The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE

Monday 20 September 2010

Session 3

Printed and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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CONTENTS

END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE
6th Meeting 2010, Session 3

CONVENER

*Ross Finnie (West of Scotland) (LD)

DEPUTY CONVENER

*Ian McKee (Lothians) (SNP)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Cathy Peattie (Falkirk East) (Lab)

*attended

THE FOLLOWING ALSO ATTENDED:

Margo MacDonald (Lothians) (Ind)
Lynda Towers (Solicitor to the Scottish Parliament)

THE FOLLOWING GAVE EVIDENCE:

James Anderson (British Psychological Society in Scotland)
Dr Tony Calland (British Medical Association)
Malcolm Clubb (Community Pharmacy Scotland)
Kirsty Freeland (Association of Palliative Care Social Workers)
Theresa Fyffe (Royal College of Nursing Scotland)
Dr Bill Mathewson (Royal College of General Practitioners Scotland)
Dr Stephen Potts (Royal College of Psychiatrists, Scottish Division)
Professor Colin Robertson (Royal College of Physicians of Edinburgh)
Ruth Stark (British Association of Social Workers)
Detective Superintendent Brian Yule (Association of Chief Police Officers in Scotland)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 2

Scottish Parliament

End of Life Assistance (Scotland) Bill Committee

Monday 20 September 2010

[The Convener *opened the meeting at 14:35*]

End of Life Assistance (Scotland) Bill: Stage 1

The Convener (Ross Finnie): Good afternoon. I welcome everyone to the sixth meeting of the End of Life Assistance (Scotland) Bill Committee. As usual, I remind everyone to switch off any electronic equipment that might interfere with proceedings.

We have received no apologies. As always, we welcome the member in charge of the End of Life Assistance (Scotland) Bill, Margo MacDonald, who will participate in the proceedings. She will put questions to witnesses following committee members' questions.

There is only one item of business on the agenda, which is the continuation of the taking of oral evidence on the bill. We have two panels of witnesses. I welcome our first panel, which comprises Dr Tony Calland of the British Medical Association; Professor Colin Robertson of the Royal College of Physicians of Edinburgh; Dr Stephen Potts of Edinburgh royal infirmary, where he is a consultant in liaison psychiatry, and the Scottish division of the Royal College of Psychiatrists; and Dr Bill Mathewson, who is deputy chair for policy at the Royal College of General Practitioners Scotland.

We will move straight to questions.

Helen Eadie (Dunfermline East) (Lab): I have a question that is specifically for Dr Potts and which relates to his submission. I was interested to read about the relatively small number of psychiatrists that there are if we boil down the figures. I think that your submission refers to 16 consultant psychiatrists. According to the survey that your organisation undertook, perhaps six consultant psychiatrists would be willing to participate in the bill's arrangements and to be party to the work involved if the bill were to be passed. I was further concerned when I read more about issues in rural parts of Scotland, where there might not be any access to psychiatry. Your submission raises many issues, but that is one of the most important. Will you comment further on that?

Dr Stephen Potts (Royal College of Psychiatrists, Scottish Division): Thank you for giving me the opportunity to clarify matters. My specialty is liaison psychiatry—in other words, psychiatry in a general hospital. I deal with people who are medically unwell or have surgical problems. Psychiatrists in that specialty are perhaps most likely to be approached first of all by people who are seeking end of life assistance. The sub-specialty is small; at the last count, there were 27 consultants working in it throughout Scotland. I circulated them all and, as members can see, 16 responded. The majority of those who responded would not wish to take part in such assessments. You are right: that leaves a very small number who would do so. A question is therefore raised: how would those who seek end of life assistance be able to access a psychiatric opinion? Many rural areas of Scotland, such as the Highlands and Islands, have no liaison psychiatry services at all, and there is limited access to liaison psychiatry services for adolescents, such as those in the 16 to 17-year-old age group, even in Scotland's cities. That raises a further question. If a psychiatrist is allowed to opt out but is expected to find a psychiatrist who will not wish to opt out, how will they discharge the duty? I ask the question; I do not have an answer to it.

Helen Eadie: In your submission, you say:

> "Most of Scotland has no psychiatric service at all for adolescents in general hospital settings, and if those few specialists providing it opt out, there will be no age-appropriate and clinically aligned psychiatric assessment available anywhere in the country."

That issue is of more interest to me. Do you want to expand a little further on that?

Dr Potts: Thank you for giving me an opportunity to elaborate on that. Perhaps I should have made it clearer in my written submission that most of Scotland has no age-appropriate psychiatric service for adolescents in general hospital settings. That is certainly true in my hospital in Edinburgh. I am aware of one psychiatrist specialising in adolescents who works in a liaison setting in Scotland.

Helen Eadie: You said in your submission:

> "Psychiatrists cannot support legislation which has the potential for discriminating against those with mental as opposed to physical disorder".

I thought that that was an important point. Will you expand on it?

Dr Potts: A number of the people who responded to my request for information made that point. They noted that the bill draws a clear distinction between people with physical disorder and people with mental disorder, and potentially will allow people with physical disorder to seek and receive end of life assistance, while people with mental disorder will not be eligible for such assistance.

We know that in the Netherlands there is an established practice of euthanasia for people who have mental but not physical disorder—there are not many such cases, but they are there and the practice is possible. The psychiatrists who raised the issue said that the bill embodies or institutionalises a discriminative distinction between people with physical ill health and people with mental ill health, which psychiatry as a body would not be keen to support.

Ian McKee (Lothians) (SNP): How many members of the Royal College of Psychiatrists are there in Scotland?

Dr Potts: I do not know the total number, but it will be several hundred.

Ian McKee: Are you restricting your comments to liaison psychiatrists?

Dr Potts: I circulated liaison psychiatrists. The executive committee of the Scottish division of the royal college also submitted comments on behalf of their subsections, such as old age psychiatry, general adult psychiatry and child and adolescent psychiatry. However, the body as a whole has not been circulated.

Ian McKee: In many of the cases that have been presented to us from other countries, the decisions were made in a primary care rather than a hospital setting. The psychiatrist who would be contacted in the primary care setting would not necessarily be a liaison psychiatrist.

Dr Potts: Yes indeed. That is true.

Ian McKee: Do you have evidence of other psychiatrists' views?

Dr Potts: I have a small number of submissions from general adult psychiatrists, so it is not necessarily a representative sample. Their views break down in roughly the same way as the views of liaison psychiatrists do, with the majority being against participation.

Ian McKee: Did you formally seek the views of all psychiatrists?

Dr Potts: No. I concentrated on liaison psychiatrists.

Ian McKee: How did you get the evidence from people, if you did not consult them?

Dr Potts: I am a member of a liaison psychiatry network in Scotland that meets and e-mails regularly. I have the e-mail addresses of all 27 of us, so I circulated people in that way.

Ian McKee: I was wondering how you got evidence from psychiatrists who are not liaison psychiatrists.

Dr Potts: My liaison psychiatry colleagues asked others to submit comments to me, and the executive committee of the Scottish division of the Royal College of Psychiatrists was free to make its views known.

Ian McKee: So liaison psychiatrists, a majority of whom do not want to be involved in end of life assistance, asked other psychiatrists and passed their views on to you.

Dr Potts: I cannot speak for liaison psychiatrists elsewhere.

Ian McKee: No. But is that how you got the evidence? Are you saying that you do not have much evidence?

Dr Potts: I do not have much evidence about non-liaison psychiatrists. I accept that. I did not seek such evidence.

Ian McKee: The majority of psychiatrists in Scotland are not liaison psychiatrists.

Dr Potts: I started with the presumption that the psychiatrists who would be most likely to be asked would be those working in general hospital settings—therefore my own group.

Michael Matheson (Falkirk West) (SNP): I want to consider a couple of points that were made in the evidence from the Royal College of Physicians of Edinburgh and the Royal College of Psychiatrists, in relation to the oversight arrangements in the bill and who would assess a patient. The Royal College of Physicians said—in the second bullet point in paragraph 4—that there would be a need to ensure that all doctors who participate

> "have the necessary knowledge and experience"

to enable them to carry out the assessment.

Furthermore, I note that in its submission, under the heading "Oversight arrangements", the Royal College of Psychiatrists refers to

> "The requirements of clinical governance, appraisal and professional revalidation"

in "areas of clinical practice"

that are relevant to the assessment process. Can you clarify for me, as a layperson, what you feel needs to be tightened up in this area? Am I correct in understanding from your submissions that you feel that the bill should make specific provision to regulate the types of clinicians and the skills that they must have to undertake the assessment process?

14:45

Professor Colin Robertson (Royal College of Physicians of Edinburgh): On the comments made by the Royal College of Physicians, I point out that the second bullet point in paragraph 4 is expanded in the fourth bullet point. At present, the bill refers to "a registered medical practitioner", which could mean that a relatively junior and inexperienced doctor might be involved not only in decision making but in the process itself. We felt that some guidance would be required not only on the grade and seniority of the individual involved but on specific training in psychiatric aspects for non-psychiatrists and the process to assist the end of life activity. That process might involve, for example, the administration of certain drugs; if so, the nature of those drugs, the way in which they would be administered and the dosages concerned would be outwith the normal experience of a registered practitioner, and additional training would be required on the drugs that could or should be used, the ways in which they should be used and possible complications. The last thing that one would want in this situation would be for the process to cause additional distress to the patient, their relatives or their friends.

Have I made myself clear?

Michael Matheson: Yes. I might come back to you after I have heard from the Royal College of Psychiatrists.

Dr Potts: A purpose of revalidation is to ensure that all aspects of a doctor's practice are subject to oversight and clinical governance. In other words, we should not be allowed to have practitioners working in isolation and at risk of becoming rogue practitioners. As far as I can see, the bill makes no provision to ensure that that is the case for the psychiatrists who might be involved in giving opinions about end of life assistance in this specific area of their work. If such work is part of and subsumed into their national health service work, those appraisal and clinical governance arrangements will apply, but if it is additional to and separate from it, additional arrangements will need to be put in place to ensure adequate oversight.

Michael Matheson: As a layperson, I want to get a clear understanding of this. If the bill were enacted and if I were seeking to exercise my rights under it, how would I be able to tell from looking at a medical practitioner's qualifications whether that individual had the necessary qualifications and skill to carry out the role? I can understand if a psychiatrist, say, is specifically registered as a medical practitioner to carry out the specific function, but what would need to be done to create that kind of transparency with regard to other practitioners?

Professor Robertson: One possible mechanism for hospital-based specialties would be to ensure that the individual had performed all the necessary tasks and examinations, had the clinical experience and had completed the full training to achieve registration as a specialist. Without ducking the question, I think that the individual concerned would, most commonly, be a general practitioner, although I defer to my colleague in that respect.

Even if an individual has an appropriate specialist training certificate, they are likely to require additional specific training in, for example, the drugs and drug administration that would be required in the situation, as that would be outwith their experience.

Dr Bill Mathewson (Royal College of General Practitioners Scotland): I agree with what Professor Robertson says. The most likely source that a patient or their relatives might go to in order to obtain an opinion in seeking an appropriate clinician would be the general practitioner. I think that that would be a natural first step. One would expect the GP to have knowledge of the consultant specialists in his or her area and to be able to assess them—or at least contact them informally or formally—regarding their willingness and the appropriateness or specialist nature of their training.

Michael Matheson: For my final question, I pick up on a comment that was made by Dr Potts. If the bill's provisions cannot be met within the NHS, meaning that the clinical governance that would normally apply to practice within the NHS would not be available, what would need to be put in place to ensure that the clinical governance and revalidation existed to support someone who was carrying out the procedure in private practice?

Dr Potts: I am not sure that I am the best person to attempt an answer to that question. The best parallel is perhaps with psychiatrists who work in private practice. I have never worked in private practice and do not know the details of the way in which clinical governance and appraisal work in that setting. Nevertheless, there may be something to be gained from seeing how they work in that setting if the bill is to be enacted.

The Convener: Can anyone assist with Mr Matheson's question?

Dr Mathewson: A doctor in private practice may not be subject to national health service clinical governance arrangements, but they will soon be subject to revalidation, as will every practitioner in due course. Every practitioner who is registered in the United Kingdom is also subject to the statutory oversight of the General Medical Council under the Medical Act 1983, and the guidance that the GMC gives out—almost annually, one would think—is well regarded, appropriately listened to and adhered to. There is a set of guidance for all aspects of clinical practice relating to probity, consent procedures and capacity issues—it is all there.

A practitioner in private practice may not be subject to the clinical governance arrangements that exist within the NHS but, within the private setting, there is likely to be some form of overarching clinical governance as well as the deeply embedded GMC guidance to which every practitioner is subject.

Nanette Milne (North East Scotland) (Con): In the discussion so far, there has been a presumption that it would be a medical practitioner who would administer assistance to end life. However, the bill does not make any provision to control who would administer that assistance. Am I right in thinking that the role could be extended to, say, someone in the nursing profession or the pharmacy profession? I presume that those people would also require specialist training. Do you have any comments on that? Am I wrong in my assumption?

Professor Robertson: That relates to paragraph 18 in our submission. As you will appreciate, the college of physicians has not taken a stance on the bill per se. However, there was a grave concern that, if assistance was undertaken by non-medical practitioners, those people should not be empowered to undertake medical procedures for which at present they have no training. I think that we would have major concerns if that route was taken.

Ian McKee: I return to a point made by Professor Robertson about asking doctors to prescribe medication in areas in which they have had no experience or training. Will Dr Mathewson update me on the latest clinical governance arrangements for GPs prescribing medication beyond the terms of the pharmaceutical company’s licence, which is issued by the licensing bodies?

Dr Mathewson: My understanding of the current situation is that a general practitioner can prescribe any drug that is in the “British National Formulary” and in relation to which he has appropriate experience and knowledge. One would not expect a general practitioner—or any practitioner, for that matter—to prescribe drugs with which they are not familiar and of which they do not have sufficient experience to prescribe. The point is explicit in some of the GMC guidance—practitioners of whatever specialty should not reach into areas in which they do not have competence, experience and knowledge. The proposal in the bill would reach into the area of practitioners prescribing drugs that they might not be used to prescribing on a general, daily basis, as Professor Robertson alluded to.

Ian McKee: I accept that practitioners require that degree of knowledge, which would have to be obtained somehow for this situation, but is it not the case that GPs fairly regularly prescribe over and above the amount officially recommended under the licence?

Dr Mathewson: There are provisions for off-licence prescribing. It is not a common occurrence and, as I understand it, in practice it usually relates to prescribing to children drugs that have been licensed for adult use but which, with the help of paediatricians, can safely be prescribed to children. That is my only experience of off-licence prescribing, but it happens.

Ian McKee: What about diazepam for people with drug problems? For example, the manufacturer’s recommended dose of diazepam does not extend to the amount that GPs prescribe almost daily.

Dr Mathewson: That is right, and it is a matter for the clinical judgment of the general practitioner. As you know, diazepam is a widely used drug, and all GPs will be familiar with its use. Local addiction services will be used to prescribing large doses of benzodiazepines, and I think that every GP in the land would be pretty familiar with prescribing out of the range of the doses that are in the BNF.

Ian McKee: It could be six or seven times the maximum dose.

Dr Mathewson: I agree with Professor Robertson that, when you reach the point of prescribing a dose that is going to be lethal—if that is the intention—you might not necessarily prescribe correctly. Such prescribing would involve expertise that your ordinary, everyday GP does not have, and the GP would have to take advice on it if he were the designated practitioner.

That takes us back to the choice of designated practitioner and their expertise and knowledge. As we all know, every patient is different in relation to body mass and metabolism of drugs. GPs are not experts in those areas, and they would have to take advice.

15:00

Cathy Peattie (Falkirk East) (Lab): Can I go back to Dr Potts’s comment about discrimination against people with mental disorders? That seems apparent, yet to me there is also a contradiction in the role of psychiatrists, which is outlined in the paper from the Royal College of Psychiatrists. Psychiatrists often work with people who seek to commit suicide or whatever. They try to work through some of those issues, and people often come out the other side. How would psychiatrists deal with that difficulty?

The other thing that I am interested in is how the decision would be made. What is appropriate in terms of the possible end of life for someone with a mental disorder and what is not? What is simply a situation that people are involved in at a particular time, due to some kind of crisis or whatever, or an on-going thing that is generally supported through medication or counselling?

Dr Potts: If I have understood you correctly, you are referring to two major areas of the work of psychiatrists in general hospitals—people who present in large numbers after self-harm or attempted suicide. Across Scotland, there are thousands of those each year. The role of the psychiatrist is to assess whether the person’s problems arise from mental disorder, and if they do, to ensure that they receive treatment, if they do not, to see what other forms of help might benefit them. That is everyday practice. It is part of the reason why some psychiatrists, or perhaps the majority, might be reluctant to participate in the measures that are proposed in the bill, because that participation apparently goes so diametrically against what psychiatrists do in the rest of their working week. Speaking personally, that is the way I view it, and I believe that it is also the way that quite a large proportion of my colleagues view it.

On the second part of your question, when somebody has developed a severe, progressive medical illness and they are understandably low in mood and anxious about their prospects, how do we distinguish between what we might regard as normal levels of anxiety and distress and what we might regard as a depressive illness that requires treatment in its own right? That is, or can be, remarkably difficult. Sometimes, the only way to tell is to give the person a trial of treatment to find out. It is often a matter of fine judgment and there is often an expectation that we might well get it wrong in deciding whether somebody with a newly diagnosed cancer is also depressed or whether their mood is simply the reaction that anybody with that diagnosis might have. It is far from an exact science.

Cathy Peattie: Thank you.

Ian McKee: I would like to bring Dr Calland into the discussion. He might be feeling a bit lonely. I read the submissions from all four of the professional bodies. Three of them state that they cannot give a view on behalf of the professional body because of differences of opinion within the body, but the BMA has no such inhibition and its submission states:

> “the BMA is fundamentally opposed to any change in the law”.

Reading your evidence, it seems that your annual representative meeting agreed to it in 2005 but that its position was reversed in 2006 and that that was that. How do you interpret that as allowing your whole body to be

> “fundamentally opposed to any change in the law”?

Dr Tony Calland (British Medical Association): Just to correct you, in 2005, we did not agree to a change in the law at all. We moved, on a very narrow majority at the annual conference, from a position of being opposed to it, which we had been for probably more than 20 years, to a neutral stance. That precipitated an absolute furore from the profession and significant numbers threatened to leave the association. The matter was redebated in 2006 and we reverted to our original position, which was to oppose any change in the law.

Ian McKee: We have heard from other countries, and it seems to make sense that, if the bill were to go through, an awful lot of the decisions would take place in the primary care setting. A lot of people die at home.

The evidence from the Royal College of General Practitioners states:

> “RCGP Scotland cannot offer a clear statement on the issue of assisted suicide as responses received directly from members are polarised, with equally strong views submitted both in support and against the concepts addressed within the Bill.”

Why are the members of the Royal College of GPs such outsiders, given that most of them must surely be members of the BMA?

Dr Calland: I am sure that they are members of the BMA. The BMA has a structure for formulating its policy—its annual representative conference. The people who attend the conference are selected by their division or craft committee to represent the opinions of the division or craft committee and to listen to the debate on the day. They vote accordingly. That is the mechanism for making BMA policy. It is a formalised mechanism that gives a clear answer, which is what we are doing.

Ian McKee: I accept that you have a clear answer. However, I was a member of the BMA in 2005 and 2006 and I cannot remember any representative asking me what I thought about the issue. The main difficulty was getting a sufficient number of volunteers to go to the meeting at all. Do you think that it might be a little optimistic to believe that the volunteers were necessarily representative of the body that sent them there?

Dr Calland: No, I do not, actually. You should have been aware that the motions were being debated. Had you had a particular view about the issue, you could have made your views known. We cannot go round beating up all our members to demand answers on all the motions that are debated. If people do not put forward their views, one has to assume that they are neutral or that they do not have a particularly strong view.

I agree that views on the issue are completely polarised. It is not an issue that people can be ambivalent about—they are either for it or against it. There are strong, perfectly reasonable and cogent arguments on both sides of the debate. However, the BMA's position, after its annual conferences and the medical ethics committee debates—which involve a much smaller gathering—has consistently been against any change in the law, certainly since 2006.

Ian McKee: I ask Dr Mathewson to help elucidate the mystery.

Dr Mathewson: The Royal College of General Practitioners Scotland has about 4,000 members from the 5,000 or so GPs in Scotland. That is a high percentage of the GPs, but a relatively small percentage of the total number of medical practitioners in the country. The BMA, in reaching its stance, has consulted or had views expressed to it by a larger number of practitioners, not just general practitioners. I am not a statistician by any means nor an interpreter of polls, but that must be one reason for the variation between the BMA stance and the RCGP stance.

The views were distinctly polarised in the written responses that the RCGP Scotland has received. In the debate at our Scottish council, strong views were given on both sides. I do not know the precise numbers, but it would have been wrong to have come out on either side, given the strength and the apparent gross equality of the views. I cannot account for how the BMA comes to its conclusions, but we are taking the stance that the United Kingdom RCGP took following the Joffe bill in Westminster.

In 2005, the RCGP issued the statement that the way forward for the college was to support the development and wider existence of caring, specialised and improved palliative care for end of life issues. That is where we stand as RCGP Scotland.

Ian McKee: We all support the wider development of palliative care—I have heard no one argue against that—but the bill is for Scotland, so I am interested in RCGP Scotland's views.

Dr Mathewson: I understand that. We do not have a constitutional problem, but that is an RCGP statement and an RCGP Scotland statement. On the bill, our members stand polarised.

Ian McKee: I understand. Unlike the BMA, which develops opinion via a representative body to which people are elected and via discussion, you said that you consulted your members. Will you tell me more about that? Was the consultation formal?

Dr Mathewson: It was a formal consultation through the faculty structure.

Ian McKee: Do you know how many responses were received?

Dr Mathewson: I am sorry—I do not have that figure.

Ian McKee: That formal consultation came out roughly 50:50.

Dr Mathewson: Yes—that is my understanding.

Ian McKee: Your submission says:

> "Members questioned the definition of the 'registered medical practitioner' within the Bill and ... requested clarity as to whether 'registered medical practitioner' referred to a medical practitioner registered with the"

General Medical Council

> "or to a patient's registered medical practitioner".

Correct me if I am wrong, but I thought that patients no longer had registered general practitioners.

Dr Mathewson: You are correct.

Ian McKee: So your worry on that score—

Dr Mathewson: The worry as expressed in the submission is not a worry.

Nanette Milne: Dr Potts, section 8 of your submission, which is on assessing undue influence, says that

> "psychiatrists have nothing to offer in assessing coercion."

I understand that, but I also understand that you are an independent assessor under the human tissue legislation. I am interested in whether that role has informed your views on how easy or difficult assessing undue influence is.

Dr Potts: That role has informed me by confirming that assessing coercion or its absence is definitely not a matter for psychiatrists. That is not to say that psychiatrists cannot do it, but their position is no stronger than that of general practitioners, nurses, psychologists, hospital specialists and others. The matter is not specifically psychiatric—psychiatrists do not bring specifically psychiatric skills to the assessment. One concern with, or possible flaw in, the bill is that it assigns the responsibility for assessing and excluding coercion to a psychiatric assessment.

Nanette Milne: That is helpful. Thank you.

The Convener: Does Cathy Peattie have a question?

Cathy Peattie: We have moved on and have covered the question that I wanted to ask.

Michael Matheson: My questions relate to Dr Potts's point about assessing mental disorder and capacity. Your submission suggests that the bill is wrong in section 9 to assign largely to the psychiatrist the responsibility for assessing capacity. I was interested to note that the presumption in the bill is that a person does not have capacity; a person must prove otherwise.

Will you expand on why you believe that psychiatrists are not best placed to make the judgment? Who else should be involved in the process?

Dr Potts: Since the introduction of the Adults with Incapacity (Scotland) Act 2000—which was the first major act that the Parliament passed and in which regard Scotland is a world leader—a common reason for referrals to departments such as mine in general hospitals has been assistance in assessing a patient's capacity. Our audits show consistently that about 25 to 30 per cent of the 1,000 or so referrals that we receive from the medical and surgical wards each year are for that reason.

Our clear role is to assist—not to lead—in assessing capacity. We assist by using a series of questions. What is the decision that is before the patient for which they have to have capacity? Are they being expected to consent to surgery or to accept a course of chemotherapy? What is it that calls their capacity into question? What assessment has been made to date before the psychiatric referral to address the first questions?

15:15

If someone has a psychiatric history and there is apparent evidence of mental disorder, of course psychiatrists can, should and do assist their physician and surgeon colleagues in coming to a view about the patient's capacity. However, we start from the presumption that we all have capacity unless it is proven that we do not. The burden of proof lies on those who would say that we have lost capacity. That burden can be quite a heavy one to discharge, although psychiatrists are familiar with the requirement to say that because of a mental disorder of such severity the patient lacks the capacity to make the decision on treatment that is before them, and accordingly to advise physicians and surgeons on the use of the Adults with Incapacity (Scotland) Act 2000.

If I have understood it correctly, the bill would reverse that presumption, although it does not make that explicit. Psychiatrists would be asked to say that someone has capacity, and to do so when there was no evidence or question of mental disorder. There is therefore a separation between the role of psychiatrists in deciding capacity questions in medical and surgical wards, and that in deciding capacity questions that would arise under the bill. I do not understand why the bill takes a significantly different view of the psychiatrist's role in assessing capacity from the existing incapacity legislation.

Michael Matheson: That is helpful. Who do you think should have that role? Going on your evidence, I get the impression that you do not believe that it should be a given individual and that a number of individuals might have to contribute to that assessment.

Dr Potts: It would depend on what it was that called the patient's capacity into question. The incapacity legislation makes it clear that the person with the lead role in assessment is the doctor who is primarily responsible for the treatment that is being offered to the patient. That doctor would know the most about the treatment and its side effects, benefits and so on. If that doctor is aware of apparent mental disorder, they can seek the assistance of a psychiatrist or psychologist in coming to a view about the patient's ability to understand. If there are questions about the patient's ability to communicate or to make known their views, the assistance of interpreters, speech therapists or occupational therapists might been needed. We need to judge what assistance is required in terms of the patient who is front of us, the decision that is being placed before them, and whatever it was that called their capacity into question.

Michael Matheson: That is helpful. My final question is on conscientious objection. The bill is silent on that, but I am interested in the views of the professional bodies that are here today. Should the bill contain an explicit provision on conscientious objection?

Dr Calland: The BMA is opposed to the bill, so we would not wish to consider that issue.

Michael Matheson: Can I put it another way? If the Parliament passes the bill, what response should we expect from the BMA and its members on the provisions in the bill if you do not think that there should be something in the bill to provide protection for conscientious objectors?

Dr Calland: In other legislation that might be considered to be similar—abortion legislation, for instance—there is a conscientious objection provision, and we support that. We would support something similar in the proposed legislation. However, that would be to assume that the bill will be passed by the Parliament.

The Convener: You have all made your positions clear to us, either individually or in relation to the organisations you represent. My colleague is not seeking to trick you into making any other presumption; he is simply asking you what I think is a reasonable question about conscience that has been raised by a large number of witnesses. He is not trying in any way to seek to change the presumption on which you are giving evidence or your basic position.

Professor Robertson: I have two points to make, the first of which relates to practicalities. In remote and rural areas, it might be very difficult for a practitioner to opt out of the system for reasons of conscience. Linked with that, the bill is not clear about how often a patient can make a request. I expect that one would not want to have a series of rolling requests, particularly if the practitioner in question did not wish to be involved in the process.

Dr Mathewson: I hope that I am not relying on it too much, but I revert to the GMC's guidance, to which, I must stress, the medical profession pays a lot of attention. In the section in its generic booklet "Good medical practice" headed "Decisions about access to medical care", paragraph 8 says:

> "If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor."

Moreover, in the latest GMC guidance "Treatment and care towards the end of life: good practice in decision making", which was issued in May, paragraph 10, which is headed "Presumption in favour of prolonging life", states that

> "Following established ethical and legal ... principles, decisions concerning potentially life-prolonging treatment must not be motivated by a desire to bring about the patient's death, and must start from a presumption in favour of prolonging life."

I simply draw the committee's attention to those points.

The Convener: That is helpful as far as it goes, but I note that although the second set of guidance that you referred to states a clear presumption, it does not necessarily answer the question whether, in the GMC's view, the bill ought to contain an explicit provision for conscientious objection that is directly related to the paragraph to which you have kindly drawn our attention, or whether doing so would help or hinder the maintaining of that presumption.

Dr Mathewson: I agree. Very often the situation puts the practitioner on the spot and presents them with a great dilemma. That is why one should consider whether there should be an opt-out for a doctor who genuinely cannot bring himself or herself to assist a patient to terminate their life. It is a very deep question on which people on both sides of the argument have deeply held views. In my view, opting out would be a proper and appropriate way of dealing with the situation.

Ian McKee: In response to Dr Mathewson's citing of the GMC guidance on not doing anything that would end life prematurely, I am pretty certain that before David Steel's Abortion Act 1967 the council's guidelines on abortion made it clear that a doctor should play no part in procuring an abortion. In that case, what the council says now and what it might say if this bill succeeds are not necessarily relevant.

Dr Mathewson: That is correct. Indeed, it is one of what I would call the big picture issues that would emerge if the bill were to be enacted. The GMC will have to take a stance either by reinforcing or redrafting its current guidelines. Surely that is how medical ethics progress, is it not?

Nanette Milne: I stand to be corrected, but am I right in assuming that the current GMC guidance puts the onus on the patient to find an alternative practitioner if the practitioner in question seeks to opt out on conscientious grounds? Am I also right in saying that under the bill the practitioner would have to refer the patient directly to another practitioner?

Dr Mathewson: As I understand it, the guidance says that if, because of religious or moral beliefs, the doctor cannot carry out the procedure, whatever it might be, he or she is duty bound to refer the requesting patient to another source of advice or to another practitioner who might be willing to consider the patient's request.

Nanette Milne: So, it is the same.

Michael Matheson: According to your comments to Ian McKee, we cannot at the moment rely on GMC guidance to deal with those issues because the guidance might be altered if the bill is enacted. Surely that is all the more reason for the bill to give legal standing to conscientious objectors' right to opt out. After all, guidance is nothing more than guidance.

Dr Mathewson: I agree; it is only guidance. The position is discussed—not frequently, but not infrequently—by ethicists and medical legal advisers in everyday and specialist practice.

The Convener: In making provision for end of life assistance while making it clear that it would not happen as a matter of course, the bill—particularly in section 4—sets out an eligibility requirement. We understand the difficulties that we can get into because of your general presumption against the bill but, as regards the matter of principle, it is important for us to know whether, as medical practitioners and experts, you have a view on whether the criteria in section 4 are appropriate and capable of being interpreted in a way that provides the intended clarity?

15:30

Professor Robertson: My understanding is that the eligibility criteria require registration with a general practitioner for 18 months prior to any consideration. Is that correct? I am not a general practitioner, but I know that it is not uncommon for individuals who anticipate increasing infirmity or inability to manage on their own to move to stay with family members or, sometimes, friends and require to reregister with a local general practitioner. That could cause a problem, because it might mean that such a person would fall foul of the 18-month rule.

The Convener: The bill says that a person must have been registered with a medical practice but does not specify that it must be the same one. As I understand the bill, that means that they can have been registered with a medical practice in Scotland for 18 months but do not require to have been with the same one for all that time. If somebody came from south of the border, that might give rise to some difficulty.

Professor Robertson: It is not unknown for people to come home to Scotland in the anticipation that they are nearing the end of their lives.

The Convener: That is perhaps more a practical difficulty rather than a matter of principle. The criteria—age, being registered with a medical practice, being diagnosed as terminally ill, having physical incapacity and finding life intolerable—are in the bill to assist. My question is simply whether, as a matter of principle, you regard them as being appropriate and capable of being easily interpreted by those who might have to practise under the bill.

Dr Potts: I will make a couple of comments about the eligibility requirements. I am aware that you have had considerable discussion with previous witnesses about whether the age cut-off should be 16, 18 or even less than 16. The Royal College of Psychiatrists is fairly clear that it should be raised to 18, for the reasons that are set out in our submission.

The requirement for those who are not terminally ill to be

“permanently physically incapacitated to such an extent as not to be able to live independently”

is clearly not a matter for a psychiatrist to judge, but it raises the question how independence is to be defined. Occupational therapists might have a view about what they can do to make somebody more independent in any given set of circumstances. The next few words in the paragraph are:

“and finds life intolerable”.

Finding life intolerable is sometimes the symptom of a depressive illness that needs treatment, rather than being an understandable response to a serious medical problem. Sometimes it is both. It is important to point out that it can be extraordinarily difficult to judge whether a patient’s finding life intolerable arises from a mental illness, a medical disorder or both. For that reason, the psychiatrists whom I represent have concerns about the use of that language.

Dr Calland: One of the reasons why the BMA takes the stance that it takes is the difficulty that we get into with definition. One fully understands the difficulties for patients who are close to death and the arguments for their wishing to hasten it.

However, the more widely you cast the net, the more considerable is the potential for incremental slippage of the legislation. It would be extremely difficult to achieve what people would want to achieve with the bill without broadening that net to the point at which there would be incremental creep in how things worked in practice.

We have seen that. The Netherlands started off fairly clearly with a bill to deal with the terminally ill, but there has been a creep towards including people who are seriously ill and find life intolerable, and even to dealing with severely handicapped newborn children. That is one of the worries that we have about any kind of legislation in the field. Once the rubicon is crossed to change the law to allow the knowing and premeditated hastening of the death of another person, we can never go back. That is one of the reasons why we are totally opposed to the bill.

The Convener: We must try to draw the discussion with this panel to a close. Margo MacDonald must have ample opportunity to speak. I ask members to confine their questions, if possible.

Cathy Peattie: I will try to do so. I want to ask the palliative care people a question. The BMA’s paper discusses palliative care, including differences in palliative care throughout the country. The BMA and others appear to be concerned that the bill may lead to the end of good-quality palliative care. In some areas, palliative care is very good, but palliative care for people who choose to die at home, for instance, can be pretty patchy and is sometimes horrific. Are you concerned that, if the bill progresses, the resources for and development of palliative care would suffer? Perhaps you could explore that matter with us.

Dr Calland: I would not like to make that assumption. I hope that there is enough understanding among commissioners of the importance of good palliative care services. I was a general practitioner for 34 years in a rural area—in fact, I had a cottage hospital. We looked after most of our dying patients within the practice and in latter years, when people started to understand palliative care, we were supported by extremely good palliative care nurses and other specialists.

We cannot overemphasise the importance of palliative care. It would be a terrible shame if the bill was seen as an easy option if it were passed. I have no view on whether that would happen, but one could argue that that is a risk.

Cathy Peattie: It is clear that the development of palliative care is important. Really good examples are provided where it works well, but it does not always work well. I am concerned that the bill is a cheap option that would mean fewer resources. I hope that we never get to that stage.

Dr Calland: I sincerely hope that things will never reach that stage. If they did, that would mean that medicine had moved into areas that I would be very uncomfortable with.

Helen Eadie: When we receive many papers, it is always difficult to be able to go through all the points. Indeed, that is clearly not possible, but we must thank you for making a number of good practical points. I have no doubt that we will consider some of the other practical points that have been made.

I have been interested in work that has been done in the Netherlands by the commissions that were set up to monitor, assess and evaluate how the legislation had worked there. I am particularly interested in what Dr Potts's paper says about reporting to the procurator fiscal, and note the point that he made about Dr Kevorkian, who was an enthusiast for developing assisted suicide, I think. I had to go online to check out exactly what he had done, as I did not know. He was prosecuted, ended up in prison, and was released early. I would like to know the thinking of Dr Potts and the Royal College of Physicians on monitoring after the event. What issues does that throw up? Clearly, if there is an enthusiast out there, there are concerns for the public.

Dr Potts: The concern that I was attempting to raise in referring to Dr Kevorkian is exactly that—that somebody might be operating as a rogue practitioner.

As I understand it, the requirement in the bill is to report cases to the procurator fiscal after the person involved has died—it is for retrospective reporting. That is my also my understanding of what is meant to happen in the Netherlands, but I believe that there is evidence that not all cases in the Netherlands are reported. In some of the evidence that has been submitted to the committee, we are told that the reporting rate has increased, but it is still not 100 per cent. That opens the door to the possibility of rogue practitioners and inadequate oversight. I wonder whether there is any way of introducing a more proactive form of regulation by the relevant legal authorities, but I have no suggestions to make about the format that that should take.

Professor Robertson: I have two suggestions. I agree with Dr Potts that it would perhaps not be in the best interests of the patient or the doctor for a case to be retrospectively communicated to the procurator fiscal. One possible mechanism would be for the procurator fiscal to be informed at the time the agreement was made. A two-day cooling-off period is already built into the bill. Notifying the procurator fiscal at the time of agreement would potentially address some of the problems to which Dr Potts has alluded and it would be an additional safeguard for the patient. If a family member or friend felt that there was any coercion or inappropriateness in relation to the agreement, they could communicate directly with the procurator fiscal.

The second possibility relates to death certification and sounds like a technicality but might not be. Is it appropriate for the individual who undertakes the end of life assistance to sign the death certificate? One way of addressing the rogue practitioner danger would be to have the same arrangement as pertains with the signing of cremation papers, for which the signatures of two independent doctors are required.

Margo MacDonald (Lothians) (Ind): I ask all the witnesses whether they can point me to a part of the bill that requires any person to take part. Is there anything that says that anybody has to take part?

Witnesses *indicated disagreement.*

Margo MacDonald: That means that the question of opting out is, by and large, tackled in a different way. Because of the difficulties that we have—of which I am sure you are aware—in constructing legislation that does not offend against the reserved functions, we sometimes have to go about things the opposite way round. No one is obliged to take part—I think that we are agreed on that.

One or two other things have come up. I will address my first questions to the BMA. Your paper talks of fundamental opposition and of firm consensus among your members that there should be no change. I will not labour the point, but I would like to know the basis on which we should take that. Is there consensus or is it, as you said, that the BMA is firmly opposed to any change in the law?

Dr Calland: The BMA policy on the issue is quite clear: we are opposed to any change in the law.

Margo MacDonald: Was the policy arrived at after a consensus had been reached?

Dr Calland: It was arrived at through our policy-making mechanism, which is via the representatives' meeting.

15:45

Margo MacDonald: How do you explain such divergent views among your members and the members of the other specialties that, although they have their own disciplinary organisations, seem to come under the overall umbrella of the BMA?

Dr Calland: I cannot speak for why the other organisations reached the decisions that they did. We have 145,000 members; it is not surprising that there is a difference of view on something as contentious and controversial as assisted suicide.

As I said earlier, although I have a particular personal point of view, I honestly believe that the opposite point of view is sincerely held and that the arguments are perfectly reasonable. There is bound to be a diversity of views in the organisation, and we have tried, through our mechanism, to take a majority view. I would be the first to agree with you that our mechanism is not beyond any criticism, but that is democracy, and we do the best that we can.

Margo MacDonald: Well, there is democracy and democracy, but the GPs' representative said that there was a pretty even split among your members—polarised views, perhaps, if you want to view it in that way. Can you estimate what the split is among your members?

Dr Calland: In a previous existence I was the chairman of the BMA in Wales, and I have also been chairman of the GP committee in Wales, during the past 10 years or so when the issue has been slowly bubbling to the surface. The majority of doctors whom I know and whom I have met through those mechanisms have been against a change in the law.

It is true that there have been some who, because of personal experience or strong belief, have a completely different view. However, I do not believe, from my experience through the official mechanism and my personal contacts, that the numbers in the BMA are anywhere close to 50:50.

Margo MacDonald: Have you any estimate for the Scottish figures?

Dr Calland: I am Welsh—well, I am English, but from Wales.

Margo MacDonald: It is all right—you can't help that. Have you any notion at all of what the Scottish split would be?

Dr Calland: I would not dream of hazarding a guess about what goes on north of the border.

Margo MacDonald: That is quite important for us to know, because we—and only we—are responsible for the effect of any legislation that we pass.

Dr Calland: I realise that. Scotland is represented at the annual meeting, and there are a lot of Scottish doctors working in England and Wales. However, I have no direct mechanism for giving you those figures—I wish I could.

Margo MacDonald: Could doctors' views have changed over time as they feel more informed? You said that the issue has been bubbling to the surface.

Dr Calland: It is quite possible that individual views will have changed, but they may have changed in both directions. The change is not all one way; doctors may look at the issue and decide that on balance—because it is a balance—they would rather stick with the law as it is.

Margo MacDonald: Just to be certain, is it correct that there were UK debates in 2005 and 2006?

Dr Calland: They were UK debates.

Margo MacDonald: Right. What advice has the GMC given to doctors following the ruling by the Director of Public Prosecutions in England that he would be persuaded on whether anyone should be pursued through the courts by the compassion and care that they displayed in helping someone to end their life?

Dr Calland: I cannot speak for the GMC, but I can speak for the BMA. We have issued guidance that explains the Keir Starmer rules and cautions doctors, because medical professionals are picked out as a group that will attract particular scrutiny. In guidance, we have cautioned all our members to ensure that they record very carefully what they do and why they do it, and to be prepared to justify how they came to their decisions.

Margo MacDonald: In other words, you have instructed your members along the lines that we have attempted to find in the bill.

Dr Calland: We have instructed members to be extremely cautious in the way in which they approach end of life issues.

The Convener: I hate to interrupt Margo MacDonald, but when you say that you have issued instructions to all your members—

Dr Calland: Advice.

The Convener: Yes. Why have you issued such advice to members in Scotland, given that the Starmer rules do not apply in Scotland?

Margo MacDonald: The DPP's writ does not run here.

Dr Calland: We have issued advice to those to whom it applies. If Keir Starmer's rules do not apply in Scotland, they are not relevant.

The Convener: The DPP does not have jurisdiction here.

Margo MacDonald: Can I take it that the BMA approves of what Keir Starmer has indicated in England?

Dr Calland: The BMA lives with what Keir Starmer has said.

Margo MacDonald: So, if the law changes—I take it from what you have said that you think that it is preferable for the law to be decided by politicians—the BMA will observe and comply with it, in the best interests of its members and their patients.

Dr Calland: Of course it will.

Margo MacDonald: Following Lord Joffe's bill, the House of Lords Assisted Dying for the Terminally Ill Committee claimed that most research on doctors' opinions is superficial. Does that include the 1995 *Doctor* magazine survey of 2,150 doctors, 43 per cent of whom said that they would consider giving assistance to patients if that became lawful? Research by Sheila McLean from the University of Glasgow produced similar findings.

Dr Calland: It is recognised that there is a significant mismatch between the general population and the medical profession. The survey to which you refer was carried out at a time before what I might call the post-millennium spate of attempts to change the law—the Joffe bill and your bill. There has always been a lack of clarity around issues at the end of life. Some doctors find the area uncomfortable—others are more comfortable with it. Although *Doctor* magazine is a perfectly reputable magazine, I would not consider it to be a font of great wisdom.

Margo MacDonald: I hope that no lawyers are present.

Dr Calland: A self-selecting group of people contribute to its surveys.

Margo MacDonald: With all due respect, we could make that observation about many things. Why does the BMA fear the slippery slope to which you referred when evidence from other countries indicates no such development?

Dr Calland: I do not particularly want to get into an argument about slippery slopes, but there has been a degree of incremental extension of the law in the Netherlands. That is one of the things that worry us. In the report of the House of Lords Assisted Dying for the Terminally Ill Committee, Lord Joffe refers to his bill, which was being discussed at the time, as a first step. It creates anxiety in the profession—certainly in the BMA—that if the rubicon of changing the law is crossed, it will be extremely difficult to stop very small, incremental stretching of the law. Whatever the rights and wrongs of the initial change, we are very resistant to that.

Margo MacDonald: Taking abortion legislation as another example, can I take it from what you have said that the BMA accepts that doctors are by and large responsible for what we have called the legislative drift in the different ways in which an abortion might be procured now?

Dr Calland: The abortion law is another area where there has been quite a bit of drift in the interpretation of the legislation. Patients, doctors and society—all people—have been involved in that. I will not point the finger just at doctors. That is indeed an example of how legislation that was set up with perfectly good heart and with a good purpose—to solve a particular problem—has crept, over time, towards something that, had it been suggested at the outset, might not have been passed.

Margo MacDonald: If doctors had refused to grant an abortion or leave to have an abortion according to the original terms of David Steel's bill, there could not have been drift.

Dr Calland: I cannot disagree with what you have just said. If doctors had refused to co-operate with that legislation, it would not have been a worthwhile bill in the first place. There is a risk in the interpretation of the law. That is why I said what I did about your categories and definitions. It becomes extremely difficult to define exactly the group of people you are aiming at.

Margo MacDonald: Is your objection to the way in which groups are categorised, or is it a fundamental objection to doctors assisting anyone in bringing about their own end before nature intends?

Dr Calland: To be honest, I find it bizarre that, earlier in the meeting, we were discussing the revalidation requirements of doctors who might be considering participating in the knowing and deliberate premature ending of somebody's life. I found that bizarre. You can take it that the BMA's position is on the fundamental principle. We should not change the law.

Margo MacDonald: Would you be willing to produce evidence that that is the BMA's position in Scotland?

Dr Calland: We are going round in a circle now. I cannot produce evidence for the BMA membership in Scotland. I have explained that we have a mechanism for producing BMA policy. It might not be perfect, but it is structured, and we get there.

The Convener: BMA Scotland was invited to produce a witness on the basis of its earlier submissions in response to your consultation, Margo. In good faith, it has nominated Dr Calland to represent it. I do not think that there is much to be achieved by trying to get into—

Margo MacDonald: I am trying to get the context.

The Convener: I understand the point that you are trying to make, but I think that we must accept what is being said in good faith.

Margo MacDonald: I have one or two points for other witnesses, starting with those from the Royal College of Physicians of Edinburgh. Having heard the evidence from others, are you reassured about the patient-doctor relationship? We heard from people from the Netherlands, Switzerland and elsewhere that that relationship had not been affected. Does that reassure you in any way?

Professor Robertson: What you are asking about lies absolutely at the heart of the doctor-patient relationship, which should not in any way be disturbed. The view of the college is that the safety of the patient—and also that of the practitioner—is paramount. We have to safeguard the patient at all times, and the relationship of the doctor and the patient is central to that.

16:00

Margo MacDonald: I agree. That is why I am asking whether you are reassured at all that the experience elsewhere shows that the relationship is not adversely affected.

Professor Robertson: I fully accept that that has occurred in certain places.

Margo MacDonald: Will you, particularly as a physician, explain why we should be different in Scotland from those other places?

Professor Robertson: I do not think that we would necessarily be any different.

Margo MacDonald: I am looking for a suggestion. Given the level of knowledge that is required, will you suggest how the bill could be amended to meet some of your concerns?

Professor Robertson: Perhaps the first point would relate to the point that I made previously about the seniority and experience of the individual clinician. The bill as constructed would mean that relatively junior or inexperienced practitioners could partake in the process, which I think would be inappropriate.

Margo MacDonald: The reason why I ask is that I do not think that there is any other legislation covering medical practice that restricts the involvement of doctors according to their years of service. Is there?

Professor Robertson: Not by years of service but, to become a specialist, one has to undertake higher examinations, practical assessments and a training programme.

Margo MacDonald: I am not sure whether that needs to be in the bill. I say that just for information, because people are concerned about the issue.

Dr Mathewson: I think that we are all agreed that clarification on the term "designated practitioner" would be welcome in the bill. I know this sounds silly and it would not happen but, as the bill stands, a non-clinical registered doctor could become a designated practitioner. I could be registered with the General Medical Council as a registered practitioner but not be in clinical practice. It is highly unlikely that anybody would take that approach, but the bill opens the way for a person to make an application to a public health doctor or to ask a general practitioner to become a designated practitioner.

Margo MacDonald: Right. I promise that I will find out about that.

We have had assertions from psychiatrists that it is stock in trade for psychiatrists, whether with Dr Potts's specialty or another specialty, to assess people's capacity. Do you agree, Dr Potts?

Dr Potts: I do not think that that was the language that I used. I said:

> "Diagnosing and treating mental disorder is the stock in trade of psychiatry as a whole. Assessing mental disorder in the physically ill is ... the stock in trade of liaison psychiatry."

I have no doubt that psychiatrists can and should assist in the assessment of capacity, but it is not primarily the psychiatrist's role to make those assessments.

Margo MacDonald: Would you be satisfied if there was consideration of a requesting person's desire by an inclusive support team? Would that meet your objections?

Dr Potts: It might be worth pursuing further the Oregon model, whereby if the doctor who is centrally involved is concerned about mental disorder, he or she can seek a psychiatric assessment, but that is not required in the legislation.

Margo MacDonald: I have a question for the Royal College of General Practitioners. Is there any evidence that GPs would euthanise—I think that that is the correct term—as an alternative to offering more traditional palliative care?

Dr Mathewson: I am sorry, but I did not quite pick that up.

Margo MacDonald: We have heard some people posit the idea that palliative care and an earlier end to life are alternatives. Is there any evidence to show that a GP would view them as such?

Dr Mathewson: Not that I am aware of. You know what palliative care is. The GP ought to be driven to give care and alleviation to the patient—that is the first instinct and duty. The whole nub of the issue—this is axiomatic—is whether a medical practitioner's duty to the patient in front of them extends to assisting that patient in meeting the end. That is where the polarisation occurs, not on the need to alleviate and give care, compassion and drugs appropriately. In our discussion at the Scottish council, one or two people were in favour of such assistance who had personal experience—not experience as GPs—of distressing situations in their own families. The nub of the question is whether the individual GP is prepared inside himself or herself, given all the other options that are available, to assist the patient in ending their life. That is where the polarisation occurs.

Margo MacDonald: I have one last question, if the committee will put up with it. It is a general question on patient autonomy. The bill rests on patient autonomy. What is your reaction to that?

Dr Calland: The BMA is a strong supporter of patient autonomy, but patient autonomy cannot always trump everything else. There are plenty of examples of patient autonomy being trumped by legislation. The legislation on seat belts was hugely controversial, as people did not want to wear seat belts, but it was generally accepted that that would result in the best health outcome for the general public and it has proved so. There was a similar situation with the legislation requiring the wearing of motorcycle crash helmets. Many motorcyclists did not want to wear a crash helmet, but their autonomy was trumped. Our position is that, although we fully recognise the wishes of a relatively small number of competent, intelligent people who want to end their lives prematurely, we do not believe that that autonomy should trump the protection of the general public that is required for all the reasons—some of which we have given today—of which you will be well aware. That is our position on patient autonomy.

Professor Robertson: I reiterate the centrality of the patient-doctor relationship.

Dr Potts: I will make two points. First, I think that I speak for psychiatry as a whole in recognising that the maximisation of patient autonomy—whether someone has a mental disorder, a physical disorder, both or neither—is very important. However, the bill appears to introduce an exercise of autonomy that might give doctors a duty to assist. Secondly, psychiatrists regularly and correctly override patient autonomy when they detain and treat patients under the Mental Health Act 1983. That is what we do—it is the unique selling point of my specialty. That is a clear example of circumstances in which patient autonomy has well-drawn, well-circumscribed and well-overseen limits.

Dr Mathewson: Patient autonomy is of the utmost importance in medical practice. It is the most important thing. That said, the practitioner—I speak only for general practice—has a duty of care that they must exercise. Patient autonomy is recognised and accepted, but a doctor does not have a duty to comply with the decision of an autonomous, capax patient in every situation.

Margo MacDonald: That is why the bill talks about a "requesting person", not a demanding or forcing patient.

The Convener: I thank the panel for their contributions, which have been valuable and much appreciated.

16:10

Meeting suspended.

16:19

On resuming—

The Convener: We move to the second panel of witnesses. I have pleasure in welcoming Malcolm Clubb, policy development pharmacist, Community Pharmacy Scotland; Theresa Fyffe, director, Royal College of Nursing; James Anderson, clinical psychologist, Scottish national spinal injuries unit, and member of the special interest group on spinal injuries of the British Psychological Society in Scotland; Detective Superintendent Brian Yule, adult support and protection working group, Association of Chief Police Officers in Scotland; Ruth Stark, Scottish manager, British Association of Social Workers; and Kirsty Freeland, senior social worker and bereavement service co-ordinator, Scottish regional group, Association of Palliative Care Social Workers.

I invite members to ask questions.

Michael Matheson: I turn to two submissions that we have received, from Community Pharmacy Scotland and the Royal College of Nursing.

Community Pharmacy Scotland raises concerns around the supply of the medicines that would be used for physician-assisted suicide and cases in which the person administers the medication themselves. Can you expand on the issue? It raises the question whether there may be problems with the Medicines Act 1968, although the submission does not provide much of an answer. Since writing the submission, have you had the opportunity to examine the issue in more detail to ascertain whether there are problems?

Malcolm Clubb (Community Pharmacy Scotland): The Medicines Act 1968 governs the supply of medicines in the UK; my understanding is that it is reserved legislation. I do not think that it has ever encompassed physician-assisted suicide or euthanasia. In addition, during the past few years the misuse of drugs legislation, for example, has been tightened up with regard to the supply of medicines, but I am not aware of whether those legislative provisions have implications for the issue. The prime purpose of all that legislation is to provide for the safe supply of medicines to patients, and the medicines that would be used in this arena are perhaps not covered by that.

Michael Matheson: If I was to turn up at a pharmacy tomorrow with a script from my GP that contained a potentially lethal mix of drugs, would the pharmacist refuse to fill it?

Malcolm Clubb: The pharmacist would refuse to dispense it at that immediate point. They would probably contact the GP and discuss the prescription to ensure that they were satisfied that it would be used for what the GP intended it to be used for, and that it was safe to supply to a patient.

Some changes to such a prescription might be required, or it might proceed as is because a hospital recommendation had been made for certain reasons. Provided that the pharmacist could satisfy themselves, they would supply those medicines.

Michael Matheson: So if the GP says, “No, that is fine—that is exactly what I intended the patient to have”, the pharmacist would dispense it.

Malcolm Clubb: Provided that the pharmacist could satisfy themselves that it was the safest thing for the patient.

Michael Matheson: What do you mean by that?

Malcolm Clubb: If the registered medical practitioner indicated what the pharmacist perceived to be a substantial overdose and still wished to prescribe it, the pharmacist’s prime concern would be the duty of care to the patient. They would not necessarily be satisfied and happy to dispense it at that point, and might require further clarification.

Michael Matheson: If, under the bill—if it is enacted—a GP issued a script to allow someone to administer the medication themselves in order to hasten their death, would that be a legitimate reason for a pharmacist to supply it?

Malcolm Clubb: If the pharmacist was satisfied that they should do that, that is what would happen. We are requesting that prescriptions are endorsed with the reason for any large doses of opiates, barbiturates or insulin, to smooth the patient’s journey towards the supply of the medicines.

Michael Matheson: You have cleared up that issue for me.

My second point is on the evidence from the Royal College of Nursing. I note that the RCN is concerned about the lack of detail around process and about the administration of drugs in physician-assisted suicide where the drugs may be passed to a nurse. Can you explain what changes you would like to see in the bill that might address your concerns?

Theresa Fyffe (Royal College of Nursing Scotland): We are concerned about the lack of detail about who will provide the assistance. If the decision is to be taken by a “designated medical practitioner”—and we think that the detail around decision making is actually much clearer and safer—we would prefer that person to provide end of life assistance instead of another professional being engaged. In the bill as it stands, the medical practitioner is not required to discuss or agree things in advance and we think that that might give rise to conflicts in understanding about, for example, the time, the method and the place. As a result, we feel that it is better for the designated medical practitioner to provide the assistance.

Michael Matheson: You seem to be strongly in favour of the inclusion of a conscientious objector provision in the bill. Why do you believe that to be necessary?

Theresa Fyffe: I heard Ms MacDonald’s earlier comment that, under the way in which the bill is set up, practitioners have to opt in rather than opt out. We have taken a balanced, neutral view on the matter because of the range of the views of our members, some of whom are definitely for the proposal and some of whom are definitely against it. Those who are strongly against the proposal want a conscientious objection provision to allow them to state that they do not have to participate in the process.

Nanette Milne: On page 4 of its submission, the British Psychological Society in Scotland expresses

> “concerns about the impact on vulnerable newly injured people”.

We have probably all heard of examples of people who after being severely disabled through accidents or whatever have gone on to lead very productive lives, although I know of one well-publicised case in which the reverse happened. Can you elaborate on your concerns in that respect?

James Anderson (British Psychological Society in Scotland): It is probably our primary point although, first of all, I should state that the

BPS has taken a neutral position on the bill because our members have differing views. Members responded to an ethical question and I am here to give evidence as a member of a professional body.

This takes us back to the criteria governing who is allowed to request such assistance. The terminally ill are in a separate and different group from those who are permanently physically incapacitated. Whereas with the first group, who are dying, the issue is the speed at which they are approaching their unfortunate but inevitable death, the life expectancy of the permanently physically incapacitated might be normal or nearly normal. That also applies to those who have suffered head injuries, significant strokes or—my area of expertise—spinal injuries, and I suppose that my concern is that someone who is newly injured has to go through a process of adjustment, learning and understanding that requires a vast mechanism of social workers, occupational therapists and rehabilitation doctors. It might well take those people months, or even years, to adjust to their injury. The committee should be aware that the vast majority of people with those injuries are happy to be alive and can lead worthwhile, useful and fulfilling lives but, as I say, it can take a while for them to reach that point.

My concern is that although the bill and many of its accompanying justifications rightly address certain palliative care and terminal illness issues, the period of two or three months that is given for a process that could bring to an end the lives of the patients with whom I work is simply insufficient for the process of adjustment or for nursing and social work colleagues to assist the entire team to help the person in question reach a point at which the infrastructure is available to allow them to live a valuable life. That discrimination—what is different about being physically incapacitated—is important, and I worry about the process of adjustment being unnecessarily curtailed.

Nanette Milne: Given the timescales that you have mentioned, do you think that, realistically, the bill could be amended to take account of your concerns?

16:30

James Anderson: As I am a psychologist, not a legislator, I am cautious about suggesting amendments. My role today is to set out thoughts, provide suggestions and highlight problems. Certain amendments could be made. For example, you could say that, as we are talking about a different group of people, a different set of policies and procedures would apply, but that does not get us away from particular issues of equity and questions of who would be included. If you say that the bill applies to the terminally ill alone, many of the people referenced in the policy memorandum, such as those with degenerative disease, would be removed from its realm. Equally, you could say that it applied to those who have suffered a traumatic injury and set out criteria in that respect but, again, evidence suggests that degrees of trauma or incapacity have very little relationship with the quality of life that people experience. Any one of us could suffer a stroke or be hit by a car as we left the building, leaving us with a physical incapacity that required a carer to visit us in the mornings. We might well find that quality of life intolerable. Such issues do not go away by parcelling out or narrowing down what comes under the auspices of the bill; indeed, they are intrinsic to the bill.

Helen Eadie: I was very interested by the section on insurance implications in Detective Superintendent Brian Yule’s submission. Does anyone wish to comment on that matter?

Detective Superintendent Brian Yule (Association of Chief Police Officers in Scotland): Some insurance companies will not pay out in the event of suicide, and there will need to be liaison or interaction with them to get their opinion on what they would do in such circumstances. For example, would they require a minimal period between the insurance policy being taken out and an assisted suicide? We take out insurance policies when we are young and do not know what is in front of us, but I suspect that insurance companies will be looking for some guarantees on that issue.

Helen Eadie: Can you elaborate on the Scottish police service’s view on section 9 of the bill, which relates to the consideration of capacity by psychiatrists?

Detective Superintendent Yule: Unless the provision in this section is very well defined, it could be open to challenge either before or after the event. Drifting slightly from the question, I listened to the earlier discussion about reporting to the procurator fiscal and I suspect that it will be with regard to terms such as capacity that the medical people involved could find themselves facing legal challenges, if you like, over what has taken place.

Helen Eadie: Thank you very much.

Ian McKee: I was interested to read in Community Pharmacy Scotland’s submission that as the Medicines Act 1968 and the Misuse of Drugs Act 1971

> “are reserved legislation ... there is a need to examine where precedence lies and if supplies for this purpose are permitted.”

I wonder whether Mr Clubb can expand on that. What would happen if the bill were to pass through Parliament and become law in Scotland? I do not know whether you heard the previous evidence, but it was obvious from that that doctors often prescribe medicine not in accordance with the drug's licence but by using their own judgment. Surely it would be acceptable for a doctor to prescribe a drug in accordance with an act of the Scottish Parliament.

Malcolm Clubb: That is a very leading question. I am not sure with which act precedence would lie. The Medicines Act 1968, which ensures the safe supply of medicines, is being reviewed to ensure that it is fit for purpose for the 21st century.

We have to ensure that legislation that is approved in Scotland is permissible in that context. The community pharmacy contractors whom I represent will be regulated by the General Pharmaceutical Council from 27 September, when the GPhC comes into being. The GPhC will be a reserved organisation and it will give advice on a United Kingdom basis, as the General Medical Council does. You are right to suggest that the system might have to make adjustments in light of Scotland's requirements and Scottish legislation.

I am not an expert on which bit of pharmaceutical law would take precedence. I do not know whether the Medicines Act 1968 would be robust and whether pharmacists would supply the medicines in the context that we are discussing. As you said, doctors prescribe medicines outside the licence relatively frequently, but the pharmacy profession tends to be much more rigorous in the application of law. If we are given guidance by our regulator that we should not prescribe drugs under the bill, that is possibly the guidance that will carry weight.

Ian McKee: Can you remind me what the 1968 act and the 1971 act say about the current situation?

Malcolm Clubb: I am unclear about what they say. As I said, the 1968 act is being redrafted to include amendments and move other issues forward. Once that work is complete I will be in a better position to respond to your question.

Ian McKee: You do not know whether the law says anything about the issue in the first place.

Malcolm Clubb: No.

The Convener: You have raised an interesting point of law. I do not want to interrupt Ian McKee's line of questioning, but Lynda Towers might give her view at some stage.

Ian McKee: I would be happy to hear from the solicitor and pick up the thread afterwards.

Lynda Towers (Solicitor to the Scottish Parliament): The provisions of the 1968 act and the 1971 act are reserved, but there is nothing in the bill that indicates whether medication can be used at all in the context that we are discussing. The bill does not regulate how the medicine is given, so the general provisions would apply.

Ian McKee: That is helpful. Thank you.

Malcolm Clubb: The guidance from Holland is that the use of opiates, barbiturates and insulin is the standard treatment. At some point, medicines might be an option for assisted suicide.

Ian McKee: The evidence in your submission is mainly about your specialty—and rightly so. You talked about how your fellow pharmacists would cope. However, you went on to say:

> "Community Pharmacy Scotland is concerned that whilst the patient is satisfied that seeking to end their life is their chosen path, families of the patient may not be as satisfied that this decision is appropriate."

What is your locus in that regard?

Malcolm Clubb: If the bill were enacted, people who provide end of life assistance would be exempt from prosecution, but is it intended that that would include people who supply medicines? The supply of medicines could well be required, and pharmacists and general practitioners are each 50 per cent liable for the dispensing of any prescription, so there is a chance that the family would say, "The pharmacist has no legal exemption under the act". We might get entrenched in legal issues.

Ian McKee: Some families might give you a bit of a tongue-lashing for what you were doing.

Malcolm Clubb: That is quite possible.

Ian McKee: Are you concerned about that?

Malcolm Clubb: Yes. There is always a chance of that happening. What a person chooses to do in discussion with their family and so on might well be their wish and their right, but their families might not agree and might want them to pursue another route.

Ian McKee: Are you seriously suggesting that the law should depend on what a third party might think in the situation that we are discussing?

Malcolm Clubb: In our submission we were looking for a bit of tightening up around what is meant by "assistance" and for clarification that the supply of medicines is intended to be included.

Margo MacDonald: May I ask a question about existing practice, which might help?

The Convener: I think that Michael Matheson has a question on the same track.

Michael Matheson: Yes, I do. If the bill or associated legislation were to come into force, would it be helpful if the law did not specify the medicines but specified more generally that a muscle relaxant and then a drug that would kill someone—however we describe such a drug —should be used? I understand that there is some guidance on that in the Netherlands. Would pharmacists find it helpful if the legislation said that a muscle relaxant should be included?

Malcolm Clubb: It is more a case of reassurance about the fact that the legislation exempts pharmacists from being prosecuted for a prescription that they may or may not supply—if that makes sense. There is quite good guidance on medicines in Holland, which the Dutch seem to find useful. I would be keen for guidance on methods and safeguards to be put together by the appropriate royal colleges. If that was all agreed, it would perhaps improve the use of the legislation.

Margo MacDonald: At the moment, do you keep a record of the opiates requested by doctors who are treating patients in hospices? We have heard from doctors that sometimes doses are given that have double effect. I assume that that means that they have to ask for more opiates from you. Is a record kept of that?

Malcolm Clubb: Every dispensing episode involving a controlled drug in the UK is registered in a community pharmacy or a hospital pharmacy—wherever it is supplied. That is standard practice. We must record all controlled drugs that are supplied.

Margo MacDonald: So you could look back in your records.

Malcolm Clubb: I could look back to see what was supplied to a particular patient, what their address was, when it was supplied, whom it was given to—a concern in the Harold Shipman case was whom the medicines were supplied to, so we now record that—and which pharmacist supplied it, including their registration number.

Ian McKee: I have a quick question for Theresa Fyffe. It is my understanding that the RCN’s policy used to be to oppose legislation such as this. Am I correct?

Theresa Fyffe: Yes.

Ian McKee: What happened to change your stance?

Theresa Fyffe: We had a sense that the balance of opinion of our members was on a spectrum, so we did a consultation. We had a big response and found that we had to go to a neutral position because there was no representative group either for or against.

Ian McKee: Would you say that there were quite large numbers of your members on both sides of the debate?

Theresa Fyffe: Yes, and that is still the case. We took a particular interest in the response from our members in Scotland. When you do a consultation, you often find that those who are more opposed to something come forward, so we had a lot of debate and spent time with individual members to find out how they felt about the position of neutrality. We have been working on the issue with our members for about the past 18 months.

Ian McKee: Is your stance any different from the stance of your colleagues in the rest of the United Kingdom?

Theresa Fyffe: In relation to nursing? Absolutely not. We found exactly the same situation throughout the UK.

Ian McKee: Thank you.

I am interested in Kirsty Freeland’s experience. You are a bereavement service co-ordinator. Is that right?

Kirsty Freeland (Association of Palliative Care Social Workers): Yes.

Ian McKee: You co-ordinate work not only with people who have been bereaved but with those who experience palliative care.

Kirsty Freeland: Yes.

Ian McKee: Does every relative of someone who has been through the palliative care experience tend to be totally happy with that experience? I am sure that the vast majority are, because it is a very good service in Scotland.

Kirsty Freeland: On the whole, they are content with palliative care services, but they often have issues with the way in which they were told about the diagnosis, and about treatments, or lack of treatments—that is, when treatments are brought to an end. There are lots of issues that they can get angry about. In relation to the bill, we are concerned that family members could be left with a lot of extreme feelings about how it happened, about not knowing that the patient had chosen to do this and around how many options were explained to them—

Ian McKee: Sorry, that the patient had chosen to do what?

Kirsty Freeland: End their life.

Ian McKee: So you already deal with people who end their lives.

Kirsty Freeland: Yes, but what concerns us about the bill is that family members might have complicated grief reactions due to the fact that they may not have known that the patient had chosen to be assisted to end their life. They might experience anger about how the person was assisted to do it and about the assessment that was made of their capacity.

16:45

Ian McKee: I can understand that. You have said something that surprises me, however. I presumed that your work was with people who had been through the palliative care process and who had died in that process. You are implying, however, that you deal with quite a few relatives of people who actually ended their own lives as they were in the middle of that situation.

Kirsty Freeland: No, I am sorry—I meant that if people were to be allowed to end their life under the bill—

Ian McKee: Sorry, but I was not asking you about the hypothetical situation. I am asking you about your actual practical experience. Have you come across any families who have told you, “If it had been a horse, we would have put it to death”, or, “If it had been a dog, we would have shot it, but it was my dad, and he wasn’t helped that way”? Have you ever experienced that, or do people just say, “Thank heavens there was good palliative care”?

Kirsty Freeland: In relation to the palliative care that patients have received, I cannot think of anybody who said something like that. Very occasionally, there have been comments about the treatment that they have been given, the suffering that they endured during that time, or the perception that their treatment should not have come to an end.

Cathy Peattie: I will pursue some issues around social work and support. I am interested in any discussions that have taken place regarding social work. Your role is a special support role, and you are involved with families. Are you saying that families can be frustrated if they have not known about the patient’s choice? Can it be difficult to support people through their crisis, and do you find yourselves counselling families? Are there particular issues there?

Kirsty Freeland: We have concerns. There are only a few social workers in hospice and palliative care in Scotland. Within that number, most of us provide not only the social work service but the bereavement service. We have concerns about the conflict between the two roles. As social workers, we could be providing support to a patient who has decided to ask for assistance to end their life. Social workers cannot opt out—we have to support the person regardless of our individual opinion, so we would support the person through that time. Then, we might have to provide bereavement support to the family, who might be in total disagreement with the patient’s choice. There might be conflicts, and we would have to consider how they could be overcome.

Cathy Peattie: Ms Stark, what discussions have been going on in your association on the roles of social workers? Kirsty Freeland has spoken about social workers not being able to opt out, and they will have a particular relationship with the families.

Ruth Stark (British Association of Social Workers): It is difficult for social workers to opt out. I have been thinking through the concept of the bill being written in such a way as to make it possible to opt into it. That is not familiar to us. I have still not got my head round it. If we were given a statutory duty to do something, society would expect us to do it. Even if it was not called a “duty”, there would still be a culture of expectation that we would be involved. That is exactly the same with our involvement in bereavement counselling.

One of our association’s issues about the proposed legislation is around coercion. We work with families all the time, and we know how difficult it is to assess coercion within families. I am surprised that we have not been written into the bill, although we feature in mental health and adults with incapacity legislation because that is what we do—we assess for abuse and harm being caused to people. I repeat: I find it surprising that we are not mentioned in the bill.

The issue about people’s capacity to make decisions is new to us in psychiatry, psychology and social work. Capacity comes and goes. With someone who has a brain injury, one moment they can be very fluent and able to make a decision, but the next they might not be able to do that. There are issues about how capacity is defined in the bill and how that might be pursued.

We are also deeply concerned about the age limit, which we firmly believe firmly should be over 18, in line with the United Nations Convention on the Rights of the Child.

I am not sure whether I have answered the questions, but I must say that the issues have been difficult for us. Like the RCN, our association has a great spectrum of views on whether the bill describes a right that we should respect or whether it is a difficult issue because of our ethics and the way in which we work to help reduce harm and abuse. Like every professional who has spoken in the meeting, it is difficult for me in representing my profession to say how our association would want to approach the issue, because one group says that the bill is good and another group says that it is bad. I think that, like the RCN, we would want to be neutral.

James Anderson: I support that point entirely. Our psychiatry colleague on the previous panel investigated that issue in more depth.

If the bill is to proceed, it would be worth bearing in mind that assessments, whether in palliative care or in hospital settings, are multidisciplinary. A single assessment by somebody such as me or a psychiatrist, even with the authority that might seemingly come with that, is nothing compared with—I say this only slightly with tongue in cheek—that of the auxiliary nurse who has worked on the ward for six months with the person, or the social worker who has gone into the person's home. A psychologist, at least in my practice, might not do that. There is a question about what, and how broadly, we require people to assess. The bill would benefit from having that clarified.

Another issue that was debated extensively with the previous panel was the point that I and all my colleagues work from the presumption that people have capacity. As Dr Potts said, the bill assumes that people do not have capacity and that it must be established in a fairly generic sort of way, but that is not how the issue is necessarily approached at the moment. I support that point entirely. Those issues need to be considered, too.

Helen Eadie: I am interested in the case of a person who wishes to change their mind right at the very last minute. The Association of Chief Police Officers in Scotland's written evidence mentions the need for a witness to be present, which is a good point. Will you elaborate on that?

Detective Superintendent Yule: To protect everyone who is involved, parts of the process, or all of it, should be witnessed. As our submission says, right up to almost the last minute, someone might wish to change their mind. We could imagine the difficult situation in which medical people were put on the spot by families or others saying that there was a change of heart. If the process was witnessed, that would assist everyone who was involved and would add to the integrity of the process—it would help to prevent it from attack, as it were.

Michael Matheson: I want to go back to the issue of capacity, and in particular Mr Anderson's and Ruth Stark's comments about the multidisciplinary nature of the capacity process. The evidence from psychiatrists highlighted that they do not think that they should be the individuals who are left with responsibility. Given the timescales involved for someone who was, for example, diagnosed as terminally ill and advised that they had less than six months to live, if they chose to exercise their rights under the bill—if it was enacted—how would a multidisciplinary team be brought together in time? Until that time, the patient might have had no involvement whatsoever with social workers, clinical psychologists or anyone else, but we would expect a multidisciplinary team to come together and carry out a capacity assessment. How could that be managed?

James Anderson: As I said earlier, it is difficult to write law and it is also difficult to write service policy. At one level, for some people who are on a terminal care pathway, sufficient people might be involved, although I am not familiar with such care services. It might also be the case that people who are physically incapacitated and not independent, however that is defined, already have social workers, responsible doctors and so on. However, one of my concerns is that bringing such a team together could be very difficult.

I also suspect that the burden might fall on my medical colleagues who are either the responsible psychiatrist or the responsible medical practitioner to determine whose opinion they require so that they can decide whether the patient has the specific capacity as outlined. That also presents problems, but the people who might be needed will not always be the same people. It is hugely difficult. However, within my professional body's neutral position, we believe that leaving the decision entirely to a psychiatrist or a doctor is not ideal. Legislation like the Adults with Incapacity (Scotland) Act 2000, which refers to other professionals who can be drawn in to answer specific questions, might be more appropriate, but I cannot answer the question about whether it would provide sufficient protection or would interrupt timeframes.

Michael Matheson: My second point concerns the role that social workers can play, and has been touched upon by Kirsty Freeland and Ruth Stark. I am conscious that there is a small number of specialist social workers in the palliative care field, but a significant number of them will be employed by hospices. Last week, when we were receiving evidence from those who are involved in hospice care provision, I was keen to get a picture of the practicalities if the bill is enacted. It was clear that they oppose the bill. If a patient was receiving terminal care in a hospice and they wanted to exercise their rights under the legislation, what would happen to them? I came away with the clear impression that the hospice's policy was that a patient could not exercise such rights in the hospice, and they would have to leave and go to another place.

In practical terms, what would it mean for someone like you, who may have been involved with a person's care at home well before they came into the hospice, if they had to leave the hospice in the final stage of their terminal phase? Do you envisage a situation in which, as a hospice employee, you would have to withdraw your support and advice from the family and the case would be passed to a local authority social worker, who could provide support and assistance?

17:00

Kirsty Freeland: There is no easy answer to that question. The difficulty arises from the fact that social workers in hospices are there to promote quality of life for as long as someone has left. If a patient said that their situation was intolerable and they wanted help to end their life, that would contradict what palliative care social work is about. That is the initial problem. If they decided that they wanted to be assisted to die and had to leave the hospice for that to happen, ethically and morally a palliative care social worker—like any social worker—would be expected to follow them to wherever they went and to continue to support them, even though their decision went against what we believe in. That is what we do—we support the individual patient and their family.

Michael Matheson: How does that sit with the fact that you are an employee of a hospice that says that you should withdraw your support at that point? I see both the professional and the employee difficulty that the situation creates.

Kirsty Freeland: That is what I am saying—there is no easy answer. Basically, it is a difficult position to be put in.

Michael Matheson: What happens normally in circumstances where a social worker is working with a girl who wishes to have an abortion and they do not find that morally acceptable? What are the practical implications?

Kirsty Freeland: If I were faced with the situation that you describe and did not believe in abortion, I would either support the person concerned through the process, even though I did not agree with their decision, or, if I felt so strongly about the issue that I was unable to do that, I would ask a manager to assign the person to someone else.

Ruth Stark: You would be expected to continue to work with the person, because you are there to work with them and they have the right to self-determination. The issue is not limited to abortion—the people we work with can decide to do many things. Our job is to advise, assist and guide them. We do not give up because we have a personal preference and do not agree with what they are doing.

Michael Matheson: I am married to a social worker, so I know that they never give up and that it is never an easy job.

Ian McKee: She has stuck with you.

Michael Matheson: The fact that palliative care social workers have a specialist role and are employed by hospices has the potential to create an insurmountable professional dilemma, with serious implications. I can see no easy way around that.

Ruth Stark: It has implications for those who are left behind—family, children, brothers and sisters. Those are the people whom we will continue to work with afterwards. As Kirsty Freeland suggested, our colleagues could find themselves in quite burdensome situations.

Ian McKee: What proportion of patients who die in the care of Macmillan nurses die in hospices and what proportion die at home?

Kirsty Freeland: I am not sure of the exact statistics, but I know that a lot more people die in hospices. They may have said that they wanted to die at home, but they end up dying in hospices.

Ian McKee: Yes, but do you know the overall numbers of people with a terminal illness who die at home or in a hospice? Do you know the ratio?

Kirsty Freeland: I do not know the exact figures.

Nanette Milne: Mr Anderson, towards the end of your submission, you state:

> "Irrespective of how well services are provided, it would be utterly unacceptable to consider allowing the provision of assisted dying for anyone with a terminal illness where there are not also appropriate palliative services offered as an alternative."

Do you think that the offer of services is sufficient, or do you agree with some of our respondents who have said that people should have to experience palliative care before being allowed to make their decision?

James Anderson: There are several bits to that question. First, on a professional level, I suggest that people should experience palliative care. Human beings often do better when we are doing, experiencing, living and trying, which includes accepting assistance—whatever form that may take—and taking some sort of risk to see whether life can be improved. I would be supportive of patients giving palliative care a try.

Secondly, there is a question of equity. We talk a lot about terminal illness and palliative care, but we are also talking about a group of people who are not dying, and the reasons for the intolerability of their lives emerge out of something entirely different from the situation of the terminally ill. It would be abhorrent to say to that group of people, "There are no palliative care services, but you are free to avail yourself of end of life assistance." That is seen as being inappropriate, yet the bill does not seem to provide sufficient guarantees for people with a physical incapacity—be that a head injury or any of a number of things that we can imagine—that services will be provided to remove the intolerability that emerges from, let us say, their having inappropriate housing or from the insufficient provision of care where they live to ensure that they are washed and ready for work in the morning or that they are put to bed at a reasonable hour of the night. There is also that question of equity.

I think that people should experience palliative care. When we talk about the length of time that it takes to adjust, my appeal to patients is, "It's early days. Let's experience what's out there, and then you can have these thoughts." If we are going to include physically incapacitated people in the bill, there should be a clear expectation that those people will have a choice. In my professional experience, the intolerability that those people speak of is environmental and societal—it is about access to work and all those kinds of things—and it is within the ability of the state to do something about that. My accent aside, I am extraordinarily proud to live in a state that provides as much assistance as it does, but there is no guarantee that those services will be provided equitably to address the intolerability that assisted death may also address.

Nanette Milne: Do any of the other witnesses have any comments to make on whether palliative care should be experienced rather than just offered?

Theresa Fyffe: The case has been well made about the difference between the experience of palliative care services by terminally ill patients and the experience of those who do not fit into that category. It would not be as easy to be clear about what was being provided for them. There are good support services, but the services would have to be provided equally, otherwise the bill would disadvantage one group.

Kirsty Freeland: I was going to say more or less the same thing. Those who work in palliative care services would tell you, from their experience, that lots of families are initially resistant to getting those services involved because of a fear of what it is all about. However, when they experience palliative care, they completely change their opinion.

Margo MacDonald: Has any witness spotted anything that makes them think that there is provision in my bill that would prevent a doctor or psychiatrist from taking advice or guidance from people such as social workers or medical social workers who have been part of a support team when they have to reach a conclusion on an application that a requesting patient has made to them?

James Anderson: No. Nothing in the bill would prevent that from happening. However, my concern is that that is not highlighted as something that should occur and that the tasks that are given to the assessing psychiatrist may not necessarily be within their remit or ability to judge professionally.

Margo MacDonald: I think that I can put your mind at rest. The issue has nothing to do with that; rather, it has everything to do with the division of powers. Powers to do with the regulation of employment, for example, are reserved. That is where the professional associations come into things and give guidance. Does that help? I wanted to clear up that matter, as it has come up once or twice.

Is the RCN aware that the bill says that the medical practitioner must agree the different aspects of how the medication is to be administered and what it will be, and that that information must be given to the patient?

Theresa Fyffe: Yes, we are, but we do not believe that the details on that fully cover what we would expect in arrangements involving the designated practitioner. We understand why you have gone for not specifying who can give support—that is to allow for choice—but we think that having unspecified persons is a risk, particularly if the person was a health care support worker or somebody who did not feel fully informed about the decision to be made.

Margo MacDonald: I have a question about expertise for the RCN, which leads on from what we have been talking about. Following the DPP's statement on who would be pursued under the law, the BMA guided its members on what would be good practice. Will you do the same?

Theresa Fyffe: As an organisation, we are working on guidance for our members in response to that change. We are clear that, if the bill is enacted, we will work on the appropriate guidance to support our members. At the moment, our business is to ensure that we have got the balance right. I understand what you said about patient autonomy. We feel strongly about the right of patients to have a choice and to be heard, but we must also ensure that our members are not put at risk and that practices are safe and effective. There is a tension, but I can see that it could be managed.

Margo MacDonald: Is the British Psychological Society in Scotland aware of the opinion polling that the Scottish Disability Equality Forum undertook on whether the bill devalues the lives of disabled people? The forum found its members' views to be diverse. There was no consensus.

James Anderson: I am not aware of that particular work, but I am aware that the disability groups are as divided as members of my society are. I hope that my comments today have been restricted to the practical problems that members of my society have seen. Patient autonomy should be paramount in my mind, as it is for my colleagues and medical professionals. In that context, the people with the illnesses and disabilities that I have spoken about should determine matters. Their views on their inclusion in the bill should be crucial. I hope that I have illustrated some of my members' concerns about how that has been done.

Margo MacDonald: I asked the question because the concern that I described has been voiced.

Are you aware of the research by Margaret Battin in 2007, which showed no disproportionate impact on vulnerable people in the Netherlands and Oregon?

17:15

James Anderson: I have had a chance to look at some documents and I have read some of that research. I know that the committee has spoken to the ethicists, but I observe that the bill sees one group of people who are not dying as worthy of end of life assistance, whereas other people who might claim that their lives are equally intolerable are not included in the bill. The research would say that there is no practical implication, but that does not necessarily take away from such issues.

Margo MacDonald: Are you aware that requesting patients should have all the possibilities explained to them?

James Anderson: Having all the possibilities explained to patients is good and valuable, but I do not know—I am not a legislator—whether having possibilities explained necessarily translates into an obligation for the clinician who gives the explanation to act on what emerges or for other services to deal with issues that give rise to intolerability. Discussing possibilities does not necessarily mean that they will happen. I do not know whether the committee is concerned about that.

Margo MacDonald: I might return to that, but I will move on to ask the police a question. On revocability and people changing their minds, I presume that you look for corroboration, as with evidence in Scots law.

Detective Superintendent Yule: Yes.

Margo MacDonald: What are your comments on the notion of patient autonomy?

Detective Superintendent Yule: From what I have heard and from my own knowledge, I think that patient autonomy is probably the guiding principle in interactions between patients, health services and health care.

Margo MacDonald: We have talked quite a bit about establishing the patient's capacity. Are you aware that, under the Adults with Incapacity (Scotland) Act 2000, GPs—so they inform me—now assess such capacity much more?

Detective Superintendent Yule: Yes. The provisions in the bill and existing measures are fine and good, but what might arise from the bill—I would not call it a difficulty—is that a whole load of emotive issues would be brought to the fore, which would make those who were involved in making the decisions more liable to legal attack. Given that, the bill must be tighter than provisions elsewhere.

Margo MacDonald: I do not disagree.

I have social work questions for Ruth Stark. You are concerned about the family and relatives. I am not unconcerned about them, but I maintain that the requesting patient is the central figure. How do you deal with the grief and anger that a family might feel after a patient follows through with an advance directive or decides to withdraw from treatment under existing law?

Ruth Stark: We must work with families to help them to understand the decisions that have been made. People die in all sorts of circumstances. Our work is to support those who are left, to help them to work through their reactions to what has happened and to try to make sense of it. To us, it is about how we work with them. Regardless of their circumstances, our methods of working are the same. However, we do not want to have built into that an additional conflict—another part of the matrix of complexity.

Margo MacDonald: So you just want an easy life.

Ruth Stark: I would not be a social worker if I wanted an easy life. The reality is that we must work with what is given to us.

Margo MacDonald: In principle, there is no real difference between your having to deal with a family's grief and anger after someone has refused treatment and, if the bill becomes law, your having to deal with a situation in which someone has received assistance to bring their life to an end.

Ruth Stark: There is no difference for us—the difference is for the people who are left.

Margo MacDonald: It is for you to help them. Would you like the matter to be dealt with in law? Would you prefer to have the sureness of legislation to which you could refer and to which you could refer families, rather than the position that exists in England at the moment, where the law has not changed but the pursuance of people who offend against it has?

Ruth Stark: I am not sure that it makes a great deal of difference to us whether the matter is or is not dealt with in law. We will engage with people who want to engage with us. We have to engage with people when the law directs us to do that—in criminal justice social work, under mental health legislation or in children's hearings. We are not talking about that kind of intervention. We want to ensure that families are supported and are provided with the services that they need. It may be a resource question more than a question of legislation.

Margo MacDonald: I am not snubbing the man from Community Pharmacy Scotland. Right at the start, he answered Ian McKee's question about what happens currently when big doses are suddenly prescribed.

The Convener: I thank all the witnesses for their valuable contribution. I remind both the public and members of the committee that we are scheduled to meet again tomorrow morning, when the committee will take further evidence on the bill at stage 1. That concludes the formal business for today.

Meeting closed at 17:23.

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