JUSTICE AND HOME AFFAIRS COMMITTEE

Wednesday 1 March 2000
(*Morning*)

£5.00

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JUSTICE AND HOME AFFAIRS COMMITTEE
9th 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:

Iain Gray (Deputy Minister for Community Care)
Angus MacKay (Deputy Minister for Justice)
Dr Richard Simpson (Ochil) (Lab)

CLERK TEAM LEADER

Andrew Mylne

SENIOR ASSISTANT CLERK

Shelagh McKinlay

ASSISTANT CLERK

Fiona Groves

LOCATION

The Chamber

Scottish Parliament

Justice and Home Affairs Committee

Wednesday 1 March 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:35*]

Adults with Incapacity (Scotland) Bill: Stage 2

The Convener (Roseanna Cunningham): Now that we are all assembled we shall proceed. Phil Gallie is not here.

Mrs Lyndsay McIntosh (Central Scotland) (Con): He will not be coming today.

The Convener: I welcome Richard Simpson, who is back for a second bout. We have a lot of work to get through this morning, one part of which looks as if it might take some time.

Section 48—Authority for research

The Convener: We start with section 48 of the bill. The first amendment for consideration is amendment 83, which has already been debated with amendment 124 on day one of stage 2. I will therefore understand if nobody remembers it. However, I must ask the minister to move the amendment formally.

Amendment 83 moved—[Angus MacKay].

The Convener: I will not embarrass you by asking you to speak to the amendment, minister.

The Deputy Minister for Justice (Angus MacKay): Please do not.

The Convener: The question is that amendment 83 be agreed to. Are we agreed?

Christine Grahame (South of Scotland) (SNP): I oppose that amendment.

The Convener: In that case, there will be a division. Amendment 83 was part of a group of amendments, and I recall that Christine opposed that group.

FOR

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

AGAINST

Christine Grahame (South of Scotland) (SNP)

The Convener: The result of the division is: For 9, Against 1, Abstentions 0.

Amendment 83 agreed to.

The Convener: I call the minister to speak to amendment 323, which is grouped with amendment 183, in the name of Margaret Smith, and with Executive amendments 324 and 325.

The Deputy Minister for Community Care (Iain Gray): The purpose behind amendment 323 is to ensure that research will not involve adults incapable of giving consent if it could be conducted equally effectively on adults who can consent. That is a basic tenet underlying all research on incapacitated adults and was therefore not specifically spelled out in the bill. However, because we are ever mindful of the need to protect adults with incapacity who are involved in research, we now think it prudent to spell that out.

Amendment 183, proposed by Mrs Smith and supported by Dr Simpson, would have the same effect, but we think that the Executive amendment is more precise. It is also better in that it puts the exclusion at the beginning of section 48 and thus gives it more prominence. I hope that Mrs Smith and Dr Simpson will therefore withdraw amendment 183.

Amendment 324 carries through the Executive's commitment, made during the stage 1 debate, to make an exception to the direct benefit rule. We have carefully considered the comments that were made directly to us and in written evidence to the committee, and have been persuaded of the necessity of making an exception to the direct benefit rule.

Without this amendment, some research for the benefit of other and future sufferers will not be lawful. That research might not be possible if we were to apply the real and direct benefit rule, and the amendment allows such research to take place. Generally, research must benefit the individual. However, as the committee indicated in its stage 1 report, there is widespread support to enable research to be undertaken to help future sufferers of conditions such as Alzheimer's disease and stroke, which have devastating effects on sufferers and their families. I hope that committee members will feel able to support this amendment.

A further safeguard is that all research involving adults with incapacity will be subject to approval by the ethics committee, for which we shall make provision in regulations. Amendment 325 will enable ministers to require the ethics committee to

take specific matters into account in determining whether to grant approval for research. The use of regulations will provide a degree of flexibility to take account of future developments.

We think that the transparency in these extra regulatory powers to set additional conditions will reassure people who are caring for an adult with incapacity, and I hope that the committee will support the amendment.

I move amendment 323.

The Convener: Richard Simpson, I take it that you are here to speak to Margaret Smith's amendment.

Dr Richard Simpson (Ochil) (Lab): That is correct. First, on behalf of Margaret and the Health and Community Care Committee, we accept that the phraseology of amendment 323 is better than that of amendment 183, so we will not be moving amendment 183. However, I have been asked by the committee to raise a number of questions.

First, can the Executive be certain that the amendments ensure that this section now meets the requirements of the European Convention on Human Rights and Biomedicine?

Secondly, the now rewritten first paragraph of section 48 seems to us not entirely to make sense. Perhaps it will make sense once it has been printed out in its full amended form—if the Justice and Home Affairs Committee passes amendment 323 and the other sections—but I am not sure that it does.

A question that we would like to be considered between now and stage 3, as it cannot be an amendment to stage 2, is why the Executive has chosen to define the type of research. In most aspects of this bill, and in rejecting other amendments, the Executive has not wanted to make the definition specific and has preferred to make it general and inclusive, but in section 48(1), it has left the research as

"surgical, medical, nursing, dental or psychological".

It has not included sociological or econometric research. It may well be that those are not in any way harmful to individuals, but, nevertheless, by trying to define the research, the Executive has created the potential for bits of research to be left out.

Amendment 324 seeks to amend section 48(3), but will the amendment to 48(1), if passed, apply to the new section? I am not absolutely clear about that. If the conditions in 48(3) are fulfilled, presumably the conditions in 48(1), including the new bit, will also apply.

My last question is on the ethics committee. Will that involve the existing Scottish regional ethics committees, or is it proposed to establish a new committee?

Margaret Smith has asked me to welcome amendment 323 as proposed, because it now allows research to be carried on only if it cannot be undertaken on adults without incapacity. That is appropriate, and is in line with the evidence that was given to this committee, rather than to the Health and Community Care Committee, from both the British Medical Association and the Mental Welfare Commission. We welcome it.

Iain Gray: I thank Richard Simpson for withdrawing amendment 183 and for welcoming the Executive amendments. I will try to respond to the specific points that he has raised. The intention in specifying particular types of research is to reassure people who had raised fears about the extent of the research that might be allowed. It is an attempt to cover research that would require an intervention but that would also, in certain circumstances, not be possible to be done on adults who are not judged to be incapable.

Dr Simpson wondered whether the wording of one particular paragraph made sense. It is difficult to look at that quickly, but if there is a drafting error, we want to pick that up prior to stage 3. The ethics committee would not be the existing regional ethics committees; it would be a national committee set up by regulation to consider specific research in regard to adults with incapacity in terms of the bill.

Christine Grahame: This may be a cheeky suggestion, given that I am not a drafter. Would it not be more appropriate, when adding amendment 324, to move paragraph 3(a), which says, "the research is likely to produce" and to add the word "or" before the amending paragraph, which says, "Where the research is not likely to produce"?

The thrust of the bill is that research must be of benefit to the adult, but the amendment appears to separate out that particular condition in the existing paragraph from all the other conditions—that is, research that is just for general purposes of research but which is subject to the conditions listed in 48(3). I suggest moving the present paragraph (3)(a) from the general list of conditions that people would look at, to stress that there is an alternative.

10:45

Iain Gray: I take that comment in the helpful spirit in which I think it was given. We will certainly consider Christine Grahame's suggestion in terms of correcting the drafting, if the amendment is inaccurate.

Amendment 323 agreed to.

Amendment 183 not moved.

Amendments 324 and 325 moved—[Iain Gray]—and agreed to.

Section 48, as amended, agreed to.

After section 48

The Convener: Amendment 326 has been withdrawn, so we move on to amendment 333, which is in the name of the minister.

Angus MacKay: Amendment 333 establishes an appeal mechanism, which will be open to

"any person having an interest in the personal welfare of the adult"

and which will apply to decisions taken on medical treatment under part 5 of the bill, other than those appeals to the Court of Session allowed already by section 47.

The amendment is a catch-all provision that ensures that any decision, other than the exception that I have mentioned already, can be appealed. We do not expect that provision to be used widely, as most treatment decisions are reached amicably after discussion between the parties. The amendment, if agreed to, will ensure that no one with an interest can be excluded easily from such discussions or decisions, by establishing a route for challenging them.

I move amendment 333.

The Convener: Gordon Jackson has been wondering on my right. I wonder if he wishes to wonder on the record as opposed to under it.

Gordon Jackson (Glasgow Govan) (Lab): I must confess immediately that there have been so many other difficult issues in this section that I have not considered this amendment in detail.

How wide is the definition of "person having an interest"? For example, there are organisations that, quite properly, have an interest in the general principle of treatment in this area. If someone is not getting proper treatment, they are in danger of dying—ask not for whom the bell tolls—which is a matter of interest to everyone. Organisations that have a duty to monitor treatment in such circumstances might feel that they have an interest. Would those organisations have to have an interest in such individuals as a class, or would they have to have an interest in the individual as an individual? I appreciate that I must sound like a man thinking aloud.

Angus MacKay: The wording of the amendment is "having an interest", rather than "claiming an interest". We think that having an interest is a sterner test than claiming one. In our view, it is for the courts to decide exactly who has an interest. The intention is that that wording should be applied to include relatives and carers, while excluding, as appropriate, organised pressure groups or others who pursue their own ends rather than acting in the interests of the adult with incapacity. Our intention is that it should be a personal interest.

Gordon Jackson: I accept that. I suspect that someone will eventually test that intention in the courts. So what? That is what the courts are there for.

Christine Grahame: I was directed to this point by the Law Society of Scotland. Under section 76 there is a definition of a "person claiming an interest" and you have now brought in the idea of a "person having an interest". Do you think that that is appropriate?

There is also an issue about whether the section is compliant with the European convention on human rights, article 8.2 of which states:

"There shall be no interference by a public authority".

However, the local authority is included in the definition of a person claiming an interest, which I take to be more serious than "having an interest". That is an issue that has been raised and that should be addressed.

Angus MacKay: The specific provision that we are attempting to make in the amendment is for someone who has an interest, rather than someone claiming an interest. The definition of "claiming an interest" that you referred to, and which appears elsewhere in the bill, relates to public bodies and so on. That is what this provision attempts to exclude by defining "having an interest". Taken together with the right of the appeal to the court, that provision should satisfy the requirements of the European convention on human rights.

Christine Grahame: I see.

Gordon Jackson: I suspect that the fact that both phrases appear in the bill will help matters, because it will differentiate between having and claiming an interest. The comparison makes the position more clear.

Christine Grahame: Perhaps that distinction should be made clear in the bill.

Angus MacKay: Our position is that we think that the point is sufficiently clear. However, as Gordon Jackson has said, the courts will be the place in which that is properly tested.

The Convener: Are there any other comments on the amendment?

Amendment 333 agreed to.

The Convener: Amendments 121 and 308 have been withdrawn. We move on to amendment 327 in the name of Michael Matheson.

Michael Matheson (Central Scotland) (SNP): Although this is the last amendment, it is by no means the least. Amendment 327 seeks to address one of the most fundamental concerns about the bill. I recognise that, from the outset, the Executive has said that it does not intend to provide for living wills or the legalisation of euthanasia. However, there is genuine concern that the bill may provide for passive euthanasia. The Executive has recognised that to some extent and has tried to provide some safeguards. That was made clear in yesterday's meeting in the response to Malcolm Chisholm's comments on proxies. However, I do not believe that the Executive's safeguards deal with the issue of passive euthanasia.

There are three areas of concern. The first relates to the terminology in the bill. That has been partially addressed by an Executive amendment on the definition of treatment. However, the common law position on medical treatment must be taken into account. Furthermore, the term "benefit" in the bill raises issues in relation to common law. The British Medical Association guidelines have been referred to in evidence to the committee and there is a question about the effect that they may have on interpreting some parts of the bill.

To give some background to those concerns, I will consider briefly the position in common law, on which I understand the committee has received a briefing. In common law, passive euthanasia rests on the Law hospital decision. That decision redefined the question of assisted feeding and hydration. Previously, assisted feeding and hydration was seen as basic care, rather than as medical treatment. Under common law, notwithstanding the Executive amendment, assisted feeding and hydration is now regarded as medical treatment.

The Law hospital decision also redefined the term "benefit". Under common law, the definition of "benefit" includes an assessment of the benefit of the continued existence of the patient rather than strictly of the treatment. It concerns the value of continuing with any form of assisted feeding or hydration and is not necessarily a clinical decision.

The judgment also made it clear that a doctor did not have a duty to give assisted feeding and hydration to a patient whose continued existence was considered not to be a benefit by

"a large and responsible body of medical opinion",

which was the guidance issued by the BMA ethics committee. That guidance seeks to cover not only people in a persistent vegetative state, or PVS, but people who suffer from conditions such as severe dementia, advanced dementia or a severe stroke. The decision whether to withhold or withdraw artificially administered food or fluids to such patients can be made on the ground that it is not to their benefit to continue the treatment.

The BMA's guidance seeks to allow doctors to withdraw treatment such as assisted food and fluids, and the bill's terminology can extend that principle to incapable adults. The combination of the bill's guiding principles, common law and the BMA guidelines is the real source of people's concerns about passive euthanasia.

In case there is some confusion, I stress that the amendment would not reverse the Law hospital decision; members who suggest otherwise should put forward the legal reasons why they take that view. As in the Law hospital case, people would still be able to go to court and put their case under court scrutiny. Without the amendment, food and fluid could be withdrawn from an incapable adult without court scrutiny because it was not considered to be of benefit to them. I do not believe that that was the bill's intention, and the amendment would give an appropriate safeguard to ensure that that did not happen.

I move amendment 327.

Mrs McIntosh: Michael's presentation has left me very little to say. In supporting his amendment, I should point out that we are all aware that the bill's principles will benefit the many, not the few. However, we have to guard against the possibility that a very few people will abuse the regulations.

More people have corresponded with us on this subject than on any other issue in the bill. Even as late as yesterday, I was being given hand-delivered letters pleading with us not to allow people with incapacity—however incapacitated they might be—to end up in a state where the basics of life such as food and water could be withdrawn under any circumstances without proper scrutiny. Michael Matheson has given a wonderful presentation of the case, to which I can add little. I very much support the amendment.

The Convener: We will have a round-up of questions before I ask the minister to reply.

Maureen Macmillan (Highlands and Islands) (Lab): I welcome the chance to discuss this extremely important issue, about which I have thought for a long time; I have talked with the minister about it at least three times. Like Michael, I am concerned about the possibility that nutrition and hydration could be withdrawn from patients who are not dying. I realise that we cannot seek to reverse the Law hospital decision on this matter and I am not convinced that the amendment would not set up a conflict between statute law and case law in this area. Even though the amendment uses the words "in this Act", I need clarification on that point.

11:00

I was alarmed by the evidence that the British Medical Association gave to the committee, which seemed to suggest a cavalier approach to the provision or withdrawal of nutrition or hydration from patients who had suffered a stroke or were in advanced dementia, even if they were not dying.

I would like to be reassured that the legislation will not extend the Law hospital verdict by making it legally possible for adults with incapacity to be denied nutrition or hydration without recourse to the courts. That fear has been voiced in some quarters and has been backed by legal opinion.

Following on from what Michael said, I would like reassurance about the definition of "benefit" in the bill. It should not extend to concepts such as the quality of life of a patient; it should just mean clinical or medical benefit and should relate to physical and mental health.

I do not know whether it is competent for the minister to speak about the BMA guidelines, which I find disturbing, but I would welcome his comments on them.

Dr Simpson: I understand the concerns that have been expressed, but I do not feel that the amendment is necessary in any way. The BMA guidelines are now well established. Any doctor who did not follow those guidelines would have to justify his or her action in terms of his or her duty of care. This bill provides substantial additional protection against any idiosyncratic proposal by a doctor to withdraw treatment or not to treat. Any doctor who now fails to take into account either the present or previous wishes of the adult—and of relatives, carers and proxies, as outlined in section 1(4)—will not be undertaking care in an appropriate manner.

Nowadays, doctors are unlikely to make decisions on their own—they are more likely to do so as part of a team. That is particularly true in cases of withdrawal of treatment, but there are circumstances in which a patient will be terminally ill and will require to have treatment, fluids and food withdrawn because it would be invasive and unpleasant to continue to administer drugs, fluids and food. I have reached such a decision on a number of occasions in my professional life in discussion with the relatives. The bill will promote exactly that good practice.

The combination of the duty of care—which has always been required of doctors but which is reinforced by the guidelines that have been issued only in the past two years—and the bill will cover all the elements of the amendment, so the fears that are being expressed will not be realised.

Christine Grahame: I wholly support Dr Simpson on this matter and defer to his professional experience. This is a very difficult area, but we should consider it rationally in terms of practice and the structures proposed in the bill. Maureen Macmillan used the phrase "not dying", but that is a difficult concept. Members have heard what Dr Simpson said about terminally ill people.

The amendment includes the term "however administered", so I take it that we are discussing artificial nutrition and hydration. We are not talking about not putting food or water in front of someone; we are talking about invasive means and about medical and surgical treatment.

I will go back to the first principles of the bill and work my way through it. The first principle of the bill is in section 1(2):

"There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult".

That is the crucial test. If there is no benefit to the adult—or if there is de minimis benefit—decisions have to be made about ways of managing the illness.

Section 1(4)(a) says that account should be taken of

"the present and past wishes and feelings of the adult so far as they can be ascertained".

If an adult made a view known about the issue two hours before a decision about intervention needed to be made, for example, how much input would that opinion have into the making of the decision? Many things have to be taken into account, such as the feelings of the family. At present, where there is a conflict about the decision, there are routes by which the procedure can be halted. I say to Michael Matheson that going to court is not an answer, given how often the circumstances will arise in a general hospital.

I do not think that Michael's suggestion would be of service to the incapable adult. I know what his intention is, but I think that the amendment should be rejected. I am satisfied that, with the safeguards, the guidelines and the duty of care that is placed on doctors to act in the interests of their patients, the bill will ensure that proper care will as far as possible be given to incapable adults.

Gordon Jackson: I agree with Christine Grahame. Like most of us, I have spent more time on this difficult issue than on any other. Some of us have discussed it for hours at a time. I wondered whether we should agree to the amendment on the ground that it does not do any harm. However, a number of things convinced me that that was not a good idea.

I am not persuaded that the amendment has no impact on the common law position. Michael Matheson says that it would not reverse the Law

hospital case; I understand that he has had legal advice to that effect. However, in almost every case—almost by definition—wrong legal advice is given as well as right legal advice. My instinct is that the amendment would be used in a Law hospital situation. People who are in that situation are incapable adults, so the bill would apply to them.

A doctor could secure the proxy's consent to a decision to remove a feeding tube, but I have no doubt that in such a case the groups that are against such action would use the amended section in court to say that the action was not permitted. That argument might not win—I can see arguments against it—but it is wrong to say that the amended section would not be used in a Law hospital situation. I would have no difficulty in using it for that purpose, although I might not be successful.

That is not the ruling factor for me, however. It is correct to say that a doctor and a proxy might collude and—quite improperly—allow a patient to die, but that evil should be dealt with in other ways. I do not mean to be facetious, but doctors and nurses can do all kinds of horrendous things that are not prohibited in the bill. Dr Simpson is right: there are procedures for dealing with that sort of thing.

The purpose of the bill is to allow a necessary intervention to be made. Yesterday, when dealing with section 47, we included a safeguard in the bill. The safeguard that is suggested by this amendment, however, would not help the structure of the bill. At the moment, incapable adults are dealt with by their families and doctors. The bill improves the situation and introduces more safeguards. Although I sympathise with the intention behind the amendment, I have to say that it is not helpful to use this section to cover a perceived danger that has nothing to do with what the bill is for. The amendment would impinge on the common law.

Euan Robson (Roxburgh and Berwickshire) (LD): I, too, had thought that there would be no harm in including the amendment and I share the general sentiments behind it. However, like Gordon Jackson, I have come to the view that it could impinge on the common law. I also think that it is in the wrong place and that, if such a measure is to be progressed, it should be in the form of a separate statute.

Does the minister agree that the measure proposed in the amendment would have been better placed up front, rather than at the back end of this bill? Does the amendment relate to terms and conditions that are not explained in the bill? If so, that would lead to further confusion. After considerable thought and reflection, I am not minded to accept the amendment.

The Convener: Some of the comments that have been made seem to suggest that death can be regarded as a benefit that justifiably could be brought about by medical means, possibly by the withdrawal of treatment. Minister, is that the position of the Executive?

Iain Gray: We have had an interesting debate and I hope to respond at length to all the questions that have been raised, with your forbearance.

Much of the discussion has been about medical practitioners and how they might behave. I will clarify a point that I made yesterday when Mr Gallie, who is not here today, unfortunately, asked about the definition of "medical practitioner". My response was, to say the least, rather clumsy and I will clarify the definition now. "Medical practitioner" would cover doctors registered by the General Medical Council, but not nurses or other health care staff. As I said to Mr Gallie, the definition would not include a dentist, unless he was registered as a doctor. The medical practitioner has power, under section 44 as amended, to delegate authority to treat to other health care professionals such as nurses, dentists, physiotherapists and opticians.

As Mr Matheson says, amendment 327 might be the last amendment that we will deal with but has caused one of the most important debates that we have had. I acknowledge the sincere concerns of Mr Matheson and of other committee members over amendment 327. There has been an anxious debate over the issues raised by the amendment, and fears have been expressed that the bill opens the way to what has been termed passive euthanasia.

As we have said before, nothing could be further from the case. The Scottish Executive has no plans to change the law in respect of euthanasia. We repudiate calls to legalise euthanasia. An act of euthanasia, in which the injuries are not self-inflicted, would be regarded as the deliberate killing of another, and would be dealt with under Scots law, under the criminal law of homicide. Nothing in this bill changes that position. Right away, therefore, we have a very powerful response to Mr Matheson's fears. Any health professional, like any other individual who acted by any means—be it by withholding treatment or by denying basic care such as food and drink—with the objective of euthanasia, would be open to prosecution under criminal law. That is the general position, and this bill does not alter it.

11:15

I will turn to some of the assertions made, firstly by those who read sinister intent into a bill which is designed to do the precise opposite: to protect the adult with incapacity. We have had useful

discussions with a number of groups with an interest in the bill. They have made sincere, carefully argued points, underlining their wishes and concerns. Many of them have communicated in a similar way with their MSPs and with members of this committee. However, those groups have been ill served by articles in newspapers over the past few months, and indeed in the past few weeks. Some of those articles were, I think, referred to by the convener yesterday. They have distorted the issues that we are discussing today. I know that we have examined the facts in a measured way during the debate. We have not responded to the irresponsible scaremongering which has found its way into print, and we can be proud of that.

I appreciate Mr Matheson's concerns, however, and I certainly do not include them in those last remarks. I am grateful for the opportunity to clarify what the bill does and does not do. I wish to examine, one by one, the questions that have been raised of which there are many.

The first, and most unlikely, which has been included in some of the arguments made to committee members, is that doctors under pressure, perhaps because of a shortage of bed spaces, may collude with unscrupulous proxies, who perhaps have an interest in the estate of the patient, to deny treatment and basic care. The committee has already discussed the standard of decision making required of proxies such as attorneys and guardians. It has agreed that the bill should not include statutory duties of care, because there are already good safeguards to ensure that the proxy acts in the adult's interest. The committee has also agreed that it was unnecessary and undesirable to prohibit proxies from certain actions and decisions similar to the harmful ones referred to in amendment 327.

We have provided, in our amendment to section 47, that anyone with an interest in the personal welfare of the patient can challenge a treatment decision in court. Even if a welfare attorney or guardian were to behave unscrupulously and sought to enlist a doctor's support in bringing about the death of a patient, they would have to contend with the possibility of a challenge from others.

Those who disagree with the proposals in part 5 of the bill have further suggested that doctors may refuse life-supporting measures to patients whose existence is not considered to benefit them. To suggest that is to confuse the provisions of the bill, which are about helping and healing adults with incapacity, and the common law in relation to patients in a persistent vegetative state. Much of Michael Matheson's argument was based not on the Adults with Incapacity (Scotland) Bill, but on the common law. Our amendments specifically underline that the provisions of part 5 are made without prejudice to other enactments, or to the common law. It is misguided to suggest otherwise. The bottom line is that this bill does not supersede the Law hospital judgment. I will return to that judgment later.

Opponents of part 5 of the bill have claimed to recognise, in its general principles, which require all interventions to be for the benefit of the adult, a way of introducing euthanasia when existence can be shown not to be a benefit. Section 1 does not, however, authorise any substantive action or omission; on the contrary, it sets down guiding principles. It can operate only along with provisions of other parts of the bill, and cannot be used to justify the withholding of basic care.

The Executive has already undertaken to consider an amendment to the bill, at stage 3, to clarify that an intervention may be either an act or an omission. That fact was referred to by Christine Grahame, who is correct. That would further strengthen the protection that is offered by these general principles. A closer examination shows that section 1 also requires any intervention to be

"the least restrictive option in relation to the freedom of the adult."

Clearly, to cause a person's death would be the most restrictive option imaginable. So, even considering section 1 of this bill in isolation, the fears that have been expressed are groundless.

I now turn to one of the most frequent criticisms of this part of the bill—that it will allow patients to be starved or dehydrated, for whatever reason. Those who put forward that suggestion do so in the face of the facts. Section 44, the section that those people criticise, cannot be read as allowing any such thing, as it limits the doctor's authority to treat an incapable patient in two ways.

First, it authorises him to do only those things that will safeguard or promote the physical or mental health of the patient. Any action or omission which does not have that effect is not authorised by this bill. It must be obvious that the withdrawal of food or liquids, however they are administered, when that will lead to death, does not safeguard health and is therefore not permitted by the bill.

Secondly, the doctor is limited, in section 44, to doing

"what is reasonable in the circumstances".

That qualification is objective, and is not solely a matter of the doctor's opinion. He is therefore limited to action that he will later be able to justify as reasonable in the event of challenge.

As we are discussing the level of safeguard that is provided by the bill, it might be worth

considering the steps that a doctor will be required to take when planning treatment for patients who are incapable of making their own decisions. First, he will have to satisfy himself that the treatment that is proposed will benefit the adult, and that such benefit cannot reasonably be achieved by other means. Next, he must satisfy himself that the treatment that he plans is the one that least restricts the freedom of the adult with incapacity. Both those tests, which are required by section 1, have already been approved by the committee.

That section further requires the doctor to take account of the views of the nearest relative, the primary carer and any guardian or attorney who has been appointed. Having done that, the doctor must examine whether what he proposes to do would be regarded as reasonable by others. Then he must assess whether the proposed action will safeguard or promote the physical or mental health of the patient. Finally, as always, the doctor is bound to follow his professional judgment, act in accordance with his professional ethics and comply with the general law. Only if the proposed treatment complies with all those requirements is he authorised to carry it out.

I mentioned professional ethics. Some concern has been expressed, in the course of this morning's debate, over the British Medical Association guidelines. I want to respond to that concern in two ways.

In relation to the decision in the Law hospital case, the guidelines are generally accurate. However, in saying that the judgment did not require every PVS case to be referred to the court, we must remember that that must be taken with the Lord Advocate's subsequent statement that he would not authorise prosecution of a doctor who, acting in good faith and with the authority of the Court of Session, withdraws or otherwise causes to be discontinued life-sustaining treatment or other medical treatment from a patient in persistent or permanent vegetative state with the result that the patient dies. In other words, to take that action without the authority of the Court of Session would leave the doctor open to prosecution. That is the effect of the Law hospital judgment and the Lord Advocate's statement. This bill does not change that position.

Concerns have also been raised regarding the comments in the BMA guidelines on non-PVS patients, such as those who have suffered a stroke. The Law hospital case only applies to PVS. To withdraw hydration and nutrition from a non-PVS patient with the purpose of hastening death would leave a medical practitioner open to criminal prosecution. Let us be clear about that.

There is a further point. In the bill before us, section 74 makes it an offence, punishable, as appropriate, with imprisonment, for any person exercising powers under the bill—which would include a doctor or proxy—to wilfully ill-treat or neglect the adult. That is a further powerful sanction against doing anything that would result in an adult's death, or in lesser forms of harm.

I want to be clear about the effects of those safeguards. This bill does not authorise the withholding or withdrawing by any means whatsoever of feeding or hydration. The bill makes no distinction between different means of delivering food and water. To withhold food and water would not be treatment

"to safeguard or promote the physical or mental health"

of an adult with incapacity, and thus is not authorised under the bill.

The new Labour slogan "For the many not the few" was referred to. This bill applies not only to the few and not only to the many, but to all adults with incapacity. It does not authorise the withdrawal of nutrition and hydration by any means. These are stringent safeguards. It is right that they should be so. They will ensure that any treatment given to an adult with incapacity will keep that adult as well as possible, and will offer hope for improvement where possible.

I hope that what I have said will be recognised as a categorical assurance that nothing in the bill will permit a patient to be denied basic care, or to be starved, dehydrated or otherwise mistreated. I hope that it will be seen that those fears are unfounded, and I hope that Michael Matheson in particular will accept that we have no intention of permitting euthanasia, either active or passive, and that he will accept that the provisions of the bill, with the proposed Executive amendments, ensure that.

I have sought to demonstrate that the amendment is unnecessary, but I would like also to demonstrate that the amendment is unwise and, indeed, flawed. First, the title of the amendment states that it is a prohibition, but if it is intended to create a prohibition, it does not. The amendment carries no sanction. It merely attempts to introduce a prohibition without any penalty for its contravention. That is unsatisfactory. On the other hand, the Law hospital judgment, taken with the then Lord Advocate's statement, is much more definitive. Immunity from prosecution under the criminal law is only guaranteed where the doctor has the authority of the court to withdraw or withhold treatment.

Further, our policy, stated, for example, in "Making the Right Moves", clearly affirmed the view that it was premature to legislate in relation to patients in PVS. Mr Matheson's amendment, with its reference to withholding or withdrawing treatment or food or fluids

"with the purpose of causing or hastening the death of that adult",

clearly runs the risk of legislating prematurely. A legislative provision, positive or negative in this regard, is arguably encroaching on the area of the common law that is currently covered by the Law hospital case. Whether that is the amendment's intention or not—and I believe that it is not, as Mr Matheson has made clear—none the less, as Gordon Jackson argued powerfully this morning from many years of experience, this amendment would run the risk of encroaching on the Law hospital case. In addition, Euan Robson is right that the amendment introduces new, undefined terms to a considered legislative regime, and that is dangerous.

I am confident that the bill, as improved by the Executive amendments under discussion today, is sufficiently watertight not to permit any action that would have the purpose of causing or hastening the death of an adult with incapacity. I therefore return to where I started. This bill is not about euthanasia or harming adults with incapacity. It is not about interfering with the common law. It is about protecting and helping adults with incapacity.

11:30

The committee, by and large together, has worked its way through a difficult moral maze, as Gordon Jackson said in the press earlier this week. We have held firm to some principles in doing so—that we are legislating to help rather than to harm adults with incapacity, and that we will not stray beyond the scope of the bill and interfere with the common law. The bill gives no authority to do anything that would deprive an adult of life. We have held to those principles, and I hope that the committee will continue to hold to them, will accept that amendment 327 is unnecessary and unwise, and will therefore reject it.

Michael Matheson: I will be brief because, if I were to respond to all the comments made against my amendment, I would probably require the 11 advisers that the ministers have brought with them today. I am grateful to the minister for going into such detail in his comments. However, the free legal counsel that I was given by Gordon Jackson today encourages me to believe that legal opinion is often wrong. In this case, I believe that the legal opinion of the Executive is wrong, and I am not convinced that the bill protects against passive euthanasia.

The minister referred many times to the need for treatment to be of benefit to the patient. The problem is that the bill provides no definition of benefit. The only definition of benefit that can be referred to is that which is contained in common law, and I referred to that in my earlier remarks on the Law hospital decision. It is still my view that the bill will extend the principles that were arrived at under the Law hospital decision to include incapable adults. I regret that that is likely to happen without scrutiny should a proxy and a doctor agree that it is not to the benefit of a patient for nutrition and hydration to continue.

When she gave evidence to the committee about challenging proxies, Professor Sheila McLean said:

"I am not sure on what basis you could challenge them because a proxy decision maker could always say that they had acted in good faith."—[*Official Report, Justice and Home Affairs Committee*, 17 November 1999; col 395.]

My amendment provides the overarching safeguard that is required to prevent passive euthanasia.

The Convener: The question is that amendment 327 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Roseanna Cunningham (Perth) (SNP)
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 3, Against 7, Abstentions 0.

Amendment 327 disagreed to.

Long title agreed to.

The Convener: That concludes stage 2 consideration of the bill. I thank committee members, ministers and officials for participating in this long process. I fear that I may see some of you again quite soon when we start stage 2 of the Abolition of Feudal Tenure etc (Scotland) Bill.

On Monday afternoon, one of our items for discussion will be a draft report on prisons. In keeping with our usual practice, I ask the committee to agree to hold that part of the meeting in private. Are we agreed?

Members *indicated agreement.*

Meeting closed at 11:34.

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ISBN 0 338 000003 ISSN 1467-0178