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Pàrlamaid na h-Alba

Official Report

END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE

Tuesday 28 September 2010

Session 3

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END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE

8th 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)

THE FOLLOWING GAVE EVIDENCE:

John Deighan (Bishops Conference of Scotland)
Chris Docker (Exit)
Sheila Duffy (Friends at the End)
Pam Duncan (Inclusion Scotland)
Jan Killeen (Alzheimer Scotland)
John Logue (Crown Office and Procurator Fiscal Service)
Gordon MacDonald (Care Not Killing Scotland)
David Manion (Age Scotland)
Johanna McCulloch (Scottish Disability Equality Forum)
Frank Mulholland (Solicitor General for Scotland)
Tanith Muller (Parkinson’s UK)
Sarah Wootton (Dignity in Dying)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 1

Scottish Parliament

End of Life Assistance (Scotland) Bill Committee

Tuesday 28 September 2010

[The Convener *opened the meeting at 10:04*]

End of Life Assistance (Scotland) Bill: Stage 1

The Convener (Ross Finnie): Good morning. I welcome everyone to the eighth meeting of the committee. I remind you to switch off such electronic equipment as might interfere with transmission. I welcome, too, Margo MacDonald, the promoter of the bill.

The only item of business is to continue taking oral evidence. We have two panels this morning.

First, I welcome Frank Mulholland QC, the Solicitor General for Scotland, who is accompanied by John Logue, the head of policy division at the Crown Office and Procurator Fiscal Service. The committee is conscious that there are certain elements of prosecution policy that the Solicitor General will be unable to assist us with, but there are also matters of Scots law that it is important for the committee to have on the record from someone of his standing. Although Lynda Towers advises the committee, that advice—while important in assisting us in how we proceed—does not form part of the official record. Therefore, in so far as there are serious and fundamental legal issues to do with the law of Scotland, it is important for us to hear from the Solicitor General and we are pleased that he is here.

I invite the committee to lead questions on the matter.

Ian McKee (Lothians) (SNP): I appreciate that we cannot go into matters of policy, but I would be grateful if Mr Mulholland would explain the situation in Scotland as opposed to England. I gather that the Director of Public Prosecutions for England and Wales has given some advice on who would be prosecuted and who would not in the case of people helping others to commit suicide when they have a strong reason for doing so. Am I right in saying that the situation is different in Scotland?

The Solicitor General for Scotland (Frank Mulholland): Yes. It might be helpful if I first state that I am here as the Solicitor General wearing my prosecutorial hat. It is the job of a prosecutor in Scotland to apply the law, whatever they may think privately of the law. Our job is not to change the law or to innovate on it by means of prosecution policy. What the law should be and whether it should be changed is a matter for the Parliament. That was recognised as recently as this year by Lord Hope, the deputy president of the Supreme Court. The public prosecutor applies the law, and will apply the law that the Parliament enacts. The court is not there to change the law but to interpret the law and, where there is any ambiguity about the law, to try to make sense of it and clarify it. In Scotland, the High Court used to have a declaratory power, in which it could assert that a particular action was a crime, but, as a result of the European convention on human rights and the presumption against retroactive operation of the law, that power no longer exists.

As I indicated, our job as prosecutors is to apply the law. It might be helpful to answer your question by outlining the general considerations that are taken into account when a case is reported to the procurator fiscal by the police. There is a step approach to assessing whether to prosecute. We have to answer a number of sequential questions, the first of which is whether there is sufficient admissible, credible and reliable evidence that a crime has been committed. If the answer is yes, in the case of homicide the question is whether the criminal act caused death.

Next, in the case of homicide, we have to answer the question whether the criminal act was carried out with intent to kill or with such wicked recklessness that it was regardless of the consequences. That is what is referred to as the mens rea—the intention for murder. For murder, we require an intention to kill or a wicked recklessness regardless of the consequences. In relation to the latter, if I stab someone 14 times to the body, an inference could be drawn by the jury that those actions and the multiplicity of blows were wickedly reckless because my actions show that I could not care less whether my victim lived or died. We consider the intent.

Having answered that question, we will then assess whether there is provocation, which reduces the crime from murder to culpable homicide, or whether the perpetrator’s responsibility was diminished. The appeal court looked at the concept of diminished responsibility fairly recently in the context of the Kim Galbraith case, which involved a woman in Argyll who shot her husband who was a policeman. The appeal court redefined diminished responsibility. The test used to be that diminished responsibility had almost to amount to insanity in law. The court redefined it as some condition that affects your responsibility and intention for the act. For example, if someone is suffering from significant bipolar syndrome, that might—depending on the expert advice that you get as a prosecutor—be sufficient to reduce the charge from murder to culpable homicide.

Once we have assessed that there is sufficient, credible, reliable and admissible evidence, mens rea and causation and whether diminished responsibility or provocation apply, we will apply the public interest test, to which you are alluding. The factors that we take into account as a prosecutor in assessing the public interest are published in the "Crown Office and Procurator Fiscal Service Prosecution Code", which is available on the Crown Office website. In fact, last night I Googled "prosecution code Scotland" and the first hit was the prosecution code, so it is readily available to the public.

In assessing the public interest, the prosecutor looks at the nature and gravity of the crime. It stands to reason that the more serious the crime, the more likely it is that the public interest will require a prosecution. Consideration is then given to the age, background and circumstances of the perpetrator—I am trying to make things as neutral as possible by using the word "perpetrator". We then look at the age and personal circumstances of the victim—the deceased—and their family; the attitude of the victim and the victim's family; the motive for the crime, if that can be ascertained; any mitigating circumstances that affect the prosecution of the accused; and the risk, if any, of reoffending. All those considerations are taken into account and weight is given to them in reaching an ultimate decision about whether it is in the public interest to prosecute.

I want to make a few points on assisted suicide. First, the consent of the victim is no defence in law in Scotland. That has been the consistent position. In 1947, there was the HMA v Rutherford case. There was also the Smart v HMA case. Two persons were brawling in the street and the defence was that the person who came off worse consented to it. In law, that is no defence.

Secondly, the state of the health of the victim does not matter. In Scots law, you take the victim as you find them. Nor is the chain of causation broken by voluntary ingestion. For example, if I supply someone with a lethal cocktail of drugs and that person ingests them, the chain of causation is not broken, so that would be a sufficient causal connection.

Motive is irrelevant in relation to criminal liability. It obviously has a relevance in relation to proof of homicide but not in relation to criminal liability.

The law of concert applies in Scotland. If a person assists another person—thereby acting in concert—to take their own life or attempts to do so, they will be dealt with under the law of homicide that applies in Scotland. "Assists" means undertaking a positive act towards the execution of his or her purpose.

Finally, the Suicide Act 1961, which was relevant to the House of Lords's interlocutor that the Director of Public Prosecutions publish guidance, applies only to England and Wales, not to Scotland.

To answer your question in relation to the law, the law in Scotland that covers this field is the law of homicide.

Ian McKee: Thank you. That was very helpful. It seems that the law has covered every base. Without specifying what they are, can you conceive of circumstances in which a prosecution would not be brought if someone helped someone else to end their life, or would a prosecution always be brought?

10:15

The Solicitor General for Scotland: It is difficult to second-guess what the circumstances might be, but in general terms the indication would be that it is our job to apply the law; it is not our job to change the law by prosecution policy.

In a case in 2006 a man was convicted of culpable homicide for assisting to end his brother's life—I think that his brother was suffering from Huntingdon's disease. He was convicted of culpable homicide and admonished. That case was the last reference that I could find. That indicates that in those circumstances our prosecution policy, applying the public interest test in that particular case, was to prosecute.

To answer your question, it is difficult to look forward, as it would depend on all the circumstances, but I go back to a point that I made previously. The more serious the offence—the crime—the more likely it is that, on current law, the public interest is that we should prosecute.

Ian McKee: But homicide is in itself the most serious crime that there can be, so your stance is really that you are almost certain that, at the moment, everyone would be prosecuted but it would be up to the courts to decide what the punishment should be.

The Solicitor General for Scotland: I would not like to say that almost everyone would be prosecuted. I go back to what I said about assessing the public interest and the sufficiency of the evidence. We would know whether the crime was murder or culpable homicide, and the more serious the offence, the more likely it is that the public interest demands a prosecution. I would not say that a prosecution would be mandatory or would occur in all cases, but there is more than a fairly strong possibility that, applying the law, the public interest would lie in a prosecution. Ultimately, it is for the court, in sentencing, to take account of the mitigating circumstances that may exist in a particular case.

Ian McKee: I am still a bit confused, because your initial answer seemed to rule out just about every mitigating circumstance that could prevent a prosecution, but you can say that there would be some occasions—they would perhaps be very rare—when you would not go ahead with a prosecution.

The Solicitor General for Scotland: I would not rule out that we would take no proceedings, but it is difficult to look into the future and try to answer questions based on hypotheses.

Michael Matheson (Falkirk West) (SNP): I would like to take a slightly different tack. An issue that interests me is where a person’s death occurs. If the bill were enacted and someone chose to exercise the rights that it provides, they might seek physician-assisted suicide within, for example, a facility that was owned by the national health service. Alternatively, they might commit suicide, but assisted by the prescription of drugs that, again, took place within an NHS facility. Would that be legal in Scotland in terms of the legislation on which the NHS is based and how it operates?

The Solicitor General for Scotland: No, that would not give you statutory cover. You would look at the jurisdiction of the act, and if it occurred within Scotland or actions in preparation for the suicide occurred in Scotland, that would give you the jurisdiction under existing law to look at the matter under the law of homicide.

The position in the future would depend on what the law was and what the change in the law was. If it occurred, for example, within an NHS facility in Scotland, we would have to look very carefully at the act that the Parliament had passed and at what was covered by and what was exempt from the law of homicide, as provided for by the act, to assess whether there was criminal conduct.

Michael Matheson: I was trying to raise a point about the NHS (Scotland) Act, of 1971, I believe. I wondered whether the provisions in the bill, if enacted, would be outwith the scope of the NHS (Scotland) Act 1971. Would we be in the territory of possibly having to amend the NHS (Scotland) Act because what would be provided by the bill, if enacted, would be outwith the scope of the NHS (Scotland) Act?

The Solicitor General for Scotland: It would be difficult to comment on that. As a prosecutor, I would look at the criminal liability element rather than cover under NHS legislation or amendments to the 1971 act.

The Convener: For the record, I think that the act in question is actually the NHS (Scotland) Act 1978, but that does not change in any material way the question asked or answer given.

The Solicitor General for Scotland: I am obliged.

Helen Eadie (Dunfermline East) (Lab): As a prosecutor, do you think that if it were to be passed by the Parliament the bill would have any unintended consequences?

The Solicitor General for Scotland: What sort of unintended consequences did you have in mind?

Helen Eadie: Well, as a prosecutor who might have to make a judgment on such matters, do you think that the other complex pieces of legislation of which you have advised us this morning would have to be modified or altered because of the bill?

The Solicitor General for Scotland: With regard to criminal liability, if the bill were passed a defined set of circumstances would be taken outwith the criminal sphere. By decriminalising such actions, you set boundaries or parameters within which criminal liability no longer exists. However, it still exists outwith those boundaries and any good legislation would need to consider any consequences and interaction with other acts of Parliament that might have a bearing on it to ensure consistency.

The Convener: You might not be able to help with this matter but, as you are well aware, the bill seeks to give relief in respect of not only the criminal offence of homicide, the decriminalisation of which you have already touched on, but the law of delict. How will the ordinary citizen be affected with regard to the relief that is sought in that respect?

The Solicitor General for Scotland: As you know, delictual liability was considered in the Law hospital case of a few years ago, in which the family of a person in a persistent vegetative state wished the provision of nutrition to the patient stopped. The medical personnel dealing with the patient applied to the court for a declarator—in other words, authorisation to stop the nutrition—to ensure that there was no delictual liability on them. The Lord Advocate intervened in the public interest and in recognising that there was a delictual issue in this case, the court issued a declarator saying that nutrition to the patient could be withdrawn. In such circumstances, therefore, delictual liability sits alongside criminal liability and the bill would give delictual cover to the acts that it covers and authorises.

The Convener: Thank you.

Margo MacDonald (Lothians) (Ind): I will ask about a number of legal details. First, however, you said that motive is irrelevant in your stepped assessment. How does that relate to the double-effect medication that is currently given and about which we have had evidence? The physician will give that medication for the relief of pain, but they will be well aware that it will also have the effect of shortening a person’s life.

The Solicitor General for Scotland: I have been giving some thought to that matter, as I am aware of a couple of articles in legal journals that mention a double effect. The doctrine in question applies in England and Wales; the articles questioned whether it also applies in Scotland.

If the intention is to alleviate pain, but that may hasten or cause death, the issue goes back to mens rea. The intention underlying the act would be assessed. One would assess the double effect, whether the medication relieved pain, whether that was the primary intention, and whether it was known that the medication might kill the person. The primary intention of the act and whether that is covered by criminal conduct would be assessed. An actus reas is needed for criminal conduct; an act and an intention are needed. Intention is well defined in the law of homicide and has been well known in Scotland for centuries. It is well understood by the public. As prosecutors, we would assess what a person’s intention was in providing drugs to the patient.

Margo MacDonald: Do you agree that that is a somewhat hazy corner of the law, as two intentions must be assessed, and which was the greater must be decided?

The Solicitor General for Scotland: Absolutely. Such judgments are difficult to make. Under the current law, all the circumstances would be considered, medical records would be assessed, and there would be statements from the medical personnel who were involved in the patient’s treatment. A prosecutor must determine what the intention was.

Margo MacDonald: Are any such cases ever reported to you?

The Solicitor General for Scotland: No such cases have been reported to me in 27 years. I am glad to say that, because such cases are very difficult. England and Wales have a special unit to deal with them. If such cases arose tomorrow or in the near future, say, they would be dealt with at the highest level by the local procurator fiscal and the highest level of crime counsel. Ultimately, I think that the law officers would deal with them.

Margo MacDonald: Forgive me if this is a policy question rather than a legal question, but would it be better to have a clearer legal demarcation line?

The Solicitor General for Scotland: Sometimes trying to engineer a demarcation line can cause more problems than the line was intended to solve. Such cases are very fact-specific cases. I think that 16 factors in favour of a prosecution and six factors against a prosecution are listed in the bespoke guidance that the DPP in England and Wales has issued. The difficulty lies in weighing up all the factors and deciding what weight to give each particular factor that applies to reach an overall judgment. Difficult legal concepts, such as mens rea, are involved. When someone speaks to a jury, they will explain the intention, but a man’s or woman’s mind cannot be looked into. Their actions will be considered, and one will try to infer from those actions what the intention was. In assessing mens rea, all the circumstances need to be considered to try to determine the true intention.

Margo MacDonald: You have said that you are aware of the double-effect procedure in practice. Why should there be a difference in law between that action being taken by a medical practitioner of some description and a carer, perhaps?

The Solicitor General for Scotland: There is no difference in law. It seems to me that there is no class of person to which the law does not apply or applies to a lesser extent. Obviously, you recognise that the medical profession deals with terminally ill people and people who want to end their life, and you recognise its role in giving palliative care. However, there is no separate law for the medical profession as opposed to the rest of the public; the law is applied across the board. The circumstances in which the act took place would be taken into account. That is recognised in the DPP’s guidance.

10:30

Margo MacDonald: In relation to the provisions in the bill, would the procurator fiscal require any prior notice of the procedures being used?

The Solicitor General for Scotland: In what sense?

Margo MacDonald: The process in the bill also has steps. At what stage in the process would the procurator fiscal require to be informed, before the post mortem?

The Solicitor General for Scotland: It seems to me—this is just my view—that the procurator fiscal would require advance notice. The investigation of deaths is a responsibility of the Lord Advocate under the Scotland Act 1998.

Drawing on my experience as a procurator fiscal—although that was in the dim and distant past—I remember a system being put in place for the Lothian and Borders region whereby resuscitation procedures were not to be attempted. If a terminally ill patient wanted to go home to die and did not want any medical intervention—for example, if the patient suffered cardiac arrest and the family panicked and called the ambulance paramedics—they would go home with a form stating their wish that they did not want any attempt to resuscitate them. At that time, we had discussions with the medical professions in the Lothian and Borders region to ensure that the procurator fiscal was advised of that, certainly during the bedding-in process. That was a death that the procurator fiscal would have wanted to be advised of and may have wanted to intervene in, in particular circumstances. I recently read some feedback from NHS Lothian saying that that had worked well in practice.

I would say that, from the outset, if the bill were enacted, the procurator fiscal would want to be advised in advance of the person's death.

Margo MacDonald: It occurs to me that the directive that has been followed in the Lothian and Borders region has been in place for long enough for it to have been tested to see whether the patient's family could override it or try to override it.

The Solicitor General for Scotland: It was the patient who made the declaration that they did not want to be resuscitated if they went into cardiac arrest. From memory, I believe that the guidance said that that had to be an informed expression of the patient's wishes, taking account of the patient's age and the family's wishes to ensure that the decision was made of the patient's own free will. I do not think that the family could override the patient's wishes in that circumstance.

Margo MacDonald: You mention the patient's age, which is relevant to another stream of questioning that has come up in the evidence so far. What attention is paid to the patient's age? Is account taken of the great age of the person or of the relatively young age of the person?

The Solicitor General for Scotland: I had in mind the relatively young age of the person. I will give an example of that. The Supreme Court ordered the DPP to issue his guidance following the Purdy case. I re-read the case in detail last night and the reason that the DPP was ordered to issue guidance arose from the case of Daniel James, which you might remember from the news. Daniel was a 24-year-old lad who had been badly injured in a rugby match and who wanted to travel to Switzerland to end his life. The issue was whether the DPP would raise proceedings against Daniel's family under the Suicide Act 1961. When the DPP published the reasons for his decision, the majority—if not all—were outwith the reasons published in "The Code for Crown Prosecutors".

That caused Mrs Purdy difficulty, because she did not know the criteria that would be applied if her husband assisted her in travelling to Switzerland to take her life. The court had regard to article 8 of the European convention on human rights, which provides for the right to respect for family life but says that it can be interfered with when that

"is in accordance with the law".

The argument in the case was that the DPP's issuing of reasons that were outwith the reasons in the prosecutors code meant that anyone who considered such action would not know what criteria would be applied, as that was the only case in which the DPP published the reasons why he decided not to institute proceedings. Following that case, the DPP published his guidance, which I am sure that all of you have read.

Margo MacDonald: If procurators fiscal were to be issued with guidance, would that need to be mentioned in the bill? Do your powers allow you to issue guidance?

The Solicitor General for Scotland: The factors that we take into account in assessing the public interest are set out in our prosecution code, which we keep constantly under review and updated. In fact, we are examining the code now to ensure that it is still fit for purpose and that we have missed nothing out. All the factors that we take into account in assessing the public interest under current law are set out in the prosecution code.

If the bill was passed, we would look at its provisions and consider what guidance should be issued to procurators fiscal, who might ultimately have to deal with relevant cases. We would also consider whether we needed to issue bespoke prosecutorial guidance to procurators fiscal. We would wait until the bill came into law and we would assess its implications and what guidance should be issued to fiscals. I am certain that we would provide training on the bill to procurators fiscal. We recently established a central deaths unit to co-ordinate policy, training and guidance for procurators fiscal throughout Scotland. That unit would drive the work.

John Logue (Crown Office and Procurator Fiscal Service): I will try to assist the committee on guidance. The comments on guidance are directed to the procurator fiscal's role in investigating deaths. It is important to recognise that the bill would not require guidance that is similar to the DPP's guidance in England and Wales. The DPP's guidance related to a statutory offence, whereas the bill would take a set of circumstances out of the criminal law, as the Solicitor General said.

I make it clear for the committee that we would focus the guidance and training that we talk about on our role in investigating deaths. By itself, the bill would not generate the expectation that we would need to publish guidance that is similar to the DPP's guidance.

The Convener: That answer is most helpful.

The Solicitor General for Scotland: If I conveyed the impression that the guidance would be similar to the DPP's guidance, that was not what I meant. As members would expect, we issue to procurators fiscal guidance following any new act that creates criminal offences.

Margo MacDonald: I have more questions on precise issues, which are important—is it all right to continue?

The Convener *indicated agreement*.

Margo MacDonald: Would the designated practitioner be permitted to certify death or would that offend against an existing law?

The Solicitor General for Scotland: I would hate to venture an initial and uninformed view. We will consider that further and write to you in detail.

The Convener: I make it clear that you should write to the committee's clerk. That will allow us to make the information public.

Margo MacDonald: I have seven more legal points such as that to ask about. To save the committee's ears, I could receive answers to them in writing. I am happy for everybody to share the answers.

The Solicitor General for Scotland: As I say, we are always here to help. If, through the convener, you wish to write to us with those additional points, I will be happy to write back and answer them as best I can.

The Convener: I think that that is perfectly satisfactory to all of us, if I can take the committee's mind on that. All that we would need is to have full sight of the questions alongside the Solicitor General's responses.

Margo MacDonald: I can give you the questions today, convener.

The Convener: That would be helpful.

Helen Eadie: I am not sure who should answer this question. One issue that we face constantly, quite rightly in my opinion, is the European convention on human rights. The submission from the Catholic Bishops Conference of Scotland states that the ECHR would have an impact on any legislation that we passed on the matter. It quotes the comments of the Parliamentary Assembly of the Council of Europe, which has stated that member states should respect and protect the dignity of terminally ill or dying persons in accordance with article 2 of the ECHR, which states that

> "No one shall be deprived of his life intentionally",

recognising

> "that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person"

and

> "that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death."

In other instances, cases have been taken to the European courts that have then overruled our own legislation here in Scotland. Could that happen in this case? If the Parliament decided to proceed with Margo MacDonald's bill, could we be back to square one because the European courts would rule it out?

The Solicitor General for Scotland: That would obviously need to be looked at in detail. It might be instructive for the committee to read Lord Hope's speech in the Purdy case, because he summarised what article 2 of the ECHR means in relation to the right to life and what it encompasses. As I understand the point that he made in his speech, the right to life also encompasses the right to die. I do not have the case with me, but he went into the matter in great detail and drew on all the relevant authorities. I can arrange for a copy of his speech to be delivered to the convener. It is instructive and helpful.

The Convener: We already have that. I am also conscious that, although I understand the question, it takes us into difficult territory. The bill has been approved by the Presiding Officer as being compliant with European law under the Scotland Act 1998. That does not mean to say that it will remain compliant as it goes through the Parliament, but we will not debate or rehearse that argument this morning.

I think you have answered the generality. Thanks to the legal advice that we have had from Lynda Towers, we have already been directed to Lord Hope's speech in that judgment. I certainly agree that it is important, so it is a fair point, but—

Helen Eadie: I was going to ask whether we could hear John Logue's comment. I think he indicated that he wanted to speak.

John Logue: I was simply going to repeat the point that has just been made—that convention compatibility is a matter for the Parliament. It is not for the law officers or the prosecution service to offer a view on that.

The Convener: That was the point of my intervention.

John Logue: The bill is no different from any other bill in that respect.

Margo MacDonald: It is another way of getting out of Europe.

Helen Eadie: No, no.

The Solicitor General for Scotland: Once a bill is passed, the law officers have the option of referring it to the Supreme Court if there is any concern about its compatibility.

Margo MacDonald: Can I ask a question on that?

The Convener: Is it germane?

Margo MacDonald: It is about the Supreme Court. Would the Supreme Court come to any sort of judgment in relation to Scotland in advance of an English bill being discussed, accepted or rejected?

The Solicitor General for Scotland: No. It would deal with what was before it. It would not give a prospective judgment or hypothecate on matters that were not before it.

10:45

Margo MacDonald: We have said on a number of occasions that Scots law will find decisions in English law persuasive if a similar case is judged here in Scotland. In your judgment, would the bill be persuasive in England, if it passes?

The Solicitor General for Scotland: Do you mean the act as opposed to the Supreme Court judgment?

Margo MacDonald: I mean the act itself.

The Solicitor General for Scotland: It is something that they would take into account if they were developing policy.

Margo MacDonald: Thank you.

The Convener: As we are all content, I thank the Solicitor General and John Logue for their attendance this morning, which has been most helpful. We will send you the points to which we would like you to respond and we look forward to receiving your answers in due course.

Before we move on to our second panel of witnesses, we need to rearrange the configuration of the room, because we will have a large number of witnesses. Save for Margo MacDonald, myself and Alison Britton, all members will require to move, so I would be grateful if you could gather your papers. There will be a short suspension while we change the configuration.

10:46

Meeting suspended.

10:58

On resuming—

The Convener: After a major reconfiguration, I welcome everyone to the second evidence-taking session this morning. In particular, I welcome those who have come to give evidence: Pam Duncan, a board member of Inclusion Scotland; Johanna McCulloch, policy information and parliamentary officer of the Scottish Disability Equality Forum; Sarah Wootton, the chief executive of Dignity in Dying; Gordon MacDonald, the public policy officer for Care Not Killing Scotland; David Manion, the chief executive of Age Concern Scotland; Chris Docker, the director of Exit; Jan Killeen, the director of policy at Alzheimer Scotland; Tanith Muller, parliamentary and campaigns officer Scotland for Parkinson’s UK; Sheila Duffy, a member of Friends of the Earth; and John Deighan, the parliamentary officer for the Catholic Bishops Conference of Scotland. [*Interruption*.] I am sorry: Sheila Duffy is from Friends at the End. My previous days as an environment minister have obviously got to me.

11:00

I will explain how the discussion might work. The committee took a deliberate decision to have such a large number of witnesses to try to provide as many as possible with the opportunity to give their views to the committee at this important stage, which goes on until the end of October. We have called this a panel discussion, but it will operate slightly differently from normal. We will commence with a question and I will invite a range of views on it. After that, we want to try to engender a discussion. Therefore, any witnesses who wish to participate on a particular question or contribute as the discussion develops should simply try to catch my eye or the clerk’s. We will take note of that and try to bring them in at an appropriate moment.

Committee members will get opportunities to ask questions, but we seek to listen to as many of those who have come to give evidence as possible. I appreciate that committee members have already indicated to me that there are certain areas that they wish to explore a little further. They will get the opportunity to do so.

The sponsor of the bill, Margo MacDonald, is also present and will also get the opportunity to put questions. I do not necessarily want to keep her right to the tail end. On the other hand, I want to allow the discussion to develop so that we do not have repetition. She has the absolute right to ask questions of clarification. I will certainly watch the clock so that she is afforded ample time to do that.

We will begin with a general question. It struck me that the proposition that Ian McKee mentioned to me would be a helpful way of getting the discussion going.

Ian McKee: I have a simple question before we go into the minutiae of the bill. I am well aware that some of the witnesses represent organisations that are totally against assisted suicide and ending life prematurely for reasons of religious, spiritual or other belief. For them, anything in the bill is secondary to that basic belief. There are many people in Scotland who feel that way, but there are also many people who do not have that belief and do not share those values—they have different ones. Their needs should be considered as well.

I would like to hear from people who believe passionately that the concept of the bill is totally wrong why the opinions of people in Scotland who believe that the bill is reasonable should not be valued as well. No one is making anyone who believes that premature death is a bad thing follow the terms of any bill, so why should not people who think that it is fine—that there are certain reasons for ending life early—have their say as well?

Sheila Duffy (Friends at the End): That is our point entirely. I have total and utter regard for people who feel strongly against assisted suicide, wish to have palliative care right to the end and want doctors to intervene to help them to keep going, but many of our members would like those who wish to avail themselves of assisted suicide to at least have that choice.

I do not envy the committee its remit. We have only to weigh up the amount of submissions that you all have to consider to see that you must be banjaxed and glazed over at the end of the day. Many of the submissions are against what I personally stand for, but the bottom line of what I stand for is freedom of choice. John Deighan and I are probably poles apart on that issue. Although I respect his wishes and the wishes of people who are Catholic or religiously inclined—I am not religiously inclined, although I was brought up in the Catholic Church and then the Church of Scotland—I want freedom of choice.

I know that I do not sound like an ordinary person, but I assure you that I am. I was brought up in a council house by a single mother. My brother was a bus conductor, for those of you who are old enough to remember what a bus conductor was. I had the chance to go to the University of Edinburgh, so that took me away from my roots. When I meet and speak to ordinary people, say Ann on the supermarket checkout in Waitrose, Agnes who comes and helps me in the house or Rosalind at my keep fit class, and they find out that I am interested in euthanasia and involved with Friends at the End, they ask, “What is that? I’d like to know more about a living will.” I honestly believe that ordinary people support a change in the law for those who wish to avail themselves of assisted suicide. If you look at any surveys or MORI polls that have been carried out, I think that you will find that they support that view.

I hate to sound critical at the start of this evidence session, but I think that politicians and law makers—the non-ordinary people, as I call them—are lagging behind public opinion in much the same way that they lagged behind with regard to changes to the law on homosexuality and the law on abortion. Ordinary people want a change in the law so that those who wish to avail themselves of assisted suicide—and I accept that there are many who do not—have that choice. That is what we are campaigning for: freedom of choice.

John Deighan (Bishops Conference of Scotland): Can I come in at this point?

The Convener: No, I am sorry—you came in behind Pam Duncan, so I will take Pam first.

Pam Duncan (Inclusion Scotland): Thank you very much for inviting us to talk to you today. Like Sheila Duffy, I do not envy the committee. This is a highly topical—and to an extent highly personal—issue, but it is well worth discussing today.

The issue of choice is really important. As we are absolutely against the bill, we have been asked by others, “What about choice?” The crucial point, however, is that we live in quite an unequal society in which not everyone has access to the same level of autonomy and choice as everyone else. Disabled people are disempowered and do not have the same autonomy as non-disabled people. They face huge discrimination and this disempowerment impacts on and limits their choices. I also argue that this is completely the wrong time for us to ask society to make such a choice, because with the current economic circumstances the very services that support independent living and make life tolerable are being cut. With those services being cut, we are at risk of again limiting people’s choice—and when one’s choice is limited it can sometimes be skewed.

We need to be very careful about arguments that are centred on choice. For example, in its submission, the British Medical Association says:

> “Permitting assisted dying might conceivably benefit a small number of well-informed and articulate people but in the long term it might also impinge seriously on others ... a general relaxing of the ban on intentional killing could detrimentally affect the rights of very vulnerable people”.

Furthermore, in response to the 2004 Assisted Dying for the Terminally Ill Bill, the Disability Rights Commission issued a policy statement that said:

> "in the current climate of discrimination against disabled people, and where lack of access to palliative care and social support"

—the sort of things that make life tolerable as I have said—

> "means that free choice"

for many disabled people

> "does not exist, the threat to the lives of disabled people posed by such legislation is real and significant."

Is it fair to accept that we all have equality of choice in a society with such deep-rooted inequalities? I say no and argue that disempowerment limits our choice.

We also have to consider the value that society places on disabled people's lives. Only the other night I saw on television the cricketer—forgive me, but I cannot remember his name—

Sarah Wootton (Dignity in Dying): It was Chris Broad.

Pam Duncan: Thank you.

The circumstances were slightly different, in that his partner took her own life, but, when asked about her choice in that respect, Mr Broad said that they had discussed what would happen and had agreed that she was not "the type of person who would be pushed and fed". Well, I am that type of person and I do not think that it is fair to place such limited value on my life or the lives of disabled people who need the support to live independently—support that, I should add, is under threat in the current economic climate. In that respect, we need to question the intention with regard to choice and autonomy.

John Deighan: Ian McKee made the important point that people of belief are opposed to the bill, but we have to recognise that the public square is the place where we must have the opportunity to compare our justifications for changes to the law or policy decisions. For the past 60 or 70 years, people from all sorts of background have followed the principle that emerged post-Nuremberg that, for human beings, there are certain inalienable rights—in particular, the right to life—that it would be too dangerous to remove. That right, and indeed the human rights that have been built on that pillar, have been safeguarded and developed not only by people with a faith background but by those with humanist and secular principles.

The question is whether the various justifications for the bill can be compared, and I do not think that choice for a few outweighs the impact on the many—

Sheila Duffy: But it is not the few, it is the majority. I talk to ordinary people about this day in, day out. Perhaps we will just have to agree to differ on that.

John Deighan: In submissions to the committee, 86 per cent of people who have thought about the issue deeply are against the bill. Similarly, in considering the Joffe bill, the House of Lords discounted opinion polls not out of hand but because, in its view, they did not serve lawmakers' purposes. Instead, the lords felt that they needed to hear from people who had examined the issues in some detail.

I am sure that we will discuss this issue later, but empowering people can have many negative consequences and should not happen purely on the basis of choice. The virtue of being able to choose does not justify the choice. After all, many things that we might choose to do would be too dangerous to the community as a whole, so we have to make a whole host of decisions about the kinds of drugs people can or cannot take, drink-driving limits and so on to safeguard the wellbeing of not only the majority but the whole. We must safeguard every single person's intrinsic right to life because any other approach is simply too dangerous.

Sheila Duffy: The approach seems to be working in Oregon and the Netherlands.

The Convener: I will let you back in, Ms Duffy, but first I must allow others to have their say.

Gordon MacDonald (Care Not Killing Scotland): This all boils down to a discussion about autonomy, which we will no doubt get on to later, versus public safety. That is ultimately the value judgment that Parliament has to consider, and we argue that Government's role is to protect public safety and look to the public interest, which, in this case, is not to legislate for either euthanasia or the assisted suicide that is proposed in the bill.

Although we have freedom of choice in our society, our choices are constrained by the law. I might choose to take drugs or to rob a bank, for example, but the law prevents me from doing so. Choice is not absolute and, indeed, the concept of freedom itself can be understood in different ways. There is freedom of choice, but there is also freedom to feel fulfilled or to fulfil one's potential. As Pam Duncan has already hinted, as a free society we should seek to do as much as possible to help everybody to fulfil their potential.

11:15

A few weeks ago, the committee heard from palliative care specialists. When we apply palliative care principles to the issues raised by the bill, we see that the potential of such care to allow people to fulfil their potential at the end of life is enormous and often misunderstood, particularly by the general public. We have to take the results of opinion polls with a huge pinch of salt, because most of the people who are asked do not really understand the issues, which is why the committee has taken six weeks to take evidence from a range of people so that all the issues can be explored.

Suicide or attempted suicide is not an offence in Scotland, but it is an offence to assist someone to commit suicide or to euthanise them. The point is that the proposed legislation would involve other people, such as doctors and relatives, so essentially it would have an impact on wider society.

Sarah Wootton: Thank you for inviting us to give evidence to the committee today. There is a clear majority of support for a change in the law in England and Wales and in Scotland. A clear majority of disabled people also support a change in the law. The British social attitudes survey of 2007 showed that 75 per cent of disabled people support a change in the law. The most recent British social attitudes survey, in 2010, showed that 90 per cent of the general public—if we take those without faith—support a change in the law, and of the general public with faith, 72 per cent support a change in the law. Unlike Gordon MacDonald, I believe that the public have the right to a view on that.

My colleague Pam Duncan is right to say that the law is a blunt instrument and that autonomy is not king. We cannot put individual choice before everything; it is a balancing act, and we have to take into account individual choice and the impact on society. That is why we believe that legalising assisted dying for terminally ill, mentally competent adults would give people choice and protection, as well as ensuring that no one has a duty to die or to suffer.

I have seen the evidence that the committee was given from the Netherlands, Oregon, Belgium and Switzerland. It is important that we are clear that it is possible to have neither a duty to die nor a duty to suffer. We agree that a middle pathway through that would be ideal.

We will probably talk about people’s views about dignity. I want to be clear that when we accede to someone’s request for an assisted death, we are not devaluing their or anyone else’s life. We are actually accepting their valuation of the remaining weeks or days of their life, and the fact that they do not want to endure them. The key issue is balance, and understanding that they might not want to endure that time and giving them a choice of whether to do so.

Johanna McCulloch (Scottish Disability Equality Forum): Thank you for having me along today. I am here to represent the Scottish Disability Equality Forum, which is a membership organisation. We have consulted widely with our members and the response has been diverse, so I do not believe that we can fully support or oppose the bill as it stands.

Our members raised the issue of choice, who the bill gives the choice to, and why. One point that was made a lot was, if a person is physically incapable of taking their own life, they are not equal with a non-disabled person. To assist them to do so puts them on an equal footing with non-disabled people. However, as the bill is drafted, the criteria are so wide that the disability does not need to prevent someone from taking their own life; it just needs to impede their ability to live independently. Some people feel that that indicates that disability is the only thing that can make life so intolerable as to justify assisted death. From an equality perspective, they would prefer the bill to be aimed at people who are physically incapable of taking their own life—for that to be the only situation in which assistance might be justified.

Chris Docker (Exit): Thank you for inviting me to the committee. I have really enjoyed and appreciated the comments that have been made so far. We are hearing many different principles and using those principles to justify an argument.

I will pick up on something curious that John Deighan said—he quoted statistics in favour of an argument, but then said that we should discount statistics.

Moving on to the principles that we have been discussing, Pam Duncan spoke about empowerment and disempowerment, which it is important to address, as well as a lack of access to palliative care. John Deighan spoke about inalienable rights. Gordon MacDonald mentioned autonomy versus care.

I suggest that we consider a person’s critical interests. We each have general interests in our lives, including our hobbies—what we do in our spare time. Each of us also has critical interests, which make us who we are and make life what it is. In old-fashioned language, that relates to the hero’s death. It covers every type of situation. When a person dies, we consider the things that defined that person’s life. Those critical interests are important to a person while they are alive and to their family after they have departed.

My critical interests might be very different from John Deighan’s, and I would very much like to see some provision in the bill like the provisions that were made when advance directives were being debated in England, so that a person whose critical interests are in favour of all prolongation of life or an absolute refusal of any assisted suicide or euthanasia can make that very clear and have those critical interests respected. Similarly, somebody whose critical interests and the way they define their life are very much about their personal choice, and who might wish to opt for the promise, hope and reassurance that the possibility of assisted suicide or euthanasia gives, can have those critical interests respected. We are all different in that respect.

I suggest that that way of looking at things will allow us to involve our different points of view without bouncing stuff around in the way that we have been doing.

The Convener: Michael, does your question follow on from that? I would quite like to move on.

Michael Matheson: It does.

The Convener: I will let you come in at this point, then.

Michael Matheson: In response to the comments that have just been made regarding critical interests, the principles here are indeed important, as we are dealing with the general principles of the bill. Even the issue of critical interests is based on the autonomy of the individual to express those critical interests.

I find the debate around autonomy, freedom of choice and so on interesting. I struggle to understand, however, how far in our society we should allow personal autonomy to go. From what I have heard from Sarah Wootton, Dignity in Dying seems to want a qualified level of personal autonomy, but I am not too sure whether, from Sheila Duffy's position, that should be open autonomy, with someone having the freedom of choice to go as far as they like with the choices in their life. The challenge for us as legislators is to know where to strike the balance with regard to that personal autonomy, and what factors to take into account in considering how to set that limit. I am interested to know, particularly from those who have spoken about freedom of choice, autonomy and critical interests—whichever way we want to describe it—how we as legislators should set some perimeters around the choices that people can make.

Chris Docker: Shall I respond to that, regarding critical interests?

The Convener: You can be one of those who responds—others will come in on that, too.

Chris Docker: The Solicitor General spoke earlier this morning about how to define what is in somebody's mind. Many factors can be looked at, such as their previous actions. Some critical interests are clear from looking at a person's life, the choices that they made and perhaps from the choices that they expressed in advance, but sometimes critical interests are much harder to define. However, the way in which the law works in looking at what a person wants is a good approach.

The debate is helpful in trying to define those critical interests. I looked at the Economist Intelligence Unit report on the quality of death rankings around the world. In countries where the end of life debate is strong and where this type of legislation has been passed, the availability of palliative care is increased, as is people's awareness of how they can implement their rights, interests and autonomy from whatever side of the spectrum. Such legislation has the potential to enable and protect rights on both sides—or any side—by encouraging people to define critical interests more clearly.

Michael Matheson: We have to be careful when quoting statistics about improving the provision of palliative care. The committee received evidence that suggests that the culture of those other jurisdictions means that the provision of such care is very different from the traditional nature and level of palliative care that we have in Scotland. You have to be careful if you are making judgments on the basis of such data.

Chris Docker: It was not so much a judgment.

Sarah Wootton: Dignity in Dying campaigns to improve the quality of people's deaths, not the quality of their lives; other organisations do that. We do not advocate assisted suicide; we advocate assisted dying, which is where terminally ill, mentally competent adults who feel that they are suffering unbearably have the choice of an assisted death. There is a clear distinction between assisted suicide, where someone wants prematurely to take their own life because of concerns about their quality of life, and assisted dying, where a mentally competent dying adult who feels that they are suffering unbearably shortens the dying process by a few weeks or days.

I completely see the point that you need to decide where to draw the line and where, as legislators, you have to come in on the situation. The two things that you need to look at are first, the dangers of doing nothing and secondly, the benefits of doing something—of taking some course of action. The dangers of doing nothing are that assisted death is going on anyway. There is no doubt about that; there is voluntary euthanasia and non-voluntary euthanasia in every country in the world. Recent UK research by Professor Seale has shown that something like 0.2 or 0.3 per cent of deaths are assisted by doctors in voluntary and non-voluntary ways. The key question is, do you want to have an underground practice or do you want to regulate it? We know that more than 150 British citizens have gone to Dignitas—a recent case was that of Douglas Sinclair from Newcastle who went over to the clinic.

Without regulation, doctors' decisions will not be open to scrutiny. I was interested to see evidence from the Oregon and Netherlands doctors, particularly those from Oregon, who said that there were fewer legal assisted deaths in Oregon than in neighbouring states because of the transparency of assisted dying laws. They shine a light on and bring consistency to practice that is going on. You need to think about what is going on at the moment.

What are the advantages of regulation? Apart from giving individuals choice, it improves people's quality of life if they know that they have such an insurance policy. In Oregon, about 40 per cent of people who get the prescription for drugs to end their lives do not use it. That is interesting, and means that people feel that if they have the choice, they do not need to use it, and that extends their life. That insurance policy is important.

Further advantages of proper regulation are that you can prevent early or botched suicide or trips to Dignitas.

On Chris Docker's point about the quality of palliative care, the Economist Intelligence Unit report that placed Great Britain top of the palliative care list also placed all the countries that have assisted dying legislation in the top 10. Every country was examined according to clear criteria and all the countries with such legislation, such as Belgium and the Netherlands, were up there in respect of palliative care. I would look at the dangers of doing nothing and the benefits of regulating.

11:30

Pam Duncan: Sheila Duffy made a point about how the Oregon situation is working well. I point out that when individuals were making the choice to die, as it were, they cited concerns about their loss of ability to engage in activities that make life enjoyable and their loss of dignity. We argue that we have, as a society, a responsibility to encourage people to be able to enjoy life as far as possible.

I genuinely believe that, as a Parliament, we have a responsibility to make life a better choice than death. I will read a short quote from other evidence that you have received, which might help to illustrate my point. A woman said to us:

> "When my social worker told me that they had to cut budgets I had no idea that would mean things were going to get so bad. I need help to go to the toilet. There is not enough money to take me to toilet more than twice a day. When my carer comes in to me in the morning, I go to the toilet and before she goes, she puts on an incontinence pad for me so that I can do the toilet in my chair. I have been told to wet or soil myself. When they come back at night to make my dinner, they change my pad. I am so embarrassed, I don't let my friends visit me anymore. I am so isolated and sometimes I can't see a way out".

Social structures impact on whether people find life tolerable. We should be legislating for a society that supports independent living and supports people to make life a better choice than death. The Parliament is being asked to provide for a right to die.

I would like to see the Parliament guarantee and provide for disabled people's "critical interests", as Chris Docker said, to participate in wider society—in employment and in education—if that is what we believe in. We do, because the Parliament, the Convention of Scottish Local Authorities and the disabled people's independent living movement—despite the belief that the majority of disabled people support the bill, which I will come back to shortly, because I am not sure that that is the case—have signed a vision for Scotland that says that we want disabled people to live independently and to have choice, control, freedom and dignity in their lives. That requires that we set up structures in society to support that vision, not that we make death a better choice, which is why I fundamentally believe that we are going down the wrong route.

We are distracting attention from the real issues, such as the fact that disabled people are underrepresented in education and that their lives have less value than those of other people. We have only to look at the case of Daniel James, for whom it was considered that had he not been disabled his choice to end his life at that age would have been inappropriate. That is the sort of language that we heard in relation to his case. I genuinely believe that we have a vision for Scotland and it is one of equality and human rights. I think that the bill contravenes that belief.

In response to the point about disabled people—

The Convener: I am sorry—I want to hear everybody. I have to ask people to try to tighten their responses slightly or we will not get everybody in. A lot of people want to respond to Michael Matheson's point. I do not wish to stop you, but I ask you to draw your comments to a conclusion, as they are drifting on a bit.

Pam Duncan: Okay, I will draw my comments to a conclusion.

The point that I was going to make is that a number of disabled people's organisations, which represent a huge groundswell of disabled people, are opposed to the bill. Those include the Royal Association for Disability Rights, the National Centre for Independent Living, the UK Disabled People's Council, Disability Awareness in Action and the not dead yet UK campaign. It is unfair to believe that disabled people are not fundamentally against the bill.

The Convener: Sheila Duffy was named in the question. Do you want to respond?

Sheila Duffy: I would defend everything that Pam Duncan has said. I made the point in my opening speech that I would defend people's right to palliative care. I think, for example, that the heart-rending scenario that she told us about, in which a woman has to lie in her own faeces all day because there is no money, is appalling, but I honestly believe that that issue is separate from the question of assisted dying. I am sure that Margo MacDonald wants to make a point on that, too.

It is easy to say to someone that their life is worthless, but I am not saying that to anyone. Pam Duncan is obviously a spiky individual who has plenty to say in defence of the rights of disabled people; I, too, will defend the rights of disabled people right to the bitter end. However, six weeks ago I was diagnosed with cancer. The prognosis is good and I am up for it, but I know that one of our members has refused any more cancer treatment because she has had enough. If I get to that stage, I want to be able to say that I do not want to have someone take me to the toilet and that I want to have control of my life. I have discussed the issue with my daughters and my husband.

We want good things in life now—a good death, a good home, a good sex life and so on. Perhaps that is the way things are going; perhaps we are looking for an instant hit. As I have already said—I will repeat it and say no more—the politicians and lawmakers are lagging behind on the issue. Although Margo MacDonald is a doughty fighter, I do not think that her bill has a hope in hell of getting through, but one day—perhaps not in my lifetime—end of life assistance will come. No matter how much we talk here, the weight of public opinion will move things forward.

However, I defend to the bitter end what Pam Duncan said and think that it is appalling that disabled people have to spend their lives in the way that she described for one of her friends or colleagues.

Gordon MacDonald: My first point relates to autonomy. The question depends partly on our understanding of autonomy. Is autonomy in the patient-doctor relationship the right of the patient to impose their view on the doctor? The alternative is the danger that doctors will impose their views on patients. One paper that I read in preparation for today's meeting looked at the understanding of autonomy and the relationship between doctors and patients in the Netherlands, and the debate that is taking place on the issues there. The paper's author is not necessarily on our side of the argument—I suspect that he is on the other side—but he states:

> "fear of abandonment is more pervasive in the Netherlands than fear of unwanted interventions by the physician. Patients express the need to be cared for, and not to be left alone to die."

I found that comment interesting. Margo MacDonald's bill is broader than the legislation in the Netherlands, but even in the Netherlands, we need to consider what is driving the wish for end of life assistance. Is it fear of abandonment? That brings us back to the issue of good palliative care.

Sarah Wootton sounds very plausible. I would be interested to know her definition of "terminally ill", because it seems to have changed over time. I understand that her latest definition refers to people who have less than a year to live. When the House of Lords considered the Joffe bills, Dignity in Dying supported the earlier ones, which extended beyond terminally ill people. The organisation's position seems to shift. Sarah Wootton can explain whether it shifts purely for tactical reasons or whether there has been a genuine change of heart.

The Convener: Before I bring in Sarah Wootton, I invite John Deighan to comment, as he has been waiting for a long time.

John Deighan: I return to Michael Matheson's question about how far autonomy can go. As Pam Duncan suggested, dignity is not bestowed from outside. We should treat people in accordance with their dignity, which they retain at all times and in all conditions. Autonomy, or the critical interests to which Chris Docker referred, are features of functionality. If we say that a person's dignity depends on them, we will remove the firm foundation that protects everyone and bring relativism to the lives that we are willing to value.

If the system in Holland is based on autonomy, why are there so many problems there? Reports have shown that up to 1,000 people a year are killed in Holland without requesting it. That is not an issue of autonomy. Why is it happening?

We were told that things are going well in Oregon, so why is depression of such concern there? People in Oregon are assessed but are not being assessed in detail and are being pushed towards assisted suicide. Sometimes, they are coerced by family members or are not given an adequate diagnosis of depression. We know that people who want to die generally have some form of depression. In the majority of cases, people who want to take their own lives suffer from depression. Those are huge issues, which we cannot just dismiss in the name of autonomy.

Ian McKee: I am sure that John Deighan will agree that the figure of 1,000 patients dying in a non-voluntary way was taken from the Remmelink report of 19 years ago, which was before euthanasia was accepted in the Netherlands, and that now the figure is much lower.

John Deighan: Recent figures show that the number is still more than 500. Further, in parallel with that drop, there has been an increase in people who are getting continuous deep sedation, so there is a worry that people are compensating through other means.

Look at the concern that we had around the Harold Shipman case. Are we going to dismiss 500 deaths simply because those people were elderly, sick or disabled? With the death penalty, we are worried about making one mistake. Surely 500 mistakes—

Sheila Duffy: Harold Shipman was mentally ill.

The Convener: The issue was to do with the relative position of the statistics, with regard to age and so on. I think that you have made that point.

Sarah Wootton was asked a couple of direct questions by Gordon MacDonald. Could you respond to them as briefly as possible?

Sarah Wootton: Dignity in Dying was started in 1935 as the Voluntary Euthanasia Society. Its memorandum and articles, which were changed in 2006—I will give you a copy, Gordon—make it quite clear that we are calling for terminally ill, dying, mentally competent adults to have an assisted death, if they believe that that choice is right for them.

While I have the floor, I would like to come back on the point about depression. John Deighan is referring to research by Professor Ganzini, from whom you took evidence at a previous meeting. She found that six out of the 18 people whom she studied were suffering from symptoms of depression such as experiencing feelings of anxiety, not eating and not sleeping. She wrote up her findings in the *Journal of Medical Ethics* and said, basically, that people should be screened for depression, because it is to be expected. In the introduction, she wrote that the process in Oregon is working well and that it is not a question of people being depressed and opting for euthanasia but of people who suffer from the relevant conditions feeling depressed. She suggested that further investigation into that issue might be required. I stress that the prologue to her piece stated that there was absolutely no question that people were opting for euthanasia because they were depressed but that, rather, symptoms of depression were understandable in people who were very sick indeed and within days or weeks of dying.

Jan Killeen (Alzheimer Scotland): On competence and mental capacity, Alzheimer Scotland is relieved that the bill excludes people who have a mental disorder and who lack the capacity to make informed decisions. As you know, under the Adults with Incapacity (Scotland) Act 2000, capacity must be assessed in relation to the specific decision that a person wishes to make. We also see that people who lack mental capacity are excluded from all other similar legislation in other countries.

However, our membership is interested in this bill, and I am here to reflect the broad range of opinion that exists within our membership.

Many people are fearful of dementia and have seen their parents or loved ones at the end stage of dementia and have decided that they do not want that for themselves. They feel that there is also quite a lot of pressure from those who hold the view that people with dementia are a burden on society; recently, Baroness Warnock made statements in that regard, and was almost pressing for involuntary euthanasia for people whose dementia has reached a certain stage, because they are no longer of any value or worth to society. We think that that view is absolutely deplorable.

11:45

We also see that there is a lot of discrimination against older people with dementia. I fully support the eloquent points that Pam Duncan made. With adequate resources, it is quite possible to make such people’s lives well worth living. For example, I might well feel that I do not want to be fed through a percutaneous endoscopic gastrostomy tube and that, if I were to reach that level of dependency, that would be it. However, I have helped to support a woman—the mother of a friend of mine—who had severe dementia and, having been hospitalised following an accident, was being PEG fed simply because there were not enough staff to allow someone to sit and feed her. Just think what would have happened if she had written a living will that said that she did not want to be PEG fed. In fact, when she was eventually moved into a rehabilitation ward and was fed normally, she recovered quite well, her mood improved and she was reasonably happy in her state. If she had written a living will, she would have died.

There are great dangers in this area. Issues around assessing capacity are complicated, and psychiatrists and psychologists would say that there are a lot of grey areas with regard to individuals who might or might not lack capacity in relation to specific decisions or who might change their minds later but be unable to say so because they have lost their ability to communicate.

There are a lot of issues to consider, but at this point we are, as I said, relieved that people who lack mental capacity are excluded from the proposed legislation.

The Convener: Margo, I see that you want to ask a question.

Margo MacDonald: I have three.

The Convener: No. If members of the committee are constraining themselves to one question at this stage, I must ask you to follow that pattern. It would not be fair on the members of the committee otherwise.

Margo MacDonald: Okay. I will ask Johanna McCulloch a question. In your presentation, you appeared to be critical of the way in which certain sections of the bill are phrased, but not opposed to its basic intention. Is that correct?

Johanna McCulloch: As I said, my organisation is hesitant to either support or oppose the bill. When we consulted our members, a majority were in favour, in principle, of some relaxation with regard to decriminalisation. However, when it came to the specifics that are set out in the bill, there was less support.

Margo MacDonald: Convener, it might be helpful if I asked my other questions. They are as short as that one.

The Convener: If you are seeking clarification of certain points, you will have an opportunity to do so later on. When you caught my eye, I thought that you had a substantive question to ask. I will come back to you later.

Nanette Milne (North East Scotland) (Con): I would like to discuss the safeguards against undue influence, which Jan Killeen's points touched on and which are mentioned in several of the submissions to the committee. Inclusion Scotland said:

> "The so-called safeguards in the Bill would not prevent insidious and sometimes even unconscious pressure being brought to bear on disabled people by carers, health and care professionals, as all it seeks to bar is pressure brought to bear for monetary gain."

Care Not Killing said:

> "In the real world, serious illness and disability are often accompanied by depression or feelings of being a burden. While many families provide loving care, others can be manipulative."

Finally, the Disability Equality Forum said:

> "Some of our members stated that they themselves had experienced feeling burdensome and that at its worst it had left them wondering 'whether to end it all would indeed be the best thing for everybody concerned.'"

I am interested to hear comments on that from people around the table.

David Manion (Age Scotland): Thank you. Age Scotland does not feel able either to support or oppose the bill, but we have tried to illuminate some of the debate by asking individual older people what they think about it. I think it is fair to say that, of the submissions that have been made, the most comprehensive survey is to be found attached to ours, as it includes 296 responses and details in some depth what older people have had to say on the issue. It is worth pointing out that the survey was undertaken prior to the details of the bill being published. There is a danger that the philosophical and moral polarisation that you see around the table will mean that that is the level at which the debate is conducted and that insufficient attention will be paid to the detail of the bill. The bill will stand or fall on its own merits as a piece of legislation, the high-level debate notwithstanding.

Older people have expressed concern about aspects of the bill, including the measures that are in place to protect people from exploitation; communication and interpretation issues; issues around what happens to someone who is in a rapidly deteriorating condition; problems with the definition of terminal and non-terminal illness; ambiguity about independent living; conflicts of interest in relation to care home workers and managers; and the time limits on the process. It is important to explore each of those issues in this evidence session, because the role of this process is to inform better the detail of the legislation, not just to have the high-level debate, which people with that interest have presented well.

We need to bear in mind that our sample was of only 296 people. Although there appeared to be general support for assisted suicide for people with a terminal illness, there were no definitions. I think it is fair to say that the people we asked wanted more detail so that they could answer our questions more clearly. We want to put on the table concerns about the practical end of the business, not just the philosophical considerations, as you would expect of a charity of our sort.

The Convener: Nanette, will you remind us of your question? I am rather anxious that we pick up on some of those points as the agenda moves. Mr Manion did not contribute earlier.

Nanette Milne: My question was about concerns that have been expressed about the subtleties of undue influence and how it could impinge on people who might request assisted suicide.

Gordon MacDonald: The big danger for many people, particularly older people perhaps, is that undue influence is an internal pressure; they feel that they are a burden either to the NHS or to their family, particularly if the family is involved in their care. There is a real danger of such internal pressure and, in some cases, of external pressure.

There are many holes in the details of the bill. We cannot go into all of those, but one issue that we picked up on in our submission is the definition of mental disorder, which excludes people who are addicted to alcohol or drugs. If that is the case, I presume that the bill would allow an alcoholic or drug addict to have access to assisted suicide or euthanasia.

The definition of terminal illness is not clear. We have already discussed that. What period are we talking about? The father of one of my colleagues was given six months to live, but he lived for 13 years. There are issues to do with prognosis, which is a matter that regularly exercises the Parliament: how can a clear indication be given, particularly if we are talking about a 12-month period?

People are greatly concerned about many aspects of the bill. We have gone through a process for two years since the initial declaration of intent to produce a bill, and it seems to me that there has been plenty of time to have produced a bill that was more robust in many areas.

Chris Docker: First of all, I should say where Exit is coming from. We provide information on methods of suicide that is based on the best available evidence and research. That is the least worst option for people who join our society in the absence of suitable legislation with suitable safeguards and provisions. We do not undertake our work lightly. The feedback that we have received since 1980 is that the majority of people never use that information, but obtain immense reassurance from knowing that they can protect their autonomy and can do something if the system fails them and things get too bad. Many people say that the information gives them the courage to go on, possibly in the face of further suffering or pain, because they know that they have some ultimate control. I suppose that we reassure people who want such control. That is the subject of the bill. To reassure people who might feel disempowered by the existence of the bill is possibly a separate issue.

I would like to deal briefly with depression and capacity. I followed the interesting debates that took place when the committee was considering the bill earlier, and was interested in an issue that seems to have come up internationally. Often, if people are asked to diagnose depression for a suicidal person, that is like treating them so that they will not want to end their life. A difference has been developed in countries in which such legislation exists. It will be said, “Treat the depression as far as you can so that the person has capacity, if it can be treated to that extent.” The default with legislation of the sort that we are discussing must surely be that the answer to the question about ending a life is no if it is not clear that the person has capacity and that all the safeguards are fulfilled. No doctor will lightly decide to end life. If they cannot be reassured, the default must be no. We stand for exceptions to the rule because, at the moment, the courts cannot make that judgment call.

12:00

John Deighan: There are so many points to respond to. With regard to safeguards, I take on board David Manion’s point, but I have to say to him that it is difficult to separate the bill’s pragmatic aspects from the principle. Basically, the bill allows life to be ended, has very broad scope and contains modest safeguards, all of which will have a massive impact.

If the bill is about autonomy, it does not make sense to build in safeguards. Why should this course of action not be open to anyone and everyone who has the capacity? How in two short meetings would a psychiatrist be able to detect coercion or depression? How can safeguards prevent cultural change? Earlier, Jan Killeen cited Baroness Warnock’s comment that some people are wasting others’ lives by continuing to live. Once you accept the principle that it is okay for some people to be killed, the pool simply widens. In the Netherlands, for example, the provisions have been widened from the terminally ill to the chronically ill, from those who are competent to those who are incompetent and to children. That is the sort of cultural change that happens when you say that it is okay to end certain lives, and in such a situation safeguards simply do not work.

Pam Duncan: On safeguards, the blunt fact is that the current default position—and ultimate safeguard—is that this course of action cannot be taken.

There are direct and indirect forms of undue influence. For example, people with learning disabilities are 58 times more likely to die before the age of 50 than non-disabled people and four times less likely to undergo cervical screening or other tests that might prevent their death. As the health inequalities for the group are already extremely high, it might be naive and short-sighted to rely solely on safeguards that are based on some monetary value or issued by the health profession.

Earlier, I touched on the issue of disempowerment and choice. In another life and with another hat on, I worked directly with disabled people, trying to secure living support for them. A 21-year-old woman whom I worked with did not choose the socks she wore in the morning not because she was incapable but because she had been disempowered. How will we ensure that there is no undue influence on certain people if they are not even able to choose for themselves the colour of socks they pick out of their drawer in the morning because that job is done by someone who rushes in for 15 minutes and has no time to listen to them saying that they want to wear black socks instead of white ones, ones with spots on or even odd ones?

I return to the issue of the economic climate. We will be the last generation that will be able to use the £61 million of the independent living fund that comes to Scotland. It will simply wither on the vine. I accept that the fund is controlled by the Westminster Parliament, but it nevertheless has resonance in times of austerity. When we spoke to the Department for Work and Pensions about the matter, it said that the money will be saved through natural wastage. How quickly can such natural wastage happen? I realise that I sound as if I am scaremongering, but we have to consider such questions. I think that Sheila Duffy said that these issues are separate—and she is right, because independent living is about living, not dying. However, in focusing on assisting people's deaths, we are simply moving away from the real agenda.

In its own anti-suicide campaign, the Government makes it clear that

> "Most people who attempt suicide do not want to die; they want to end the pain they are suffering";

and that

> "Every life lost to suicide is a tragedy—whatever the person's age. One suicide represents lost life, lost talent, lost creativity, a lost mother or father, brother, sister, son or daughter and a wound that does not easily heal in those who are left behind."

In Scotland, the target is for a 20 per cent reduction in suicides by 2020 and the approach that is being taken focuses on services and support to ensure that people realise that life is a better choice. Why are we not trying to do the same for the lives of disabled people? To all intents and purposes, everyone who can be assisted to die under the bill is a disabled person according to all the legislation including the Disability Discrimination Act 1995, that covering eligibility for disability living allowance and so on. I find that somewhat contradictory and ambiguous and I would like a commitment to ensuring that life is a better choice than death.

We know that, as our society has less and less money, there will be more reliance on informal care and such situations are very difficult for people to live in. Finally, I point out that in Oregon the percentage of cases attributed to patients' reluctance to be a burden rose from 12 per cent to 42 per cent and again to 45 per cent in 2007. That rise is representative of the decline in services and funding available to help people to realise that life is a better choice.

Johanna McCulloch: Pam Duncan has covered a lot of what I wanted to say far more eloquently than I could have done. Many of the responses that we had on people feeling that they were a burden related to their immediate family and the lack of support for carers and the lack of short breaks from caring.

From a more practical perspective, I note that another point that was made was that an assessment by a psychiatrist or a medical doctor should be supported by obligatory counselling sessions between the two requests.

Helen Eadie: David Manion made a number of important points. One issue on which I would value the views of the panellists is independent living and how precisely you would define that. Secondly, how would you define "intolerable"?

David Manion: That is quite the point.

I have a general point about the perils of legislating in this area. The Parliament supported the Adult Support and Protection (Scotland) Bill, which had its genesis in concern about elder abuse. The present debate is like holding a mirror to that; philosophically, it is almost the reverse of it. As a general observation—to answer the point that John Deighan made—we see our role as being to help MSPs to find areas of the bill that would benefit from amendment if and only if MSPs choose to support it.

The Convener: I am sorry, but we invited you here to give us your views. You raised the two issues on which Helen Eadie has offered you the opportunity to expand. It would be enormously helpful if you could zone in on the question, please.

David Manion: Thank you, convener—you are quite right.

As things stand, there is great concern about what living independently means, and the bill does not provide sufficient definition to give meaning to that. Some people would regard living independently to mean relying on no one else; some would see it as being associated with a place of domicile. There clearly needs to be greater definition around that.

What was your second point about?

Helen Eadie: It was about "intolerable".

David Manion: The same applies. What we are picking up from the comments that older people have made to us is that that is in the hands of the person who is affected. People have said things to us such as, "I would not wish to live in continual pain," and, "I wouldn't want to be in pain with no quality of life." What comes through from the comments of individual older people is that they want to be in the driving seat at that point in time.

Sarah Wootton: I agree that the definition of intolerable suffering is a subjective value judgment. No one can say when someone else has reached an intolerable level of suffering; it is for the individual to decide.

There is an issue that I would like to address, in case we do not come on to it. From what I have read in the media, it seems to me that Margo MacDonald has made it clear that she would like to change the bill and would like to restrict its application to terminally ill people, in which case Pam Duncan's arguments would seem to be defunct because the bill would no longer include disabled people.

The Convener: There will be every opportunity for the member who is sponsoring the bill to decide what she wants to do with it, but the difficulty for the committee is that we are considering the bill as published and as it has been presented to us. The purpose of the stage 1 process is for us to determine whether to recommend that the various principles that are enunciated and articulated in the bill be approved. Amendment is a matter that will be dealt with after the current process has been completed.

Sarah Wootton: In that case, I would like to make it clear that Dignity in Dying would not want people who are suffering from a progressive condition or from permanent physical incapacitation to be covered by the assisted suicide provisions. I have made it quite clear that we are calling for assisted dying for terminally ill adults only.

Chris Docker: We have a slightly different position from that of Sarah Wootton's organisation. Our organisation is not saying that assisted dying is just for terminally ill people. Our definition is one of intolerable, unbearable, unrelievable suffering, and that is rather similar to the Dutch approach. Although that is defined by the individual, the safeguards that have been discussed also come into operation.

As far as those safeguards are concerned, I am slightly surprised that nobody has mentioned that, as well as medical definitions of capacity, there are also legal definitions of capacity. It is clear from the points that the Solicitor General made this morning that there is a structure for the law to intervene if the requirements are not satisfied. We can bring in a lot of safeguards—the person must be terminally ill and they must have been diagnosed by two psychiatrists. In the evolution of the Oregon bill, if I remember rightly, many of those safeguards were brought in to reassure opponents of the bill, and one can understand why that was done. The basic safeguard lies with the law, whose conditions might not be satisfied.

Helen Eadie: How would your proposal cope with Gordon MacDonald's point concerning someone he knew being diagnosed as having six months to live but going on to live for 13 years?

Chris Docker: That is very much for the person concerned to cope with. The law has to recognise the possibility that an individual can make a mistake. We recognise that as part of our liberty, but we try to protect one another from making mistakes. However, we cannot treat everyone as children for ever.

Pam Duncan: Addressing another point that Helen Eadie made, I note that the definition of independent living that the Scottish Parliament and the Convention of Scottish Local Authorities have signed up to—you can look at the vision statement that is on our website, which I can offer to the committee later—is as follows:

> "Independent living means disabled people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life."

As a young child going to school, I grew up thinking that independent living was about being able to put my socks on to a piece of plastic and to pull them on myself—and then missing my first hour of school. I remember saying to my mum, "This can't be what independent living is about." I was missing English. I did not like English, but I still wanted to get my higher. Sometimes I missed art, and I was really annoyed about that, because I liked it. Surely independent living is about me being able to decide what I need to support myself. The Government and the Parliament recognised that that is what independent living means.

However, the bill does not do that. It says that, if someone has to depend on someone else and they do not live independently, they could, technically, find life intolerable. That touches on the question of what "intolerable" means, and that is entirely subjective. People tell me that I have a high pain threshold. I had a tattoo on my foot last week, and people asked me how I could bear it. Tolerability is very subjective. We argue that if people are coming from a social model of disability—the Government has signed up to that approach; hence why we find the bill slightly incongruous—they understand that the issue is one of structures. It is the fact of being left in their own faeces or to soil a wet nappy that makes someone's life intolerable.

On the issue of longevity and whether someone has six months, 10 months, 20 years or whatever to live, I will share a story from Stephen Jay Gould, the great American Darwinist. He was told in 1982 that he had incurable mesothelioma of the abdomen. He researched how much time he might have remaining with his family, and at first he was depressed to find that the median mortality after the discovery of mesothelioma is eight months. Then, he asked what median mortality actually means. It means that half of those with the disease will have died within eight months; it also means that the other half will live longer.

Stephen Jay Gould quickly worked out that his chances of being in the other half of the curve were quite high. On what basis? He was young, his disease had been recognised early, he was affluent, he was a middle-class male and he would be able to command the best medical treatment available. He had everything to live for, and he had the support of a loving family and friends. He did not die in 1983, 1984 or 1985—he lived until 2002, 20 years after his initial diagnosis. I am not saying that the same thing can happen to everyone who is told that they have only three days or 10 months to live, but the point is that there are mitigating circumstances—not always, but sometimes—outwith the individual's medical condition that can have an impact.

12:15

This is controversial to say, but we need only consider the case of Mr al-Megrahi who, while he was in prison, was diagnosed as having six months to live. When he came into the comfort of his family and the love and support of his friends, his mindset changed and his life expectancy is obviously increasing. Whatever you think of the release, we cannot deny that. That helps to demonstrate the point that we are making about the social model of disability and how we as a society have to take account of the structures that make life intolerable and that can impact on whether someone chooses to die or wishes to make life the better choice.

Gordon MacDonald: It is important to be reminded that what people perceive to be intolerable can change over time. Just because somebody might think that something is intolerable at one point, that does not mean that they will continue to think that as the illness progresses. It is very subjective, and other factors can influence the situation. We must be aware of the looseness of the definition and of how the situation can change over time.

I was astonished, when I was listening to the evidence that was given a few weeks ago, to hear the former head of the Dutch right-to-die association saying that there was no slippery slope in the Netherlands. John Logue has picked up on this point. The issue is the cultural change. If we cross the rubicon and have the policy just for terminally ill people—if Margo MacDonald changes what she is proposing—there will be a cultural change, with the potential for us to progress in the way that has happened in the Netherlands. The fact that we have three different organisations around the table that all seem to be advocating different legislative changes—with different ages, different categories of people who should fit into the criteria and so on—indicates that, if the bill goes through, the agenda will not stop with that. It will continue to be pushed and there will be an attempt to broaden the categories, make it available for younger people, and so on.

Sarah Wootton: On the definition of "terminally ill", the plural of anecdote is not data. In fact, doctors tend to underplan for the length of time that people will live, and they tend to state that they will live longer than they do. There are clear definitions, and the decisions that are made by doctors are probabilistic.

However, there are guidelines. There is the end of life care strategy, which was published in 2008. There are the General Medical Council guidelines, which were published this year, which have clear definitions of what constitutes "terminally ill". To access palliative care, people need to be terminally ill.

Tanith Muller (Parkinson's UK): I represent Parkinson's UK. As our submission clearly states, we do not have a position in favour of or against the bill. We recognise that people who are living with Parkinson's have a wide range of views on this issue.

It is important, as part of this debate, to raise a specific point concerning people with progressive neurological conditions. The social model of disability that is being clearly proposed seems to apply rather differently to people with a progressive condition that will be life shortening for them as a result of their advancing symptoms. That explains why there are a number of people living with progressive neurological conditions who are in favour of the bill. We also recognise the strong feelings of those who are against the bill.

The arguments that have been advanced about people who are disabled do not necessarily cover the interests and the situation of people who are living with life-shortening conditions. That draws me into the questions around how we define a terminal condition, which is particularly problematic for people whose conditions can fluctuate from day to day. In some cases, the medical establishment does not really recognise the life-shortening aspect of those conditions, and it might not recognise when somebody is in the last year or six months of their life. That creates all sorts of ambiguities, which we outline in our submission, to do with how we define terminal illness and what we do about people who have fluctuating conditions, who might qualify to be recognised as having palliative care needs but might, for a variety of reasons to do with their condition, subsequently dip out of that care pathway again.

For neurological conditions as a whole, there is not that much stuff behind what everyone has said about palliative care, by which I mean that the research base on the ability of people with neurological conditions to access palliative care is lacking, as is the research base that we need to make decisions on when people are within the last year or six months of their life. That is the context in which the people in my organisation and their families are making their own decisions about the bill and why it is important. Basically, neurological conditions have been neglected in the mainstream debate about disability and independent living and they have also been neglected in the debate about palliative care.

People who are living with Parkinson’s disease often have quite nuanced points of view. I hear from people who previously opposed a change in the law but who are starting to change their position as their condition is becoming more advanced. I hear from families who are concerned that their relative would feel coerced. I hear all those arguments, but the situation for people who are living with these conditions is extremely complicated. It seems to me that, if we look at the heart-rending stories about people who have decided to go to Dignitas or have taken other measures to end their lives, it is often people with progressive neurological conditions who are in those newspaper stories. I just want to ensure that the committee is considering those difficult issues.

Cathy Peattie (Falkirk East) (Lab): Convener, I would like to move on a bit. If the Parliament agrees to the bill and it becomes law, there will be a number of issues. There was a discussion earlier about autonomy, choices and rights. I am interested in the rights of people in the medical profession—doctors, nurses, nursing assistants and so on—and people who work in care homes and nursing homes. I am sure that some of the organisations that are represented round the table are involved in the provision of care homes or nursing homes.

I am interested in people’s views on the right to opt out and how easy that would be. It might be easier for a doctor than it would be for a nurse, a nursing assistant or a nurse in a care home, who might well be one of only two folk who work there. Has there been any discussion on that issue? Do people have views on it?

Gordon MacDonald: It has been fairly well articulated in previous evidence sessions that there should be, at the very least, some sort of conscience clause in the bill. That should apply not just to doctors but to health care staff, social workers and others who are involved in end of life care. However, there is a danger. An analogy has been made with the abortion legislation. Although the UK has such a conscience clause in the Abortion Act 1967, there are attempts, particularly at the international level, to remove that right from doctors. That has happened at the United Nations and a debate is taking place at the Council of Europe at the moment about removing the right for doctors to have a conscientious objection. We need to be careful because, even if a conscience clause is included, which no doubt should happen if the bill is to be passed, a wider cultural debate is taking place and the conscience clause might not be safe for ever, particularly if the international climate changes and people are deemed to have a right to terminate their lives early.

The other thing to bear in mind is service provision. What would happen if every general practitioner in the Western Isles chose not to take part? Would people have to travel to Glasgow to have their lives ended? There are practical issues as well.

Chris Docker: Looking at the practical issues, and bearing in mind that not passing a bill is a choice in the same way as passing a bill is, we should ask what will happen to the people, many of whom are disabled through illness, who at the moment go to Switzerland. What will happen to the people who obtain literature to end life by themselves? There is a lack of safeguards, consultation and opportunity to increase efforts for good palliative care for those people.

On the conscientious objection of doctors, is it a question of how far we want to pass the buck? Do we want to say, “We don’t want to get involved—let the Swiss do it,” or, “We don’t want to get involved—let it happen in the backstreets”? Our society has to look at how far we want to pass the buck and leave people to their own devices, or how far we want to come in with the best will and say that in certain cases we can help, not only giving people the hope of the possibility of assisted dying but offering them increased palliative care and looking at their case a little more intensely. At the moment, we wash our hands of the issue. It is a question that doctors, too, have to deal with—how far do they want to pass the buck?

David Manion: I draw the committee’s attention to the issue that we flagged in evidence. At a practical level, if the bill goes through, there needs to be some consideration of clinical best practice—that applies in almost every clinical situation. That would be a natural consequence of the bill going through, and I suspect that it would require a lot of work by those involved in medicine and so forth.

My second point touches on the point about cultural change, which is well acknowledged. It is possible to raise or lower the bar of expectation, so one of the practical effects of the bill being passed will be the management of expectations. I recently attended the launch of a document by the Scottish Human Rights Commission on trying to raise standards in care homes and better awareness of human rights among care staff. It is a fantastic piece of work which, in a different context, touches on many of the issues that we are debating. There would probably be an expectation among older people that they should know in detail what the bill is about. It would not be something that could just sit there on the legislative books; there would have to be significant awareness raising if the bill were passed.

Margo MacDonald: Gordon MacDonald, I want you to go back to your statement on palliative care. Do you maintain that it is capable of giving a peaceful, dignified death to everyone?

Gordon MacDonald: The figure that I recall quoting was 95 per cent, but I am not a palliative care specialist. You heard evidence from palliative care specialists that made it clear that it cannot always do that, although they said that there were only a few cases in which it did not. I found it interesting that Stephen Hutchison said that, in the one case that he had recently in which he did not perceive that the care was having any impact, that was not the perception of the patient. We do not always know what other people perceive.

Margo MacDonald: That is my point.

John Deighan, you were a bit sceptical about opinion polling evidence. Do you discount the Age Scotland poll? I found it very helpful because, although it was based on a smaller number, it seemed to parallel many of the other tests of public opinion that I have seen done.

John Deighan: No, I would not discount opinion polls. It is important to take the temperature of public opinion, but I pointed out that, when the House of Lords looked at the issue, it argued that it is important to have qualitative information. I think that more than 600 submissions of qualitative consideration of the issue outweigh a straw poll of people who have not looked at the issue in any depth. That is my point—86 per cent of respondents to this committee were against the bill.

What we have experienced within the church is that although people look at the headlines and think, “When I get to that position, give me a pill or a jag,” when they start to examine the issues, they see that the negative consequences are so vast, widespread and difficult to contain that they end up being against it.

12:30

Margo MacDonald: Do you maintain that the negative consequences are there and that they can be evidenced?

John Deighan: Yes.

Margo MacDonald: Nothing that we have heard—

John Deighan: Let us look at some cases, such as the Barbara Wagner case in Oregon. Barbara Wagner was diagnosed with breast cancer and when she tried to claim on her health insurance she was told that she was not covered but that she would be covered to have her life ended. That is the sort of culture change that there is in Oregon.

You must be aware of the Groningen protocol whereby newborn babies can have their lives ended. You must be aware of cases such as the Chabot case, where a woman who had lost her two sons went to her doctor and said that she could not face her life without her children, and he ended her life. That is the sort of evidence of culture change that we have to show that the consequences cannot be contained.

Margo MacDonald: What evidence do you have that it is cultural change that has brought about the outcomes that you have described? I have not seen the evidence for all of them.

We know that the double-effect remedy has been used for generations in our society, but we cannot measure it. How do you measure cultural effect?

John Deighan: Double effect is a very important principle that balances two important rights: the right to life and the right not to suffer. We apply the double-effect principle to ensure that people are not suffering. We alleviate the suffering, which, in some cases, will hasten death. However, as you heard from the Solicitor General for Scotland, intention is everything when it comes to the sanctity of life and protecting life. We are solidly behind the principle, as for more than 60 years the whole human rights regime has been built on the fact that every human life must be protected from being intentionally deprived.

Margo MacDonald: I do not want to go into the highways and byways of this philosophical debate.

John Deighan: It is a legal, social and cultural debate, too.

Margo MacDonald: I simply want to find the evidence that shows that it is cultural change that has brought about—

John Deighan: Opinion polls in Holland show that people are more supportive of euthanasia and assisted suicide now. That is a cultural change that can be measured.

Margo MacDonald: I do not think that it can be. I have certainly not seen—

John Deighan: Strasbourg accepts the principle of—

The Convener: In fairness to everybody else, you should not be having an individual debate when a range of opinions has been expressed. You are making very fair points, but—

Margo MacDonald: I apologise, convener, but lots of people have referred to cultural change. Although there might have been cultural change, there is no evidence to show how you can measure it.

John Deighan: You use the examples that I have cited. At one time, it would have been unimaginable that a woman who said that she had lost two sons should have her life ended. That would have been unimaginable two decades ago, but now it is happening. It would have been unimaginable for Baroness Warnock to say that people who have dementia are wasting others' lives, but that becomes imaginable when you start to propose that some lives are not worth living.

Margo MacDonald: I do not want to pursue that, not because I would not like to but because of time pressures. I think that I would prefer to see evidence on the point that cultural change is bound to result from a bill that does not obligate anyone to use its provisions. Is anyone around the table under the misapprehension that the bill would force anyone to take part?

John Deighan: We believe that that choice would be influenced. That is our point.

Margo MacDonald: What evidence do you have for that?

John Deighan: Well, in the first Remmelink report, 1,000 doctors admitted that they had killed a patient without the patient asking for it. Professor Alexander Capron from the department of ethics at the World Health Organization described the safeguards in Oregon as "largely illusory". That is not someone from the Catholic Church; that is someone from the World Health Organization. If you have "largely illusory" safeguards, we do not really know what is happening below the surface. We know from Holland that one in five cases of assisted suicide goes wrong. In one in five cases, it is not about alleviating suffering; in those cases, you are actually inflicting suffering.

Margo MacDonald: We certainly have not heard evidence to that effect.

John Deighan: I am happy to provide that evidence to the committee.

The Convener: If there is evidence, someone will have to produce it. Does Margo MacDonald have a further question?

Margo MacDonald: A wide range of issues has been raised and I will leave it at that. I do not want to reopen questions that we have passed.

The Convener: I apologise to Michael Matheson, whom I had down to ask a question earlier.

Michael Matheson: My question is specifically for Sarah Wootton of Dignity in Dying. Under point 5.1 in your written evidence, you refer to the policy that was published recently by the DPP in England and Wales. You assert that the policy

> "demonstrates the need for a safeguarded assisted dying law across the UK."

I am not sure how you arrive at that position. You will be aware that the DPP policy does not apply in Scotland.

Sarah Wootton: While I am answering Michael Matheson's question, can I—

The Convener: No, no, no. I am sorry. I have been very tolerant, but you have been asked a specific question and we are getting to a point at which the debate could drift on.

Sarah Wootton: I promise not to drift, convener. I can enlarge on the point.

The policy statement from the DPP clarifies for the first time that those who act compassionately will not be prosecuted. In effect, it is a decriminalisation of people in England and Wales who act compassionately. I mentioned the Douglas Sinclair case. That is a good example of somebody reading the DPP's guidance in order to ensure that his assisters would not be prosecuted. It was pretty clear to him that, if his actions followed those guidelines, those people would not be prosecuted.

Given that change in prosecuting policy, would it not be better to have up-front safeguards? Rather than the investigation of a case after somebody has died, should there not be a law under which a case would be investigated up front, when someone made the request to die? That would give them a chance to talk through their concerns and, if they had unmet health care needs, would allow those needs to be met. Crucially, it would ensure a more safeguarded policy. That is what I mean when I say that the policy demonstrates that, ultimately, we need a safeguarded assisted dying law in the UK.

Michael Matheson: I go back to my original question. The DPP's policy does not apply in Scotland. We are dealing with a Scottish bill. We have already taken evidence from the Solicitor General for Scotland, who is one of our two law officers, and he has made the position on prosecutions very clear. Why would a safeguard in Scots law be necessary?

Sarah Wootton: Because you have the same practice going on. You know that you have got—

Michael Matheson: No, we do not. The Solicitor General for Scotland made that very clear this morning. Scotland has an entirely different legal position on the matter.

Sarah Wootton: Yes, but do the cases exist in Scotland? Cases exist in England and Wales in which the assisters have not been prosecuted. The Solicitor General for Scotland did not want to talk about future cases in which assisters would not be prosecuted—how could he? However, there are undoubtedly cases in which assisters have not been prosecuted because prosecuting them would not have been in the public interest.

Chris Docker: You still have people going to Switzerland from Scotland.

Michael Matheson: When did the Solicitor General for Scotland refer to that in the evidence that we received?

Sarah Wootton: This morning?

Michael Matheson: Yes.

Sarah Wootton: He would not give criteria for non-prosecution in the future.

Michael Matheson: He cannot do that, as he cannot look into a crystal ball. I do not understand your call for

“a safeguarded assisted dying law across the UK”

in relation to the principles of the bill and a policy that does not have any basis in Scots law.

Sarah Wootton: I presume that you agree that people from Scotland go to Dignitas.

Michael Matheson: I understand that some people have, yes.

Sarah Wootton: Yes, and their assisters have not been prosecuted as a result of that. I am saying that there is a practice here of non-prosecution.

Michael Matheson: Do you understand that the position in Scotland is different because the Suicide Act 1961 does not apply in Scotland?

Sarah Wootton: Of course. The Solicitor General made that clear this morning. It does not alter the fact that the practice goes on. The DPP’s policy does not change the law in England and Wales.

Michael Matheson: You give the impression that there is some confusion around the matter and that there is a need to clarify it and to create safeguards. I took it from the Solicitor General’s evidence this morning that there is clarity in Scots law on the matter. On that basis, I cannot see why you would want to create safeguards. I understand that there is a different debate in England and Wales, but the Solicitor General was very clear about Scots law on the matter.

Sarah Wootton: If people are going to Switzerland for an assisted death and their assisters are not being prosecuted, the practice exists. Are you claiming that no one in Scotland has an assisted death?

Michael Matheson: No, I understand the situation. People do different things. Some people in Scotland commit suicide, for whatever reason. That is not a statutory offence in Scotland in the same way as it is in England. From what I can see, your argument is that there is a need for some sort of safeguard. I do not understand that, as the Solicitor General made the position clear today. There appears to be no confusion in Scots law on the matter.

Sarah Wootton: I can only say again that the practice is that people in Scotland are having assisted deaths but their assisters are not being prosecuted. Would it not be better—

The Convener: You need to be careful here. I am not sure which law I should quote, but I understand that a person may be prosecuted for assisting someone to go to Switzerland. There is a distinct difference on the issue of where the death takes place and our jurisdiction over that. I will allow Lynda Towers to make that clear. Michael Matheson is making an interesting point, but we are in danger of going around in circles and not quoting the law.

Lynda Towers (Solicitor): The big difference is that in England there is a reliance on statute in this area, which has given rise to the DPP’s guidance. Because we do not have a statute that creates such a prohibition, the position on what is in the public interest is very different in Scotland, where the matter is under the common law, from the position in England, where there is a statutory offence.

Michael Matheson: That is fine, but I do not understand why a safeguard is needed when the policy does not apply.

The Convener: The *Official Report* will demonstrate that we have rehearsed that point.

I thank the large number of people from whom we have taken evidence today. I hope that everyone felt that they had an opportunity to make a contribution. The committee is grateful to them for the wide-ranging views that were expressed.

I remind committee members that we will meet again next Tuesday to take further evidence on the bill at stage 1.

Meeting closed at 12:43.

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