simply fall.

Amendment 318—[Iain Gray]—moved.

The Convener: Is amendment 318, which was debated with amendment 317, agreed to?

Phil Gallie: No. I want to give Dr Simpson's amendments a chance.

The Convener: There will be a division.

FOR

Scott Barrie (Dunfermline West) (Lab)
Roseanna Cunningham (Perth) (SNP)
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)

AGAINST

Phil Gallie (South of Scotland) (Con)
Michael Matheson (Central Scotland) (SNP)
Euan Robson (Roxburgh and Berwickshire) (LD)

The Convener: The result of the division is: For 8, Against 3. Abstentions 0.

Amendment 318 agreed to.

Amendments 165 and 166 not moved.

Section 44, as amended, agreed to.

Section 45—Exceptions to authority to treat

The Convener: I ask the minister to move amendment 328, which was debated with amendment 309.

Amendment 328 moved—[Angus MacKay]—and agreed to.

The Convener: We now move to amendment 153, in the name of Scott Barrie. I point out that if amendment 153 is agreed to, amendment 319 will be pre-empted and will not be called. Amendment 153 is grouped with Executive amendment 319.

Scott Barrie (Dunfermline West) (Lab): I apologise if members cannot hear me. I am choked with the cold this morning.

Amendment 153 concerns electroconvulsive therapy, psychosurgery and reduction of libido through hormonal implant, all of which are highly controversial and not routine.

A long time ago I inadvertently witnessed ECT being performed. The thought of it will never leave my memory. There is a lot of evidence to suggest that some people have been seriously damaged by ECT, but it is clear that it has beneficial effects for others, although medical opinion cannot indicate quite how it works.

If someone is undergoing such treatment, the concept of informed consent is vital. The amendment deals with people who are unable to give informed consent, which may reduce the legal protection that exists. That would be unfortunate. There is a difference between people who are detained under the Mental Health (Scotland) Act 1984 and those who are not, which may lead to an anomaly. We must clarify the situation.

Psychosurgery and reduction of libido through hormonal implant are other specialised and perhaps controversial treatments. It is our hope that the patient’s consent will need to be given before such treatments are undergone. That is the intention of the amendment.

I move amendment 153.

The Convener: No one else has indicated that they want to speak to the amendment.

I therefore ask the minister to respond and to speak to the Executive amendment.

Iain Gray: The Executive understands the concerns that prompted amendment 153, which Mr Barrie has expressed eloquently, particularly in relation to ECT. We recognise that certain treatments should be excluded from the general authority precisely because they are controversial or, as in the case of psychosurgery, irreversible. Those treatments should be subject to special procedures.

It is possible, as the amendment seeks, to specify in the bill certain treatments or procedures and the safeguards to be applied to them, but medical science can develop rapidly and new treatments can emerge which, though potentially beneficial, merit caution in their application and use. Amending primary legislation each time it was necessary to add or delete a treatment would be cumbersome and unwieldy, particularly if parliamentary time were at a premium. That is why the bill provides for a regulation-making power to specify the treatments that should be excluded from the general authority and the safeguards that should be applied in relation to individual treatments that are excluded. We consider that regulations will provide a more flexible way of proceeding and will enable new and potentially controversial treatments to be added without the need for primary legislation.

Our initial view is that the regulations should cover ECT, for which a second medical opinion would be required, and psychosurgery, sterilisation and surgical implantation of hormones, for which the approval of the Court of Session would be required. However, I emphasise that it is the Executive’s intention to await the Millan committee’s views on what the excluded treatments should be. That is another reason not to prescribe treatments in the bill.

Other views have been expressed. For example, it has been suggested that where drug treatment for mental disorder is given for more than three months, a second opinion doctor, appointed by the Mental Welfare Commission, should approve the treatment and that that should be set out in regulations. We will consider that suggestion carefully. I also note the possible inconsistency in allowing a court to authorise neurosurgery for a non-detained person who cannot consent, but not for a detained patient who cannot consent.

I assure the committee that it is the Executive’s intention to consult fully on which treatments should be regarded as excluded under the legislation as well as on the particular safeguards to be applied in each case. In addition, there will be the opportunity to debate the regulations in Parliament if MSPs so wish. There is no question, therefore, of our seeking to circumvent parliamentary or external scrutiny in this sensitive area.

The ideal situation is, of course, for patients to be able to make decisions about their treatment, but the bill is about those who are unable to do so. While I appreciate the views expressed by Mr Barrie, it is a fact that some patients who are incapable of consenting may be in most need of the treatments. Arguably, they should not be deprived of treatment simply because they cannot consent to it.

For example, a patient with life-threatening depression may be incapable of consenting to ECT, despite the fact that it may help. Detaining such a person under the 1984 act could unnecessarily stigmatise them. However, that is a debate for another day, when the regulations are considered. Our desire now is to put in place a framework to regulate effectively the treatments or procedures to be excluded from the general authority and the safeguards to be applied, which is what section 45 does.

It is also our intention that for patients detained under the Mental Health (Scotland) Act 1984, the consent to treatment for mental disorder provisions in part X of that act should apply where appropriate. Mr Barrie's amendment would remove that protection. I am not clear whether that was the desired effect, but we believe it to be unwise. We do not want to make changes to the 1984 act before we have the Millan committee report.

I hope that those assurances will persuade Mr Barrie to withdraw his amendment.

I will speak briefly to Executive amendment 319, which is required to implement fully our policy intention, as just described, to ensure that patients detained under the Mental Health (Scotland) Act 1984 continue to be treated for their mental disorder under that act and not under the bill.

In short, the general authority to treat and other treatment provisions in the bill will not apply to patients detained under the 1984 act who come within the scope of part X of that act. For clarification, part X of the 1984 act sets out the framework for consent to treatment. Section 45(1) as drafted does not achieve that intention and could leave doubt in the minds of professionals about which provisions apply to a detained patient. The amendment aims to clarify the situation and to ensure that the Executive's policy is achieved properly. I hope that the committee feels able to accept it.

Dr Simpson: No one can doubt the minister's good intentions with regard to placing the three treatments mentioned within the guidelines or regulations, but that fails to recognise the serious concerns about long-standing treatments. The three treatments mentioned are not treatments that have emerged recently; they have remained controversial since they came in, in the case of electroconvulsive therapy in the 1930s and 1940s.

Although I am not too happy with the phrasing of Mr Barrie's amendment because of its effect on the Mental Health (Scotland) Act 1984, I ask the minister to consider inserting, before stage 3, something that indicates that the three treatments mentioned will be in the list if the amendment is withdrawn, thus giving them the emphasis of law in the bill, rather than simply in the guidelines. That would serve to allay the genuine concerns of many patients who have experienced these interventions.

Christine Grahame: The treatments will be encapsulated in regulations, not guidelines, so will have the force of statute. However, we have a difficulty that we have met before in legislation. The minister said that the regulations will be ready in the summer. Will we have the regulations when we debate the bill in the chamber? We need to consider the solid framework of the bill in tandem with the regulations, which contain some quite serious things that people are trying to insert into statute.

We are again faced with the problem of legislation interlocking with the review of mental health treatment. The Mental Health (Scotland) Act 1984 has been mentioned. It may have been superseded by the time the bill comes into force. That is a problem for me. Will the report of the review of mental health treatment be available when we debate the bill in the chamber?

Phil Gallie: Will the minister clarify the role of the welfare attorney? Will the welfare attorney have a say in these treatments? I would feel a lot more comfortable if somebody outside the medical professional were involved in the decision. Many people who have cared for individuals over many years could determine whether a treatment was valid.

I am also a bit concerned about the minister's comment that he is looking to future developments in treatments. Given the controversy that surrounds some of the treatments that have already been described, further controversy may well surround future treatments. We should concentrate on the present. Nevertheless, I have much sympathy with what the minister said.

10:30

Scott Barrie: I am sorry—I did not follow everything that the minister said, so I have some brief questions for clarification.

I would like the minister to repeat his views on my amendment's possible inadvertent effect. Did he say that Parliament, if it wished, could debate the regulations? I understand that Parliament may not necessarily wish to debate them and I must confess my ignorance in such matters. What is the process for holding such a debate? Is the fact that we are awaiting the outcome of the Millan committee part of the reason for holding a separate debate?

The Convener: The Justice and Home Affairs Committee has already debated regulations, and Scott Barrie will remember that negative and affirmative regulations are treated differently. If they are affirmative, they must be debated. If they are negative, there can be a debate if members choose to hold one. We have dealt with negative instruments in the past.

Minister, you have quite a few questions to answer.

Iain Gray: I do indeed, and I will try to address them.

Christine Grahame's response to Richard Simpson's concerns was helpful. We are discussing not guidelines but regulations, which would be subject to secondary legislation and would have the force of law. The primary legislation would not require to be amended. That approach would allow new treatments—or changes to treatments—to be included in the regulations less bureaucratically and more swiftly. Indeed, where thinking on treatments that are included in the regulations has changed to the extent that it is felt that those treatments are no longer permissible at all, the fact that they are included in the regulations would allow such changes to be made more simply than could be achieved if the primary legislation had to be amended. I stress that the regulations would have the force of law.

Christine Grahame asked whether the regulations would be debated at the same time as the later stages of the Adults with Incapacity (Scotland) Bill. I suggest that the regulations are likely to be debated next session—

The Convener: Minister, I think you mean next year. In this Parliament, "next session" means in four years' time.

Iain Gray: Sorry—I meant next year. Therefore, the regulations will not be debated at the same time as the later stages of the bill.

To answer Scott Barrie's final question, one of the reasons is that we believe that the regulations should be discussed and set in light of information received from the Millan committee on the changes that are to be made to the Mental Health (Scotland) Act 1984. I repeat the undertaking that was given by the Executive during the stage 1 discussions. We are aware that changes to that act, such as a change to the definition of mental disorder, may have an impact on the Adults with Incapacity (Scotland) Bill. The Executive has undertaken to amend the bill on that basis, rather than delay the bill by awaiting the Millan committee's report and subsequent changes to the 1984 act. The points made by members are fair—the timetable is probably not what we would have designed in an ideal world, but we must deal with it.

The convener is correct: the regulations will be negative instruments, so it will be for the Justice and Home Affairs Committee to decide whether they should be debated. It appears from today's discussion that the committee is likely to want such a debate.

On Phil Gallie's point about the role of the attorney, my understanding is that that could be included in the regulations. The regulations will set out those treatments that are excluded from the general authority and the additional safeguards that are required, such as a second medical opinion or recourse to the Court of Session. Both might include that consent be obtained from the attorney. Those points could be included in the debate next year.

On treatment developments, I take Phil Gallie's point. I also take Richard Simpson's point that some of the treatments that we are discussing are examples of long-standing treatments that remain controversial. However, that is the point—they remain controversial. Even after the passage of time, it has not been agreed whether such treatments are beneficial; that is a reason for allowing them to be available when there is a likely benefit. I gave the example of life-threatening depression, where we believe that Mr Barrie's amendment would make it impossible for someone who was suffering from that condition to benefit from ECT, even if the clinical judgment was that such treatment was appropriate.

As a further example, fast-moving developments in microsurgery might make available a range of psychosurgical treatments. However, as we do not know yet whether such treatments will become available, the best that we can do—and what we set out to do—is to set a framework that would allow us to take cognisance of such developments quickly, without taking up parliamentary time unnecessarily.

Scott Barrie asked about the unintended consequences of his amendment. The Executive's view is that the amendment would delete most of section 45(1), including that subsection's references to the Mental Health (Scotland) Act 1984, and would therefore remove safeguards from those to whom they apply already.

I hope that I have addressed most of the questions raised by members.

The Convener: There is no guarantee that the regulations would come to the Justice and Home Affairs Committee. It is within the authority of the Parliamentary Bureau to send the regulations to another committee—the Health and Community Care Committee would be most likely. Regardless of which committee the regulations were sent to, it would be open to any MSP to lodge a motion to annul the regulations, in order to trigger a debate. Therefore, even if the Health and Community Care Committee was not minded to debate the regulations, another member could lodge a motion to trigger the debate. The Adults with Incapacity (Scotland) Bill came to the Justice and Home Affairs Committee, so it is assumed that the regulations would also have to come to us, but that is not necessarily the case.

We seem to have exhausted our discussion on amendment 153.

Scott Barrie: Convener, your comments have helped to clarify that the regulations could be debated in future. On that basis, and given the minister's comments that the amendment prejudges the Millan committee's recommendations, I am prepared to withdraw my amendment.

Amendment 153, by agreement, withdrawn.

Amendment 319 moved—[Iain Gray]—and agreed to.

Amendment 329 moved—[Iain Gray]—and agreed to.

Section 45, as amended, agreed to.

Section 46—Medical treatment where there is an application for intervention or guardianship order

Amendment 330 moved—[Iain Gray]—and agreed to.

Amendment 320 moved—[Iain Gray]—and agreed to.

Amendment 167 not moved.

The Convener: Amendment 168—

Dr Simpson: I withdraw amendment 168.

The Convener: Do you mean that you do not wish to move amendment 168?

Dr Simpson: Yes—I will get it right eventually. [*Laughter.*]

Amendment 168 not moved.

The Convener: We now move on to amendment 321. Before calling that amendment, I advise members that this is another example of a pre-emptive amendment. Amendments 169 and 170 cannot be called if amendment 321 is agreed to.

Amendment 321 moved—[Iain Gray]—and agreed to.

Amendments 171 and 172 not moved.

Section 46, as amended, agreed to.

Section 47—Medical treatment where guardian or welfare attorney refuses consent

Amendments 173 to 175 not moved.

The Convener: We now move on to amendment 120, in the name of Phil Gallie, which is grouped with amendments 331, 332 and 322, in the name of the minister, and with amendments 322A to 322D, in the name of Dr Richard Simpson. Given the length of debate that we might have on those amendments, which are likely to generate a fair amount of—

Gordon Jackson: I move that we have a tea break.

The Convener: We may be best to adjourn now for tea and coffee, as we will want to spend more time on this group of amendments.

10:40

Meeting adjourned.

10:57

On resuming—

The Convener: We now move to amendment 120, grouped with amendments 331, 332, 322 and 322A to 322D. It has been pointed out to me that amendments 331 and 332 are in the name of Malcolm Chisholm; amendment 322 is the only one in this grouping in the name of the Minister for Justice, and amendments 322A to 322D—which are amendments to amendment 322—are in the name of Richard Simpson.

Phil Gallie: Amendment 120 seeks to ensure that the basic care of an individual will be continued, irrespective of the decision of someone who could perhaps be seen as something of an unscrupulous character.

I spoke earlier about the important role of welfare attorneys and the amount of effort and love that they put in to individual cases over many years. I am sure that that applies to the vast majority of people who care for the incapable adults, but there could well be unscrupulous people, or people who do not understand fully.

I feel that the well-being of the incapable adult would be best secured by adding the definitions contained in amendment 120, in particular "other than basic care", into the wording of section 47.

Under the bill, medical practitioners might feel that a patient should remain in hospital, but—for whatever reason—someone else might determine, mistakenly, that the patient should be taken away from the care that is available in the hospital to a home that is not fit for someone in their condition.

The amendment aims to deal with such cases. It includes comment on the provision of hydration and nutrition; I make no apologies for that. Earlier I agreed to accept the minister's amendment, which deleted reference to removal of hydration and nutrition, but this section requires a positive comment on that aspect of care.

I addressed warmth and shelter in my comments on hospital care. It would be wrong for a welfare attorney, no matter how well intentioned, to attempt to remove an incapable adult to accommodation that was not suited to their needs at the time. Similarly, if standards of personal hygiene were not being maintained and that was affecting the individual's medical well-being, that would give cause for considerable concern.

I recognise that the minister may not be too happy with my definition of "ordinary treatment", and I would like to hear what he has to say about that. I emphasise that my principal focus is on the basic care element.

I move amendment 120.

11:00

The Convener: Before I call Malcolm Chisholm, I should make the point that amendment 120, and amendment 331—which is in the name of Malcolm Chisholm—are alternatives. Although, strictly speaking, the issue of pre-emption does not arise, if amendment 120 is agreed to, it would not make logical sense to agree to amendment 331.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): At the stage 1 debate, I paid tribute to the Justice and Home Affairs Committee for its outstanding report on the bill. In reminding members of that, I remind them also that after full consideration of the bill they came to the conclusion that section 47 ought not to be changed substantially—certainly not in the direction that is now proposed by the Executive. I attended some of the evidence sessions, and I agree with the the committee's conclusion.

I am reminded of what Dr O'Neill of the British Medical Association said at the committee's meeting on 17 November last year, that

> "we are concerned that the proxy may not have to make clear the basis on which they are refusing treatment."

That is the issue that I am addressing in my amendments. I also remind the committee that Dr O'Neill said that

> "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."—[*Official Report*, *Justice and Home Affairs Committee*, 17 November 1999; c 378.]

Since the committee made its report, the arguments have firmed up in favour of section 47 as it stands, with an amendment to clarify and strengthen it in the right direction.

A large body of opinion is opposed to what the Executive amendment is suggesting. All along, the Executive has tried to work with the Alliance for the Promotion of the Incapable Adults Bill, which is totally opposed to what the Executive proposes.

The letter received from the alliance today supports section 47 as it stands, with only one or two changes. Individual organisations in the alliance take a similar view. I received a letter from Jan Killeen, supporting my position. All members will have received an e-mail from the Scottish Association for Mental Health, supporting my position. Carers groups the length and breadth of Scotland are appalled by what the Executive is proposing on section 47.

Perhaps more surprisingly—it is also important—some of the groups that have been invoked in favour of the Executive amendment are not in fact proposing it at all. The Scottish Council on Human Bioethics had been mentioned in the context of justifying what the Executive has done. I got an e-mail yesterday from Mary Kearns of the Scottish Council on Human Bioethics, who said that the council did not ask the Executive to alter the balance of decision-making power. It asked the Executive to insert safeguards in relation to basic care, palliative care and refusing treatment that causes the death of the patient.

In his amendment, Phil Gallie is trying to insert such safeguards. I support what he says about basic care, but I feel that his definition of ordinary treatment goes too far, because people could claim a wide range of treatments for "ordinary treatment". The point is that proxies must have the right to refuse consent to treatment when they give reasons.

Since the Executive announced its complete U-turn on the issue at the stage 1 debate, the Health and Community Care Committee has been able to take further evidence from Alzheimer Scotland and Parent Pressure, a group of adults who look after adults with severe learning difficulties. The whole Health and Community Care Committee was deeply moved and influenced by their evidence, and I hope that members of this committee have been able to read the *Official Report* of the Health and Community Care Committee's meeting on 26 January. I will quote a paragraph of what was said by a parent of a child with severe learning difficulties:

> "It seems strange to me that I have been entrusted with looking after"

my daughter

> "on a daily basis for 28 years—bathing, lifting, feeding and

medicating her and deciding when a doctor should be called—yet I would have no say when it comes to medication or surgery. That power will be handed over to a doctor who might never have met her. In 28 years, I have seen the often devastating effect of drugs on my daughter. I am the person closest to her in the world; the one who recognises her every change of expression and every sound of pain or pleasure. Doctors do not live with the side effects of powerful drugs—carers and their patients do."—[*Official Report*, *Health and Community Care Committee*, 26 January 2000; c 540.]

That is backed up by much of the other evidence that we have received from organisations in relation to drugs. I am reminded of the written evidence from Alzheimer Scotland, which talked about a common complaint from carers: that their relatives with dementia in nursing homes or in residential care are inappropriately prescribed or over-prescribed neuroleptic drugs to sedate and control behaviour. That practice has been well researched and has been borne out in Scotland.

Just as with parents of adults with learning difficulties, proxies for those with Alzheimer's disease will not in future have any right to say no to such treatment, despite the fact that they know and see the side effects of that treatment far better than does any doctor.

I am also reminded of the letter that we received from the Scottish Pharmaceutical Federation, which mentions the importance of involving patients and carers in the drug treatment administered. The federation says that when people are unable to communicate feelings of discomfort, there is even greater danger that adverse drug reactions will be missed. That is precisely what those closest to adults with incapacity are able to convey. Their rights will be taken away from them if members vote for the Executive amendment today.

In speaking to the Executive amendments to section 44, Iain Gray was adamant that the fears and concerns that people had had about euthanasia were totally misguided. The key words of section 47 are the first, which say that

"Section 44(1) shall not apply"

in certain cases. In other words, section 47 is governed by section 44. If members agree with what Iain Gray said in relation to section 44, there can be no question of proxies being able to force doctors to do things that they do not have the power to do. The letter that we received today from the Alliance for the Promotion of the Incapable Adults Bill says that a proxy cannot refuse treatment if it would mean that the doctor would have to act unlawfully. A proxy cannot refuse basic nursing care.

That has been the illogicality at the heart of the Executive's arguments on section 47. It has argued that change has to be made to reassure those who are concerned about euthanasia, yet, simultaneously, it has said that there are no grounds for concern, because they have been removed by the change to section 44 relating to artificial hydration and nutrition.

If there are still problems, if we still have to insert safeguards, and if we still have to reassure people, let us do it in a general way, by clarifying the law in relation to what either doctors or proxies are allowed or not allowed to do. Let us not do it by attacking proxies, which in many cases means attacking carers who have been looking after people for decades.

We could use the analogy of a parent. A parent has the right to refuse medical treatment for their children. We all know that there are bad parents, but just because there are a few bad parents, we do not take away the rights of parents in general in relation to children and medical treatment. It should be exactly the same with proxies and with guardians. Let us remember that a guardian has to be appointed by a sheriff; any concerns about guardians should be addressed at that stage. Let us remember that welfare attorneys are appointed by an adult when capable. Any of us, at some point in our lives, could want to appoint our wives, husbands or partners as welfare attorneys, yet if members went along with the Executive amendment today, the attorney whom any of us could have appointed would have no rights on our behalf to say no to any medical treatment. That is an appalling and unacceptable scenario.

If any guardian or welfare attorney acts against the best interests of an individual, his or her powers can be reduced or withdrawn; and, of course, in a more serious case, the person could be subject to a criminal charge.

If we go ahead with the Executive amendment, people will not become guardians. That has been stated absolutely clearly by carers who are incensed by the Executive's change to the bill. The Executive's amendment to section 47 undermines the bill, and certainly undermines the Government's general strategy on carers.

Imagine how difficult it would be for many carers to go to court. Doctors have far more of the infrastructure necessary to do that, and there is a safeguard in section 47 for them. It would be far more difficult for carers to go to court, not only for practical reasons, but for financial reasons. Only carers on very low incomes would get legal aid.

I appeal, passionately and sincerely, to members of the committee—and especially to Labour and possibly Liberal Democrat members, who appear to be whipped on the issue—that you should not follow the whip; on an issue such as this, it is completely inappropriate to follow the Executive because you are told to do so. The whole point about the Scottish Parliament is to listen to the evidence of all the groups that come before us. The overwhelming evidence is that we should stick with section 47, with the amendments that I am proposing. If, by any chance, the Executive amendment on section 47 is passed today, it will not be the end of the matter. Not only will it be revisited at stage 3, but it will be taken, I believe, as far as Europe. What is being proposed by the Executive is against article 6 of the European convention on human rights.

Iain Gray: I will talk first about amendment 120, in the name of Mr Gallie. I understand the concerns behind the amendment, and Mr Gallie expressed them—as always—eloquently. It is difficult not to sympathise with them. The amendment intends to offer protection to an adult with incapacity, where a proxy decision maker refuses consent to medical treatment. Bearing in mind the fact that medical treatment will now be defined in the widest way as

> "any other procedure or treatment designed to safeguard or promote physical or mental health",

the intention of the amendment is laudable, but I believe that the amendment is unnecessary and might even, if passed, have an effect that is opposite to that which is intended.

First, the general principles of the bill, which are set out in section 1, make it clear that any intervention—and that includes negative actions as well as positive ones—must benefit the adult concerned. It would be outwith the fundamental principles of the bill if the elementary care that is described in the amendment were to be withdrawn from any adult with incapacity.

Secondly, there is a common-law right—that is not in any way diminished by the bill—for a doctor to give any treatment that he considers necessary in an emergency.

Thirdly, the Executive amendment 322 to section 47 establishes the right of anyone having an interest in the personal welfare of the adult to challenge treatment decisions in the Court of Session.

We believe that those provisions act together to ensure that no proxy will be able successfully to refuse the basic care outlined in Mr Gallie's amendment. Indeed, any proxy who set out to attempt that would lay themselves open to charges of breach of duty and of acting unreasonably. Conversely, those responsible for medical treatment could act with some confidence in ensuring that patients continued to receive basic care, whatever the views of the proxy.

The provision of warmth and shelter requires no contact, and therefore does not require consent. Food and water will be given on the understanding that a serious deterioration in the condition of the patient would result if they were to be withheld. Finally, elementary palliative care can be given in the knowledge that in the extremely unlikely event of a challenge, there may be a good defence in that the action was taken to avoid a greater harm.

11:15

On those counts, the amendment is unnecessary, as provision already exists to ensure that basic support of the kinds listed in the amendment can be given in all circumstances, unless the courts have specifically forbidden it. In due course, guidance will be issued to health care professionals on the medical treatment aspects of the bill. I shall ensure that the published guidance makes clear the Executive's view that basic care as outlined in the amendment is not something that proxies can reasonably refuse.

I draw the committee's attention to section 74, on the offence of ill treatment and wilful neglect. We believe that if the kind of thing that Mr Gallie fears were to happen or be attempted, it would be in contravention of section 74.

Amendment 322 deals with the question of how to treat disputes over medical treatment between a doctor and a proxy. Much debate on that difficult question took place both before and after the announcement at stage 1 that the Executive was to look again at the original section 47, to change the balance in the decision-making process. That commitment was made in response to the evidence and the concerns expressed at the pre-legislative stage. I remember that the Justice and Home Affairs Committee found it difficult to reach a fixed view and also expressed concerns about the original section 47.

We have to accept that it will not be possible to satisfy all interests. Pro-life groups have argued cogently for safeguards to prevent proxies from acting in bad faith by refusing treatment that is desirable for a patient's well-being. On the other hand, we have all received moving and sincere letters from carers and pressure groups—Malcolm Chisholm referred to some of those groups—which have experienced the results of ill-considered treatment decisions in hospitals, and which want the right to overrule a professional decision that might be well meant, but which is unfortunate in effect.

Ministers have met and discussed the issue with those on both sides of the debate. I have personally met several of the groups to which Malcolm Chisholm referred. We have reflected on the issues that have been raised and we understand the difficulty of satisfying all sides. Our proposed amendment seeks to reflect the concern shown by MSPs at stage 1 and the disquiet expressed in many of the representations that we have received on the subject, bearing in mind the concerns of carers.

I do not expect many disputes of this sort to arise. Treatment decisions usually involve discussions among many people, including doctors, nurses, other professionals, proxies, relatives and carers. In almost all cases, disagreements are resolved with good will in the course of such discussions. I am sure that that will continue to be the case. The provisions of the amendment will only rarely be needed.

However, when the amendment is needed, its first effect will be to require a doctor to consult a proxy before reaching a treatment decision. It is not the case that proxies have no right to have their views considered, as Malcolm Chisholm suggested. If the proxy then refuses consent, the doctor is required to seek a second medical opinion from an independent doctor, referred to in the amendment as the "relevant medical practitioner", who is also required to consult the proxy. If the second doctor agrees with the first, treatment may proceed, subject to the proxy's right to challenge the decision in the Court of Session. The same right of challenge is given to any other person with an interest in the personal welfare of the adult, whether or not, after consultation, the proxy and doctor agree.

I repeat that it is not the case that the amendment removes carers' rights. Those rights are respected by the legal requirement, which did not exist previously, for doctors to consult welfare attorneys and guardians. It is not the case that carers will have no rights. The appeal process that we have established also works to help the proxy influence treatment decisions. What is best for the adult with incapacity is at the core of the bill. In the final analysis, we must ask who is more likely to go to the greatest lengths for the incapable adult. Who will consider such decisions important enough to have recourse to the Court of Session—a doctor, or a welfare attorney or guardian? The answer is that it will almost always be the proxy decision maker. I am confident that, in the very few cases that eventually go to court, action will be at the instigation of the proxy decision maker.

While I believe that the provisions are reasonable and workable, at the same time I acknowledge the strongly held views of carers, which have been expressed both in letters and directly in meetings with ministers. Groups such as Parent Pressure, Nucleus Support Services and Voice of Carers Across Lothian believe that the amendment gives too much power to medical interests—Malcolm Chisholm eloquently expressed those fears to the committee. I respect that view, and I respect the experience of the carers, which Malcolm described and which carers have described to me directly.

While I wish medical decisions to remain in the hands of those with medical qualifications, I want to ensure that independent medical opinions are truly independent. One of the concerns expressed to me centres on a lack of confidence in the independence of the second medical opinion, which, in the Executive's amendment, would be sought by the first medical practitioner. For that reason, I welcome Dr Simpson's amendments. He seems to have devised a formula that adds to the role of proxies. Dr Simpson allays fears that the medical mafia—as it is sometimes called—will ignore the views of carers and that an independent medical opinion will not be truly independent.

I must underline two further points. The doctor must make all reasonable efforts to identify and contact the proxy before starting the treatment. If it is reasonable for a doctor to obtain the proxy's consent, yet he fails to do so, he cannot claim the protection of the general authority to treat for any treatment decision that he then makes. Amendment 322 makes it clear, in all the circumstances that it covers, that there is authority for the doctor to give any emergency treatment that is needed.

I believe that amendment 322 offers a practical way of resolving disputes about medical treatment, while allowing the widest reasonable right of appeal. Taken together with Dr Simpson's amendments, which we are happy to accept, amendment 322 offers a fair course to be steered between giving due weight to those with qualifications—the doctors—and giving due weight to those with expertise in the needs of the patient—the carers and guardians. I hope that members of the committee agree that that combination represents the best solution that can be found to a particularly difficult position.

I repeat that I expect appeals to be rare. However, when they occur, the issues might be sensitive and complex. Appeal to the Court of Session will allow a body of case law to develop and will ensure an equitable and consistent approach in all cases. Legal aid will be available, subject to the usual rules. Cost should not deter anyone with an interest in the adult's welfare from making an appeal.

I emphasise that amendment 322 has not been lodged because of any mistrust of proxies, the vast majority of whom show a devotion that we all admire and that was expressed eloquently by Malcolm Chisholm. There is a logic to placing the balance in relation to medical decisions with medically qualified professionals. That is counterbalanced by the fact that the proxy has a right of appeal and that where that right is exercised, the final decision will rest not with the doctor, but with the court, as was the case in the original draft of section 47.

Malcolm Chisholm: Can I break in?

The Convener: That is what happens in Westminster. If you want to speak again, I will put you on the list of members wishing to speak and then call you.

Malcolm Chisholm: I am sorry.

The Convener: That is how this committee has operated.

Iain Gray: I will do whatever the convener decides.

The Convener: Thank you.

Iain Gray: I appreciate Mr Chisholm's helpful endeavour to justify the status quo in the bill. His amendments 331 and 332 require the proxy to give reasons in any case in which consent to medical treatment had been refused. I recognise that that would help identify, in cases of doubt, and perhaps put on record for all to see, why that course of action had been taken by a proxy. It would also help to meet the fears, which are held in many quarters, that proxies—not necessarily out of malice—might not always act in the interests of the adult.

However, I remain of the view that the balance of advantage lies in the procedure that is set out in the Executive amendments, which is reinforced by the constructive additional suggestion by Dr Simpson to involve the Mental Welfare Commission, which I am disposed to accept. I believe that we have now reached an equitable, balanced way forward that has at its core the purpose of the bill, which is the best outcome for the adult with incapacity. I hope that the committee will support Executive amendment 322 and Dr Simpson's amendments.

Dr Simpson: The difficulty that has been raised by all members is that this section tries to deal with people who have a serious condition, such as those who are in a vegetative state, as well as with people who have a circumscribed incapacity, which might be quite small. The amendment also tries to deal with proxies who have cared for a lengthy period for the adult for whom they act, as well as proxies who have no real life experience of an adult.

In evidence to the committee, Sheila McLean told us that studies in America have demonstrated that proxies get the wishes of the adult correct no more than 50 per cent of the time. That was a significant piece of evidence.

Malcolm Chisholm: It is the same for doctors.

Dr Simpson: Malcolm Chisholm has just interrupted with my second point: the studies also showed that doctors got it right on only about 50 per cent of occasions. We are dealing with an extremely complex situation. Equally, the people treating the patient—let us call them doctors for the moment—might have considerable experience of that adult, know them well and have treated them over a long time, or they might be faced with the adult for the first time. The situation that creates the greatest conflict is when the two extremes meet: when the proxy who has a lifelong experience of the adult in their care is faced with the doctor who has no experience of that adult. I do not think that that conflict is adequately resolved even by the Executive's amendments or by my amendments. It is questionable whether it can be resolved.

The purpose of the amendments that I had intended to lodge, which the Health and Community Care Committee discussed, was to promote good practice, to which the minister referred and which is likely to occur in most circumstances. In such cases, the doctor and the proxy agree jointly on the best course of action. I had intended to introduce a second level of mediation or adjudication, rather than a medical second opinion. That mediation would give comfort to proxies who have little trust in the ability of the medical profession to practise the art, rather than the science, of medicine. The greatest conflict will arise when the proxy is aware that the adult in their care has an idiosyncratic response to treatment, but the doctor who does not know the adult argues that the science says that that response should not occur and wishes to proceed with the treatment.

The Executive, in the amendment that it proposes, is sincerely endeavouring to accommodate two almost incompatible points of view. In safeguarding the situation through a second, albeit medical, opinion, the Executive has moved towards the position that the proxies and the majority of the alliance want. My amendments take that a little further by appointing the second medical opinion through an independent group—the Mental Welfare Commission—which should reassure the proxies that someone other than a person in the immediate vicinity of the first doctor will be drawn in to give a second opinion.

However, if Executive amendment 322 and amendments 322A to 322D, in my name, are accepted by the committee, further discussions might need to take place to establish whether there should be a lay element to the second opinion process, which might require further amendments at stage 3. For now, I commend the Executive amendment and the amendments in my name.

11:30

The Convener: Six members have indicated that they want to speak. We will get through everyone if those called keep their comments and questions focused.

Christine Grahame: I accept everything that has been said, including Richard Simpson's comments, and acknowledge the concerns that Malcolm Chisholm expressed very passionately about the attitude of carers. When we consider the wide spectrum of people to whom section 47 will apply, we must go back to the principles set out in part 1 of the bill. That is where flexibility is built in; in the degree of intervention and in the weight given to the various parties when the intervention order is made. Section 1(4)(c)(ii) also provides for account to be taken of the views of

"any person w hom the sheriff has directed to be consulted".

That section must be considered alongside the Executive's proposed amendment to section 47. So doing makes me much more content that we are trying as far as possible to build into the proposed bill enough flexibility to cope with a whole range of situations. Different principles will apply when there is a carer with many years' experience and minimal intervention from those that apply if there is somebody who is less intimate with the incapacitated person and there are emergency circumstances.

I agree also with the safeguards that have been built into Richard Simpson's amendments. Like him and the Law Society of Scotland, I had concerns in cases of dispute about accepting the opinion of a second practitioner, who might not be distant enough from the practitioner who made the first decision. There might need to be further adjustment depending on whether it is a tribunal or a panel of experts that considers the first doctor's opinion in the case of a conflict with the proxy. That would reassure proxy decision makers that there is no conspiracy in the medical profession—the package would include an independent element. They would also be reassured by the fact that, at the end of the process, there is a right of appeal. If any party that claims an interest feels that, notwithstanding the procedures that have been gone through, something is amiss, the court will consider all the circumstances.

Subject to the amendments proposed by Richard Wilson—

The Convener: Richard Simpson.

Christine Grahame: Sorry, Richard Simpson.

Reading this section in tandem with section 1 should alleviate many of the genuine concerns of carers, which to some extent have been the mischief of some of the papers.

The Convener: Richard Simpson does not look that grumpy. [*Laughter.*]

Michael Matheson (Central Scotland) (SNP): I will be brief. Iain Gray referred to the fact that he intends to include a definition of basic care in the guidelines that will be provided when the act comes into force. Does he intend to include the provision of hydration, nutrition, warmth, shelter, personal hygiene and palliative care in the planned definition of basic care? If not, does he think that such provision should be included in the guidelines?

Mrs Smith: I will first pick up on Malcolm Chisholm's points. The bill as introduced gave pre-eminence to the views of the proxies who gave doctors the right to go to court. In doing so, the bill also recognised the role of carers. Iain Gray himself asked who was the most likely to go to the greatest lengths for the adults, and the obvious answer is the carer. However, by taking on the role of proxy, carers have had to go before the sheriff; carers put forward powerful arguments to the Health and Community Care Committee that it was easier for doctors to go to the Court of Session instead. The Parliament is trying to make life easier for carers, and amendment 322 would make things more difficult.

The wisdom of Solomon is required for this matter, and I acknowledge the fact that the Executive is trying to square the circle. However, even Richard Simpson's amendments are slightly deficient. Carers lack confidence in the independence of the medical profession, which is why, even with Richard's amendments, further work is needed on this issue.

The involvement of the Mental Welfare Commission is a good move, as it has a statutory duty to protect people with mental disorders under the Mental Health (Scotland) Act 1984. The MWC has commissioners and other people who are not just medical practitioners; it is crucial that an independent secondary opinion should not come from a secondary medical practitioner. Although the involvement of the MWC strengthens the proposal, there could still be some misinterpretation about the independence of advice. If the committee is minded to accept the Executive's amendment along with Richard Simpson's amendments, we should pick up on the points that require further work at stage 3. Christine Grahame also raised valid points about tribunals.

Malcolm Chisholm: I was seeking to intervene on Iain Gray when he mentioned the superior medical knowledge of the medical profession. The same argument could be used about parents making medical decisions about children, but we believe that it is a fundamental matter of human rights for parents to have such a right.

Furthermore, it is a fundamental part of my human rights that any welfare attorney whom I have appointed should be able to make medical decisions for me when I become incapable.

Christine Grahame said that carers' concerns would be allayed by the Executive amendment. However, the fears of the carers to whom I have spoken are not allayed. The same could be said of Richard Simpson's amendments, about which I am disappointed. In the Health and Community Care Committee, Richard proposed an independent panel that would provide not just a second medical opinion. That was much better than the Executive's position, but it is not what his amendments would do. Although Health and Community Care Committee views probably will not sway the Justice and Home Affairs Committee, it should be reported that the Health and Community Care Committee agreed that, if Richard's intermediate position about such a panel was not accepted by the Executive, it would prefer my proposal to the Executive amendment.

The weight of outside opinion supports my position rather than the Executive's. In a letter to me, Iain Gray said—he has repeated the position today and in meetings with carers that have been reported to me—that the reason for changing section 47 was to deal with the concerns about euthanasia that had been raised in relation to the bill. From that point, however, his whole argument is illogical. He has already said that we do not need to have such concerns; he has assured us of that in relation to section 44. It is illogical to argue that we must change section 47 to deal with concerns that he says do not exist. If there are concerns, those must be dealt with by specific safeguards. I do not support the wording of Phil Gallie's amendment in its entirety, but if people are still concerned about euthanasia, something should be introduced in the bill to meet those concerns. The Executive cannot deal with people's concerns about euthanasia just by attacking proxies. There will be consultation, but people will not be reassured by that; we all know that consultation can mean a great many things and often does not amount to much.

Iain Gray also invoked the opinion of this committee. I remind him that, in his initial report, he supported section 47 as it stood. I do not think that anything has happened since that should have led him to change his mind. The carers have now put their point of view; they did not do so while he was working on his report because they did not see any threat at that stage. They started campaigning only after the Executive had announced the change. Some of the groups that he felt were leading him in the direction of changing section 47 have also clarified their positions. For example, the Scottish Council on Human Bioethics has said that the change to section 47 was an unintended consequence of what it was saying. It wants safeguards in the bill; it does not want decision making to be transferred from proxies to medical opinion.

If Iain Gray cannot make up his mind today and support my amendment, I appeal to everyone to leave the provision until stage 3, when we can have a further discussion of it in a meeting of the Parliament. This is an important matter, which divides public opinion. As the majority of bodies that have approached the committee—including the Alliance for the Promotion of the Incapable Adults Bill—support section 47 as it stands, with slight changes as suggested by me, I beg Iain Gray at least to leave this decision until stage 3 if he cannot bring himself to support my position today.

Gordon Jackson: I will deal with some of the points that Malcolm Chisholm has made. The argument is between section 47, as it stands, and the amendments. The question is where the balance should lie between the two. With all respect, I do not think that amending section 47 in the way that Malcolm suggests takes us anywhere—I find his amendment a wee bittie meaningless. A proxy would have to give reasons for the refusal, but there would be no evaluation of their reason; they would be able to give any reason that they wanted. The reason might be sane and logical; equally, it might be bizarre and illogical, but there would be no evaluation of that. The question is whether we make the substantive change that the Executive seeks to make and alter the balance as to who will finally have to go to court.

Malcolm Chisholm said that Mary Kearns from the Scottish Council on Human Bioethics had written to him saying that it never wanted the change. I must say bluntly and publicly that I find that astonishing and disingenuous. I had meetings with the people involved in the Scottish Council on Human Bioethics. Their position was clear—they were worried about section 47. They were worried that, in the case of an elderly person who was not necessarily in a persistent vegetative state but who was frail or had suffered a stroke, the proxy would refuse consent and the medical practitioner would, for various reasons, not bother to do anything about that.

11:45

The Scottish Council on Human Bioethics and other reputable and responsible medical practitioners expressed that fear to this committee. I agree with Malcolm Chisholm that the first thing that it wanted was to put a legal duty of care on the proxy, but we rightly decided that that was impossible. We could go back again to Sheila McLean's evidence on that. It is an unworkable and inappropriate burden to put on proxy decision makers. The bioethics people made it clear to me that, if that could not be done, they would be happy with the change that is being made, as it would not be for the doctor simply to allow the proxy to refuse consent and leave it there. I find Malcolm Chisholm's letter from the bioethics people astonishing. It expresses, to put it as charitably as I can, a disingenuous position. Be that as it may, we are not particularly driven by that; this committee is trying to take this agonisingly difficult decision and to strike the right balance.

All of us appreciate what Malcolm Chisholm says; he says it with passion and he says it rightly. We have all received these letters, in which no one could fail to recognise a legitimate argument. However—and I say this hesitantly—Malcolm is overstating the position. No one is suggesting that proxies be attacked. In particular, it is not accurate to say, as he did, that they are being given no say; that is unfair and is not what is being suggested. Any medical practitioner will need to consult that attorney or proxy decision maker. No doubt, the proxy decision maker will give clear arguments on why they do not want the treatment to be given.

If what they say is not acceptable to the doctor, the next person to address the matter will also, if I have read this rightly, have to return to the proxy decision maker—they cannot simply look at the paper work. Detailed representation will be made by the parent to every medical practitioner who is involved in the decision-making process. It is not fair to say that that is giving no say to the parent or the individual. Indeed, it would be fair to assume that there would have to be clear medical reasons for both medical practitioners to act against the input from the parent. The parent will have a clear input.

The only question that then arises concerns which party will need to enter the court process. Malcolm says that it is unfair to put the parent into the court process, with all the expense that that involves. If that level of dispute is reached—and I do not mean to be facetious—the parent will have to enter the court process anyway. The doctor will have a medical opinion and the matter will be referred to an independent assessor who may agree with his opinion. One imagines that, at that stage, the doctor could not do nothing. Either way, the parent will almost inevitably end up in the court process.

The question of expense is another matter—I am going off at a slight tangent—that this committee will need to address. There will be occasions on which legal provision will have to be made so that parents do not to have to incur any expense. That is a complex argument, but I hope that this committee will bite that bullet fairly soon after Easter. It is an access-to-justice question and I would be sympathetic to the parents' position in that situation. I suspect that this committee would be sympathetic, too.

On balance, the Executive has got this right, subject to Richard Simpson's amendments. There may be a case, at a later stage, for considering whether those amendments go far enough. I think that he suspects that his amendments do not go far enough. It is a step in the right direction. It was not good enough to say that what was needed was another medical practitioner picked by the first medical practitioner. One would not have to be very cynical to worry about that. Now we have a much more independent way of seeking medical opinion, which Richard has suggested. Although that achieves a better balance, we may have to go a bit further on it. I hope that all committee members will consider that.

Malcolm Chisholm said that we should follow our conscience on this matter. I know that that was not meant as an insult to us, but I have to say that I do not feel whipped. Perhaps people think that I am, but I am not—I am not the most easily whipped person in the world. All committee members have considered this matter with terrific care and we have not found it easy to come to a decision.

I assure Malcolm and others who are listening to our proceedings that most of us will vote as we do not because we are whipped, but because we think, on balance, that what we are voting for is the best answer for now. On that basis, as long as the Executive agrees to Richard's amendments, I will accept its proposed change.

Christine Grahame: Having heard more of the debate, I am of the view that Richard's amendments do not go far enough. Article 6 of that bugbear the European convention on human rights provides for the right to an independent and public hearing in the determination of an individual's civil rights and obligations. The Law Society has observed:

> "It may be argued that a decision as to medical treatment is a civil right in terms of the Convention."

We need to look more rigorously at the independence of the second opinion required when there is conflict between the first medical practitioner and the proxy. I have not yet come to a view on whether I support Richard's amendments. I want to hear the Executive say that it will further consider the procedures in the case of conflict.

Pauline McNeill: I have a number of points of emphasis, which are not new but are important. I listened carefully to the evidence that was put to the Executive and to me as a member of the Justice and Home Affairs committee. I am not whipped on this and the record shows that I have voted against the Executive on it. Like Gordon Jackson, I know what evidence the Scottish Council on Human Bioethics gave the committee—it cautioned us about unscrupulous relatives, but it now seems to be saying something contradictory after the event. The committee should make it clear that we expect consistency in evidence.

We were given weighty evidence on the burden placed on doctors to go to court. I support what the Executive has said and its reasons for saying that the proxy, not the doctor, should go to court. I support what Malcolm Chisholm said on consultation and I would like the Executive to come back to us on that. People want to know what consultation really means and what weight is given to it. I support Gordon Jackson's point on access to justice. Lastly, I welcome Richard Simpson's contribution; I believe that the key points of principle are that the second opinion should not solely be medical and that it should be as independent as possible.

The Convener: Phil, given that you are moving the lead amendment, it would be better if you waited until Richard Simpson and the Deputy Minister for Community Care have spoken before you make your contribution.

Dr Simpson: This has been an excellent discussion. As I said when I spoke to my amendments, I do not feel that what is proposed goes far enough. Christine Grahame, Gordon Jackson, Pauline McNeill and Margaret Smith have all emphasised that. An additional lay element is needed to give the independence required by the European convention on human rights. I hope that if the Justice and Home Affairs Committee supports the Executive's amendment with my amendments to it, the minister will concede that the issue needs to be looked at again before stage 3.

Iain Gray: Before we respond to the general debate, I want to address a couple of specific questions. The key question was that of Michael Matheson, who asked about guidelines for health care professionals on medical treatment aspects of the bill. I did not say that those guidelines would include a definition of basic care, but that I would ensure that the published guidance makes clear our view that basic care, as outlined in Mr Gallie's amendment, is not something that proxies can reasonably refuse.

Like Richard Simpson, I think that we have had a good and an interesting debate. I start with Richard because he made some extremely important points. He said that we are dealing with extremes, or two incompatible points of view. Most, if not all, of Malcolm Chisholm's arguments were made, in essence, from one of those extremes; furthermore, although he made the point that he believed my arguments to have been illogical, his contribution was rather partial.

Christine Grahame made the important point that section 47 lies embedded in the bill and should not be considered in isolation. Most of Malcolm Chisholm's arguments seemed to be about section 47 alone, rather than about the section as part of the bill. For example, throughout the bill, new rights are conferred on welfare attorneys and guardians, who will, in many cases, be carers. The right to consultation, or to be considered, runs through the bill and has legal force. That means, for example, that a medical practitioner—or somebody taking a financial decision—would have to be content that they could show, in court, that they had consulted, and considered the views of, the welfare attorney or guardian.

Further, throughout the bill there are new safeguards for adults with incapacity. Those safeguards—together with the new rights for welfare attorneys and guardians—form the framework in which section 47 lies and in which the arguments must be considered.

It has been our concern, therefore, to take the two points of view—perhaps the two extremes—and, as Margaret Smith said, try to square the circle. Margaret pointed out that that would require the wisdom of Solomon. I do not claim such wisdom, although I do claim a more careful and balanced approach on the Executive's part than the one we have been accused of this morning, particularly by Malcolm.

Much discussion has taken place about the evidence that was given. One of our Parliament's strengths is the opportunity that it provides for consultation to take place and evidence to be given during the legislative process, but some of that evidence has been presented somewhat partially. The Scottish Council on Human Bioethics, for example, looked for particular safeguards. However, the difference between the truth and Malcolm's position, is that the council may have said that it did not want the changes in the Executive amendment, were it the case, instead, that safeguards had been placed in this section that, in our belief, would have been outside the general principles and scope of the bill, and would have strayed into the territory of common law.

We did not choose to include such safeguards for those good reasons, and therefore, the council would not, presumably, be content with section 47, as it stood, without those. So the difference of opinion between its position when it spoke to the committee and now might lie in there somewhere.

The Executive has worked closely with the Alliance for the Promotion of the Incapable Adults

Bill, which I have met in the past few days. The alliance's view is that it would prefer the original position to the Executive amendment. However, it is not true to say that its fears will not be allayed in any way by the acceptance of Richard Simpson's amendment. Its fears have been allayed to some extent—that is the position that it put to me, although it is not the position that was presented by Malcolm Chisholm.

That raises a point about the weight of outside opinion. A considerable amount of evidence was given to the committee at stage 1, from one side of the debate, on one of the incompatible points of view. Considerable evidence has been taken at this stage, in a variety of ways, on the other incompatible point of view. I put it to the committee that—as Pauline McNeill said—it must consider all the evidence, from both sides of the argument, rather than giving the most recent opinion the most weight.

12:00

Malcolm Chisholm and Christine Grahame raised the European convention on human rights. Our view is that, as with all potential legislation, the bill, as amended, is ECHR-compliant. The right of public appeal under article 6 of the convention that was referred to by Christine Grahame would, in this case, be the Court of Session appeal; the bill therefore meets the requirements of article 6.

There is absolutely no intention in the Executive amendment to section 47 to attack proxies. I do not believe that the amendment undermines any of the other measures that are being taken by the Executive—in the carers strategy for example—to support carers in their valuable, dedicated work. The amendment is a genuine attempt to square the circle, to ensure confidence in the independence of the second medical opinion and to allow the guardian—who will usually have the best interests of the adult with incapacity at heart—to have the last word in the Court of Session.

I have listened with interest to the comments about the second opinion and whether it should be a medical opinion or a lay opinion, from an individual or from a panel. We have discussed section 47 with many groups and amongst ourselves. We are accepting Richard Simpson's amendments to the section because they maintain confidence in the independence of the second opinion and they are practical. We must bear in mind that a decision might have to be reached relatively quickly. Furthermore, the position of the proxy would also have to be taken into consideration, which would require consultation by the medical practitioner giving the second opinion. Appointing a panel could lead to practical difficulties that might not be in the best interests of either the adult with incapacity or their proxy.

That is the indication of the Executive's approach to section 47. We have tried to square the circle, we have listened to both sides of the argument, we have read the evidence and we have met many of the key groups who have an interest in the matter. On balance, we believe that the practical way forward is through a combination of the Executive's amendment and Richard Simpson's amendments.

That is the basis on which we have reached our position. I hope that the committee feels able to consider both sides of the argument and to come to a judgment on balance. I am under no illusion that Gordon Jackson, or any other member of the committee, is whipped. I hope that members will judge in favour of the Executive amendment and Richard Simpson's amendments.

Phil Gallie: The difficulties associated with this issue, which have preoccupied us all during recent months, have again been brought to the fore today—in particular by Richard Simpson and Malcolm Chisholm, who suggest that there is a 50:50 balance between the merits of treatment's being determined by the medical practitioner and its being determined by the proxy. The comments of the family who had given up everything to look after their daughter weigh very heavily with me. They exemplify the experience of many carers, and we must take that on board.

My amendment dealt with unscrupulous individuals and was based on a strong foundation. We need to guard against only a small minority of people. There must be protection against that small minority, but not at the expense of the majority of carers who look after those in their care with great love and respect.

The minister made the point that doctors are obliged to consult. As it stands, section 47 puts the onus on the welfare attorneys. I believe that amendment 120 gives us the best of all worlds. It is simple and specifies in the bill definitions of treatment and caring. Time and time again, the minister has said that those are the bill's objectives and that regulation and guidelines will underline them. However, the definitions to which I refer do not appear anywhere in the bill as it stands, certainly not in its later sections.

I believe that the concerns about euthanasia would be dealt with if amendment 120 were accepted. It strikes a balance between the concerns of those who have fears about the introduction of euthanasia through the back door and the genuine interests of incapable adults and those who care for them. I will, therefore, press amendment 120. If it falls, I will make up my mind how to vote on the other amendments. I urge every member of the committee to consider very carefully everything that has been said. I believe that amendment 120 is a simple way forward and I ask for members' support.

The Convener: The question is, that amendment 120 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Roseanna Cunningham (Perth) (SNP)
Phil Gallie (South of Scotland) (Con)
Mrs Lyndsay McIntosh (Central Scotland) (Con)
Michael Matheson (Central Scotland) (SNP)

AGAINST

Scott Barrie (Dunfermline West) (Lab)
Christine Grahame (South of Scotland) (SNP)
Gordon Jackson (Glasgow Govan) (Lab)
Kate MacLean (Dundee West) (Lab)
Maureen Macmillan (Highlands and Islands) (Lab)
Pauline McNeill (Glasgow Kelvin) (Lab)
Euan Robson (Roxburgh and Berwickshire) (LD)

The Convener: The result of the division is: For 4, Against 7, Abstentions 0.

Amendment 120 disagreed to.

Amendment 331 moved—[Malcolm Chisholm].

The Convener: The question is, that amendment 331 be agreed to. Are we all agreed?

Members: No.

The Convener: There will be a division.

FOR

Phil Gallie (South of Scotland) (Con)
Mrs Lyndsay McIntosh (Central Scotland) (Con)
Michael Matheson (Central Scotland) (SNP)

AGAINST

Scott Barrie (Dunfermline West) (Lab)
Christine Grahame (South of Scotland) (SNP)
Gordon Jackson (Glasgow Govan) (Lab)
Kate MacLean (Dundee West) (Lab)
Maureen Macmillan (Highlands and Islands) (Lab)
Pauline McNeill (Glasgow Kelvin) (Lab)
Euan Robson (Roxburgh and Berwickshire) (LD)

ABSTENTIONS

Roseanna Cunningham (Perth) (SNP)

The Convener: The result of the division is: For 3, Against 7, Abstentions 1.

Amendment 331 disagreed to.

Amendments 176 and 177, 332, 178 and 179 not moved.

Amendment 322 moved—[Iain Gray].

Amendments 322A, 322B, 322C and 322D moved—[Dr Simpson]—and agreed to.

Amendment 322, as amended, agreed to.

Section 47, as amended, agreed to.

The Convener: I do not intend to go any further today. We are likely to undergo another lengthy debate on the bill tomorrow, when we will move on to amendments to section 48. I ask members to return tomorrow morning, but we will start at 10:30 rather than at 9:30.

Meeting closed at 12:13.

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