The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE

Tuesday 21 September 2010

Session 3

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

Tuesday 21 September 2010

CONTENTS

END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE
7th 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)

THE FOLLOWING GAVE EVIDENCE:

Dr Salah Beltagui (Muslim Council of Scotland)
John Bishop (Humanist Society of Scotland)
Major Alan Dixon (Salvation Army)
The Rev Ian Galloway (Church of Scotland)
Leah Granat (Scottish Council of Jewish Communities)
Professor Tony Hazell (Nursing and Midwifery Council)
The Rev Dr Donald MacDonald (Free Church of Scotland)
Paul Philip (General Medical Council)
Dr Bill Reid (Methodist Church in Scotland)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 1

Scottish Parliament

End of Life Assistance (Scotland) Bill Committee

Tuesday 21 September 2010

[The Convener *opened the meeting at 10:08*]

End of Life Assistance (Scotland) Bill: Stage 1

The Convener (Ross Finnie): Good morning. I welcome everyone to the seventh meeting in 2010 of the End of Life Assistance (Scotland) Bill Committee. As usual, I remind everyone to switch off any electronic equipment that might interfere with our sound equipment. Michael Matheson has sent an apology for lateness; unfortunately, he has found himself in the middle of a traffic jam. He hopes to join us just as soon as he can.

In addition to committee members, we have with us, as always, Margo MacDonald, who is the member in charge of the bill. For those who have not attended previous sessions, she will have the opportunity to put her questions to the witnesses after the committee has questioned them.

The only item on our agenda is the continuation of oral evidence taking. We have two panels this morning. I welcome the members of the first panel: Paul Philip is the director of standards and fitness to practise at the General Medical Council and Professor Tony Hazell is the chair of the Nursing and Midwifery Council. Good morning and welcome to you both.

Michael Matheson has arrived, having fought his way successfully through the traffic jam—well done.

Helen Eadie (Dunfermline East) (Lab): I have a question about the Nursing and Midwifery Council's submission, in which it says that we should

"appreciate that any legislation of this nature affecting Scotland would have considerable implications for the NMC in its setting of UK-wide standards."

Will you elaborate on that point, please?

Professor Tony Hazell (Nursing and Midwifery Council): As you will appreciate, the Nursing and Midwifery Council is a United Kingdom-wide body. We cover all four countries of the UK. We have a responsibility for setting standards, first for the education and training of nurses and midwives and secondly for the performance of nurses and midwives once they go on to the register. We also have a responsibility for setting the standards of professional practice that we expect of those registrants once they are in practice and, as far as possible, those standards are UK wide. Only last week, in Belfast, we launched new standards for pre-registration nurse education, which will apply across the whole of the UK. That is what we mean by UK-wide standards.

Helen Eadie: How will your role be different in the Scottish context? What particular problems will that present for you?

Professor Hazell: As a regulator, our only concern is to ensure that our registrants operate within the law. Within the law, we would want them to function with great care, with professionalism and, most of all, with compassion for the people for whom they care. We recognise that if certain issues were different in one part of the UK, we would need to respond to that.

We give a lot of guidance to our registrants to help them understand how they can best carry out their responsibilities. Only last year, we launched guidance on working with older people with a view to helping them ensure that the standards of care for older people were improved. It is not a question of just setting standards and then leaving our registrants to get on with it. We try very hard to support them. In that context, we would have to give careful thought to the guidance and the support that we would give to nurses who were working under Scottish legislation. We fully recognise and totally understand the particular legislative nature of devolution.

Helen Eadie: Would it be a great problem in the longer term? Once you had given thought to and established such guidance, would it simply be a question of monitoring it and ensuring that it worked? You would have a big piece of work to begin with, but once it had bedded in, that would be it.

Professor Hazell: All our standards are reviewed regularly because things can change extremely rapidly and quite dynamically. The guidance that we issue for nurses and midwives is reviewed regularly to take account of changing circumstances. That is particularly emphasised in the context of the devolved agenda because although our standards are UK wide, we recognise that the nature of the delivery of care by nurses and midwives varies, depending on the policy in that particular devolved Administration. We try to be sensitive to those differences.

Nanette Milne (North East Scotland) (Con): I have a question for the GMC about a registered practitioner who does not want to take part in furthering a request for end of life assistance. I would like to get the GMC's view on record, for the avoidance of doubt, because there was a little bit of misunderstanding yesterday. As you said in your submission, the policy memorandum states:

"there would be a duty on registered medical practitioners who object to participating to make arrangements to see a registered medical practitioner who would be prepared to consider a request for end of life assistance."

Am I correct in understanding that the GMC guidance does not make the referring doctor do the referral himself? He can advise the patient to go for a second opinion but must arrange it only if the patient is unable to do so. Is that right?

Paul Philip (General Medical Council): Essentially, our position is that patients must be informed as much as possible in their own care, so if a doctor holds an extremely strong view in relation to an issue such as abortion or assisted dying, for example, he or she should make that known. It is important that the patient has all the information that is necessary to make an informed choice, so they should be allowed to go on and see someone who will assist them. If, in exceptional circumstances, they are not in a position to do that for one reason or another, it is acceptable for the doctor to assist the patient in doing that. However, under normal circumstances the only obligation is to provide all the information so that the patient can seek out appropriate advice.

Nanette Milne: That is helpful; thank you.

10:15

Michael Matheson (Falkirk West) (SNP): I have a question for the GMC that follows Nanette Milne's point about conscientious objection. What is the difference in standing, in the profession and in law, between the Abortion Act 1967, in which there is a specific clause that recognises conscientious objection, and the GMC guidelines?

Paul Philip: I will defer from answering a question about the law—you would need to take your own legal advice. The GMC is an ethical body and we set the standards of medicine—in other words, the ethical principles to which doctors must adhere in order to practise medicine. It is possible that we may deal with a purely ethical issue and not a legal one according to what we call our fitness to practise arrangements, under which doctors may be disciplined for various reasons. That is particularly the case with regard to evidence. We often take action against a doctor for breaching our ethical guidance when the relevant prosecutors in law have decided not to do so. Although it is a matter of ethics and not law, it is clear that ethics cannot be unlawful. Our primary advice to doctors is that they must follow the law. That is why we have no view on assisted dying: because it is unlawful in this country we do not provide guidance on the subject to doctors.

Michael Matheson: I understand the position that you stated earlier about GMC guidance on abortion and other issues of conscientious objection. There is always a possibility that such guidance could change in the future because it is exactly that—guidance. The difference would be that if a point is stated in law then the GMC is not at liberty to change anything.

Paul Philip: That is correct. If the legal position is that it is unlawful, there is nothing that the GMC could or should do about it. Our ethical guidance is updated regularly and every couple of years we hold full consultations on how we should iterate our guidance, but if something is unlawful we have not and will not produce guidance on the subject.

Ian McKee (Lothians) (SNP): I am interested in Paul Philip's statement that ethics must always be subordinate to the law. Do you not think that, sometimes, a profession's ethical structure could be opposed to the law? I offer an extreme example: I imagine that the law in Nazi Germany allowed doctors to take part in all sorts of experiments that were subsequently condemned. Some of those doctors were executed or sent to prison for many years for obeying the law. From a philosophical point of view, is it always the case that ethics must be subordinate to the law? Before the Abortion Act 1967 was passed, a doctor who procured an abortion and was found to have done so would get a punishment under the law, but he would also get the enormous punishment of being struck off the register by the General Medical Council because he disobeyed the ethics of the profession. Yet the ethics changed in 1967. By contrast, journalists sometimes go to prison for maintaining their ethical stance of not telling the judge who gave them their information. Do the medical and nursing professions have lower standards than journalists in that regard?

Paul Philip: I will let Tony Hazell speak for himself on that one. It is a good point and by its very nature a philosophical one. Our body is a creature of statute that was set up under the Medical Act 1983. The bottom line is that we exist because of the will of Parliament—the Westminster Parliament in our case—and as such we are obliged to follow the law. I suggest that it would be unethical for us to advise doctors not to follow the law.

That said, ethics are different and can be a complicated issue compared with the law. Dishonesty is an example. As far as I am aware, it is not unlawful to be dishonest. It may be unlawful in certain circumstances and may constitute a component of various crimes, but it is not unlawful to be dishonest in and of itself. However, dishonesty could well be unethical, and in the context of medical practice it often is unethical. They are different things.

Professor Hazell: I can add to that from our point of view. It is interesting that we are often on

the receiving end of what we would regard as unethical behaviour by journalists but, as I am sure that you are aware, we have to live with that.

It is interesting to recognise the important distinction between us as a regulatory body and the bodies with whom we work very closely, such as the Royal College of Nursing and the Royal College of Midwives, which as well as being trade unions are professional bodies and can legitimately express strong views. We recognise the philosophical argument about ethics and law, but our prime concern is that our registrants must behave within the law. Whether they get different advice from their professional body will be a different matter, and that is where it is so important for us to work closely with those bodies—so that, if at all possible, we do not give confusing messages to our registrants.

Ian McKee: If the legislation were to be passed in Scotland, both of your organisations would advise the people who register with you in Scotland that it is perfectly legal to take part and that they would not get into any trouble with their regulatory body. If a person in England did exactly the same thing, however, not only would they be in trouble with the law but they would be guilty of conduct that is unethical in Carlisle but not in Glasgow. Is that correct?

Professor Hazell: That is exactly the dilemma that we would face, but it is one that we would have to confront. As the regulator, we are clearly obliged to give guidance and support to our registrants, wherever they work, in the context of the legal framework that exists in that country, and we would not shirk from that responsibility.

Ian McKee: But ethics has nothing to do with that—it is purely law.

Professor Hazell: Again, it is difficult to separate the two things out. From our point of view, we would advise only on the legal position, and we would rely on our registrants' professional body perhaps to express a view about the ethical side. Whether we agree with that position is of no matter to us because we can advise only in the context of the legal situation.

Ian McKee: So you would leave the ethics to the Royal College of Nursing, for example, and forget about it yourself.

Professor Hazell: Not exactly forget about it. We would want to work closely with the colleges, as we do all the time, because it is really important that we do not give confusing messages. We have 660,000 members and they have about 440,000 members. It is really important that we do not confuse those members unnecessarily, so we work closely in order that, wherever possible, we give the same message. If we are giving different messages, we need to give the reason why.

Paul Philip: I would like to come back on that to clarify what I think the General Medical Council's position would be. I agree with Tony Hazell that the law is the law and I think that, if it were to become lawful in Scotland to assist an individual to die, the General Medical Council would be obliged to provide ethical guidance on that. The issue is hugely complicated and the challenges that Tony highlights would exist in the extent to which we could provide that guidance. It would be difficult for the council to grapple with, but I think that we would be obliged to provide guidance. Now it is easy: we say that such assistance is unlawful and, because it is unlawful, we will not provide guidance. If it becomes lawful, we will be obliged to provide guidance.

Ian McKee: You have confused me even more.

The Convener: I agree.

Ian McKee: So, if the law changes, the ethics change—otherwise the ethical guidance would be, "Don't obey the law", and it could not be "Don't obey the law" because, as you have already said, you have to obey the law. If we had a committee that brought in a law to massacre the first born, would you give ethical guidance on that?

Paul Philip: It is clear that, if the law were changed to place obligations on medical practitioners in Scotland, as the regulator we would be obliged to provide some degree of ethical guidance to doctors acting in that situation.

Ian McKee: But the ethics would be different on either side of the border.

Paul Philip: No, we have made no pronouncements in relation to the ethics of something that is unlawful in England. That does not mean that there are not ethical issues there, as you pointed out in your example a few minutes ago, but we are saying that if it is unlawful, we are not obliged to provide ethical guidance and therefore we do not. If it were to become lawful, my personal view, subject to the view of the council, is that we would wish to provide some degree of ethical guidance for doctors in that situation.

The Convener: I am bound to say that I find it intellectually extraordinarily difficult to get my head round that argument. I cannot now understand why a number of witnesses from medical backgrounds appeared to be exercised about conscience clauses if there is no ethical issue and one would arise only if the law changed. I do not follow the intellectual rigour of that argument. You either have an ethical position or you do not. If the law changes, you express your ethical position. When the law changes you do not say, "Gosh, I must think of a new way of expressing my ethics." This is the first time that I have heard that argument advanced in a committee for a while.

I am sorry, Mr Philip, but we really are going to press you. This has left us very confused. I think that in your opening comments—I do not wish to put words in your mouth—you talked about setting ethical standards in the profession. Now you say that those ethical standards are driven not by broader philosophical considerations but entirely by a determination of the law. We have trouble following that.

Paul Philip: I have obviously failed to make myself clear. There are clear ethical considerations; I am not suggesting that there are not. At this point in time, the General Medical Council does not provide guidance and is not obliged to do so because the act that we are talking about is unlawful. If the law were to change to make the act lawful, the General Medical Council would need to consider what advice, if any, it gives to doctors. That advice may well be that the act is unethical, but we have not turned our mind to it; we do not have a position on it at the moment and we do not need to have a position on it. If Scotland were to develop a legal position in relation to the matter, we would be obliged to consider it, but that would be a matter for the council, which has not considered the issue to date.

Ian McKee: I am trying to access from memory the various documents that come from the GMC. Is it always the case that you do not give ethical guidance on something that is illegal? Have you never given ethical guidance on something that is illegal?

Paul Philip: Not that I am aware of.

Professor Hazell: I think that there are some overriding ethical considerations that underpin everything that nurses and midwives do. I referred earlier to the fact that, whatever it is, if it is within the law we would expect our nurses and midwives to practise safely, effectively and with compassion. Those are ethical considerations that must pervade everything that our registrants do. Therefore, should the law change, we would still emphasise that, within that legal context, they must operate safely, effectively and compassionately and with a clear concern for the views of the person for whom they are caring. Those ethics do not change, as I would say that they underpin the profession of nursing, midwifery and medicine, although I am not really qualified to speak for the medical side.

Cathy Peattie (Falkirk East) (Lab): In the evidence that we have received there has been some discussion of opting out. I am interested in nurses and midwives, because in many cases they are simply doing the second stage, if you like, and the decisions may well have been made. How difficult would it be for nurses and midwives to opt out? What sort of discussion, if any, has there been of those issues?

Professor Hazell: One has to look at that in two ways. First, theoretically and secondly, realistically. Theoretically, that is clearly an acceptable practice. We know that that practice exists in other parts of the UK, so a nurse who begins practising in England, Scotland or Wales and moves to Northern Ireland needs to understand the different context. Even in England and Wales, nurses have the right to opt out of certain things.

10:30

I am sorry to say that the practicalities can be somewhat different. We hear about a lot of rather disturbing cases of nurses being put under enormous pressure to do things that they believe are unethical or even illegal. We have received some alarming evidence that the phenomenon is developing significantly in the primary care setting. In general practices, nurses are being told that, unless they do something, they will be sacked. That sounds dramatic, but I assure you that it is factual.

We need to be aware of the difference between theory and practice. Theoretically, a nurse can opt out; practically, in certain situations, they can be put under a lot of pressure. To support them in that regard, we are about to issue guidance on what we call escalating concerns, to give nurses the courage to bring forward cases in which they are being asked to provide care that is inappropriate. However, in small, isolated areas, it is difficult for them to do that.

The Convener: You have in front of you the General Medical Council's booklet "Treatment and care towards the end of life: good practice in decision making". Paragraph 10, on page 12, is headed "Presumption in favour of prolonging life". The first sentence of the paragraph states:

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

I put it to you that, in this publication, the General Medical Council takes an ethical position in relation to such treatment.

Paul Philip: The guidance that you mention is General Medical Council guidance, and that is what it says. I was trying to make the point that, if the legal position changed in Scotland, the council would be under an obligation to provide doctors with a degree of certainty. A change in the legal position would create a new experience or ethical dilemma for them, because hitherto in this country they have not been able to do what is proposed. I

suspect that the council would wish to say something to provide doctors in that difficult position with guidance. The booklet sets out the GMC's ethical position. This morning we have already covered the point that physician-assisted suicide is unlawful in the UK at this time.

Nanette Milne: In its submission, the GMC suggests that

"references to 'registered medical practitioners'",

especially the practitioner who provides a person with practical assistance to die,

"should be changed to 'licensed and registered medical practitioners'",

as only those who hold a licence can prescribe medicines. Presumably, that would be the preferred way of administering death-invoking treatment. Do you wish to comment further on that point?

Paul Philip: It is merely a technical clarification. In November last year, we issued licences to doctors in the UK for the first time. Hitherto, if someone was a registered medical practitioner, they could be a doctor in all of the senses that you or I would understand. Now, if someone is only registered and does not have a licence to practise, they cannot practise medicine in any sense that you or I would understand. Registration merely acknowledges someone's identity as a doctor. The vast majority of doctors who are only registered are older doctors who are not and can no longer be in clinical practice.

Nanette Milne: If the bill were to be enacted and an unlicensed practitioner were to give the treatment for which it provides, would that be an illegal act?

Paul Philip: It would. A licensed medical practitioner would have to give the treatment.

Margo MacDonald (Lothians) (Ind): I want to pick up on that last point. I presume that an unlicensed person could not prescribe medicine for bunions or anything at all, and that somebody has to be registered and licensed for every service that they accord to a patient.

Paul Philip: That is correct. If somebody treats patients at all, they need to be licensed.

Margo MacDonald: Right. Let us go back to the presumption in favour of prolonging life. Your publication that the convener mentioned states:

"However, there is no absolute obligation to prolong life irrespective of the consequences for the patient, and irrespective of the patient's views, if they are known or can be found out."

Therefore, in your ethical standards, you accept that life is not sacrosanct.

Paul Philip: That particular piece of guidance, which was widely consulted on, is designed to provide doctors with guidance on what is perhaps one of the most difficult decisions that they will ever make, which is about when to withhold treatment and/or nutrition for someone who is in a terminal state. So, implicitly, what you say is correct, but that is in a very specific circumstance.

Margo MacDonald: Oh yes—I do not deny that. I am trying to drill down into all the circumstances.

I have another question for the GMC. Paul Philip said that the GMC has never given guidance on something that is illegal. Did you give no guidance to doctors following the ruling by the director of public prosecutions in England?

Paul Philip: We have given no guidance on that. I said that, as far as I am aware, we have never given guidance on something that is unlawful. However, we did not give guidance on that circumstance.

Margo MacDonald: Why not?

Paul Philip: Because it related to something that was and is unlawful in England and therefore we did not feel the need to give guidance.

Margo MacDonald: So, if a doctor perpetrates an act to bring about the end of life and the DPP decides that it was motivated by compassion, care and love, you would not take out a sanction against that doctor as, for those reasons, he was not prosecuted by the DPP.

Paul Philip: Our fitness to practise arrangements work completely independently of the criminal process, so if someone were to bring to our attention unethical behaviour by a doctor, we would consider the various bespoke circumstances of that and decide whether to take action.

Margo MacDonald: I infer from that that Keir Starmer's instructions can encompass unethical behaviour, as far as you are concerned.

Paul Philip: I am sorry, but I do not—

Margo MacDonald: The DPP says that he will determine when something should be prosecuted in the public interest and he has already decided against prosecution in several cases that we know of. Is that unethical?

Paul Philip: I have no idea, because I have not looked at the ins and outs of what the DPP has said. All I am saying is that, in relation to a regulatory function, if a matter is brought to our attention, we are obliged under statute to consider it. We consider all the circumstances and decide ourselves—we do not rely on what the DPP thinks—whether the doctor's actions or omissions have been unethical.

Margo MacDonald: You said that you wanted to give clear guidance to doctors. Do you think that this is an area for legislation, rather than guidance?

Paul Philip: I am sorry, but what area are you referring to as one for legislation rather than guidance?

Margo MacDonald: I am talking about whether there should be assisted killing, death or suicide. The DPP has said that he has a variable attitude towards that, depending on the motivation. Do you think that the area requires legislation?

Paul Philip: It would be useful if the legal position on assisted suicide were clarified, although I am probably not the best person to comment on whether that should be done through case law in the higher courts or through legislation.

Margo MacDonald: Do you envisage the sort of difficulties to which your colleague Professor Hazell referred in relation to the different jurisdictions on either side of the border?

Paul Philip: Yes, I do. Tony Hazell made a good point on that. Regulating across borders when different primary legislation is in place is complicated. There are complications, but they are not insurmountable, which, in all honesty, was what I was trying to get at a bit earlier.

Margo MacDonald: On that business of borders and the universal application of humane standards and standards of professionalism, Belgium and the Netherlands adjoin and have different legal systems. Are you aware of any difficulties that those countries have had? They have different rules, if you like, but I assume that they must have European Union standards in certain areas of practice.

Paul Philip: I am not aware of any such difficulties. There are EU standards that apply but I point out that standards for medicine are set on a country-by-country basis, not EU-wide.

Margo MacDonald: I see a terrific likeness between the provisions in my bill on the eligibility of requesting patients and the section in your guidance headed

"Assessing the validity of advance refusals",

in which it is said that the main considerations are:

"the patient was an adult when the decision was made (16 years old or over in Scotland, 18 years old or over in England, Wales and Northern Ireland)"—

which shows that there is already an age difference—

"the patient had capacity to make the decision at the time it was made ... the patient was not subject to undue influence ..."

and

"the patient made the decision on the basis of adequate information about the implications of their choice".

Do you agree that that guidance parallels what we have tried to do in the bill?

Paul Philip: Yes, except that that guidance was clearly written against the backcloth of the fact that assisted suicide is unlawful in England, Wales, Northern Ireland and Scotland. As such, what we are dealing with here are the ethical principles that Tony Hazell espoused a minute ago about compassion, quality of life and making difficult decisions about individuals who might not have the capacity at that point.

Margo MacDonald: If my bill parallels your guidance and the intention behind both is the same, do you see any compatibility between the two?

Paul Philip: There is some compatibility but there is a big difference between acting palliatively in an individual's interests and acting intentionally to end their life.

Margo MacDonald: What is the difference?

Paul Philip: From both an ethical point of view, which we have made clear in our submission, and a legal point of view, the act is unlawful. We do not provide guidance for doctors on that basis. Instead, our guidance seeks to provide some certainty in difficult situations. After all, one of the most difficult situations that a doctor can face is how to treat an incapacitated person who is dying and we have tried to identify some guiding principles for doctors who find themselves in such a situation.

Margo MacDonald: That is certainly what your guidance—which you have called ethical guidance—says and does. You agree that that guidance parallels what is in the bill, and I am merely asking about the difference in that respect.

Paul Philip: We do not provide guidance for doctors on assisted suicide. Instead, we give doctors guidance on providing treatment and care towards the end of life. We believe that there is a difference.

Margo MacDonald: So it is just a happy coincidence that what we have tried to do in the bill coincides with your intentions and guidance.

Paul Philip: There are huge overlaps, but the fundamental difference between the two is intention. The intention for doctors and that behind our guidance is that life should be prolonged—or, indeed, that its end not be hastened—and that the people involved are made comfortable.

Margo MacDonald: Your guidance says:

"there is no absolute obligation to prolong life irrespective of the consequences for the patient, and irrespective of the patient's views".

Paul Philip: That is right. It is always a balancing act to ensure quality of life and provide the palliative care required to give the best quality of life.

Margo MacDonald: I accept that it is a balancing act and a question of conscience.

The Convener: Mr Philip, I have a final question. You have frequently referred to uncertainty in the law and Margo MacDonald invited you to comment on the guidelines issued by the Director of Public Prosecutions. Given that the law of Scotland is involved, can you clarify for the committee what you believe to be the uncertainty in that respect? Moreover, if you are going to refer to a public prosecutor, could you refer to comments made by the Lord Advocates rather than by the Director of Public Prosecutions?

Paul Philip: I have referred to uncertainty on a number of occasions this morning. I hope that, for the most part, I expressed myself correctly in saying that our guidance attempts to clarify any uncertainty in the practice of medicine, rather than in the law. As I understand it, the law in England and Wales on assisted suicide is fairly clear: the practice is unlawful. Our guidance is ethical guidance—

The Convener: I am sorry—I do not wish to interrupt you. Even I gathered what you were referring to. However, this committee is considering a bill that will, if passed by the Parliament, become the law of Scotland. I am interested in the GMC's view on any ethical or legal uncertainties that might arise in that respect.

Paul Philip: I do not think that I am qualified to talk about any uncertainties in relation to the law of Scotland. The GMC has not provided any ethical guidance on assisted dying mainly because it is not lawful.

The Convener: I thank the witnesses for their written and oral evidence.

10:45

Meeting suspended.

10:50

On resuming—

The Convener: We move to our second panel this morning: the Rev Dr Donald MacDonald, retired professor of practical theology, Free Church of Scotland; Major Alan Dixon, assistant to the Scotland secretary, Salvation Army; the Rev Ian Galloway, convener of the church and society council, Church of Scotland; Dr Bill Reid, connexional liaison officer, Methodist Church in Scotland; Dr Salah Beltagui, convener of the Muslim Council of Scotland; Leah Granat, public affairs officer, Scottish Council of Jewish Communities; and John Bishop, secretary to the Humanist Society of Scotland.

I offer a warm welcome to you all. As you will know if you have listened to the procedure so far, we are trying to engage with the panel, so we will move straight to questions.

Helen Eadie: I have a question based on what other witnesses have put to us in their evidence. The submission that we received yesterday from the British Psychological Society in Scotland states:

"Much of the criticism of the Bill stems from religious beliefs about the value of life and God's role in the giving and taking away of life. Sociological research shows that religious belief amongst the general population is in decline. For example, the 2007 UK Survey Data shows that 50% of the UK population believes in God and only around 33% describe themselves as religious. Of this 33%, 50% 'do not practice religion very much, if at all'.

On the basis of these figures, it seems that criticisms of the Bill on the basis of religious belief cannot be regarded as necessarily a generally shared position of all people."

The BPS has asked that

"in its consideration, the Committee"

should

"not confuse personal beliefs with evidence in considering this matter."

I invite any of the witnesses to comment on that.

The Convener: Obviously a moment of theological reflection has taken place before we even begin.

Leah Granat (Scottish Council of Jewish Communities): The belief in the value and dignity of any individual's life is not simply a religious belief; it is held by a wide range of people. I question the statistics that Helen Eadie has quoted. In the 2001 census, which gave people an opportunity to identify as having a religious belief, more than two thirds of the population of Scotland—67 per cent—identified as such. I question the assertion that religion is in decline. For example, there was no comparison between the number of people who turned out to welcome the Pope on his visit last week and the number who turned out to protest.

I would like to consider the basis of the bill more widely, and the use of plain English terms. We have a very good English word for what the bill refers to as

"the provision or administration of appropriate means, to enable a person to die".

That is not end of life assistance nor is it, to quote Ms Milne, about administering death-invoking treatment; it is killing. Previous witnesses to the committee have spoken about the possibility that the bill could lead to termination of life without request. There is also a very good English word for that; it is "murder". If the bill is to progress, its supporters ought to be willing for the bill to go forward in plain English—in terms such as "killing" and, potentially, "murder"—instead of euphemisms and circumlocutions such as "end of life assistance".

The Convener: Let us go back to the original question. I call Mr Bishop.

John Bishop (Humanist Society of Scotland): I am surprised to be on early, convener.

We do not see this as a religious issue; we see it primarily as one that will bring a legal framework for a moral and ethical dilemma that we all face as a society, whether religious or not. There is ample evidence that the majority of the population wish this matter to be discussed. In a sense, those who support physician-supported suicide are in the majority. That includes people of religious faith and those without. Our view is that the matter needs to be considered on its merits. I have one quote for the committee:

> "Love and compassion dictate that the legal option of an assisted death should be a right."

That is a quote not from a humanist writer but from Christians Supporting Choice for Voluntary Euthanasia.

The Rev Dr Donald MacDonald (Free Church of Scotland): I thank the committee for the opportunity to give evidence, which is a privilege that we hold very dear in our democratic system.

I turn to the question on the place of religious evidence. All over the world, it has been shown that there is some belief in God, another world or some spiritual beings. In this country, it so happens that we have a long Judaeo-Christian heritage. Our society is based on that. As a church, we take our beliefs from the Hebrew scriptures, which we share with Judaism, and the New Testament scriptures, where we find the teaching of the sanctity of life, which is based on the fact that we are created in God's image and likeness. That accounts for the unique nature of human beings in the world. We are part of creation—we have an animal existence—but we also have a spiritual aspect that reflects our nature as made in God's image. That gives us an inherent dignity that cannot be taken away from us by any physical or mental defect. Our society has been based on those values for centuries. It is only in the past 100 or 150 years that those values have been questioned.

We bring as evidence the fact that people want to hold on to life. If asked, "Would you prefer a long, lingering, painful death or a short termination of your life?", most people—I am thinking of those who are well and young—would say, "Oh yes, it would be much better to end one's life." However, when people come to the end of life, they want to hold on to it. Palliative care physicians and other staff members testify to that. They tell us that, at the beginning of the process, people say that they want to end it all, but once they have experienced the love, support and care that is holistic palliative care, on the whole they give up asking. There is an inherent desire to maintain life.

11:00

Having said that, we do not believe that life must be kept going at all cost. The time does come when we have to say farewell, and when we should not have intrusive, painful or experimental treatment to prolong life. That is not the issue. The issue is about giving the care and support that is necessary until the natural end of life.

There are many other arguments that we can use, which we can go into later, but the fact that official religion seems to be in a minority nowadays is no reason for those of religious faith not to give evidence and make their views known. Our friend from the Humanist Society has a set of beliefs. He might claim that he is entirely rational and objective, but we all know that none of us is entirely rational and objective in any way. He has a belief system and presuppositions, the same as we all have. As he said himself, we should consider things on merit, examining the arguments for and against.

There are many other arguments against the bill, which I could bring up later, but that is all that I wish to say just now.

The Rev Ian Galloway (Church of Scotland): I will try to respond to the statistical question. I am grateful to Dr MacDonald for his comments.

I am 100 per cent Scot, and there is nothing in me that is not Scottish, but it is a Scotocentric view to say that religion is in decline. The community to which I belong is a glocal community—it shows up locally, but all over the globe, too. When I take refuge in my belonging in faith, I think of myself as belonging to the community of Martin Luther King, of Desmond Tutu and of others. We in Scotland have a pride in our relationships with other parts of the world and in our international belonging. I caution against taking too local a view when faith perspectives are being listened to. When people tell you that everything is relative, that religion is dying and that religion is in a minority, they are taking a reductionist view of the community that they are talking about. That is not to say that such

a view is in no way valid, but it is a reduced view of the reality.

Dr Bill Reid (Methodist Church in Scotland): I come from a small denomination in Scotland, consisting of only 3,000 or so folks, but we are part of a larger caring society. The main function of the church, as well as being an institution of religion, is to be a caring fellowship. That is the context in which we come to the table to discuss the bill and where it might take us in the future.

We base our principles on love and hope. We have been considering what the bill would do in terms of trust in our society. What would it do for the faith that we have in each other? The bill would impact not just on the individual, but on the whole of society. When we talk about assistance to end life, the whole of Scottish society is being asked, through the bill, to assist in ending life. That is a very important thing to consider. We are not only talking about individuals whose lives would be ended; we are talking about the whole of society and how it would be impacted upon by such legislation. How would it impact on the wider family? How would it impact on the professionals who were asked to act under the legislation? How would it impact on you and me, who might not be engaged directly in it? By standing back and saying that we in Scotland are happy to have such legislation, we are part of that assisting with dying.

The bill gives us the opportunity to explore those issues, but it is a very dangerous step to take society down that route. It involves every part of society, not just the religious bodies. We represent different religious faiths here, and the humanists—we all come with our different views, and we need to reconcile all those views in this process.

Major Alan Dixon (Salvation Army): I make a similar observation to Ian Galloway. My denomination is an international one that works in 121 countries. Our approach to life in the western world might be very much an individualistic one, but the vast majority of Salvationists live within communities where community is very strong. We need to remember that. We might have that emphasis on the individual, but at the end of the day we are all part of a community. The decisions that I make affect the community. We need to emphasise that rather than just emphasise the individual.

Dr Salah Beltagui (Muslim Council of Scotland): Muslims in Scotland are a minority—1 per cent or something—but many of the principles that we believe in are common with what we have heard from most sides. We believe in God. We believe that life is given by God, that it is the most important and precious gift that is given to man, and that it is not in our hands to stop it and start it. Otherwise, life would be quite confused.

It is not only from that viewpoint that I look at the issue. I look at it from the viewpoint of the whole of humanity, the whole of the community, all the religions et cetera. The most important point is that the bill devalues the human life. That came to my mind two weeks after I read the bill, when I was asked by my local hospital to join a group that is working with the national health service to reduce the rate of suicide. If we devalue human life, whether it is for the old, the young, the ill or the terminally ill, that message will go out, and if it goes to the younger people, that is very dangerous.

I do not see how one of the terms that is used works. As I state in the bill in my written submission, the idea of an intolerable life should not be something that we go by. People can tolerate life physically by many methods such as medicine, but the important one is spiritually, mentally and psychologically. People can also be treated well by being cared for. I know people who are in very difficult conditions, but the care that comes to them from their families and friends means that they just forget the situation they are in physically. That situation also connects and brings together the people who care for the person who is in difficulty. It is really a tie. We see that in extended families when the grandparent or eldest person is in that situation—the family members are all around him, and that brings them together.

It is not the case that we can look at life as—I do not want to use the word “commodity”, but if we look at life in that way, thinking that it is not acceptable any more or is not up to standard so we can just throw it away, that is a physical way of looking at life, which is not our belief.

Michael Matheson: One of the central principles on which the bill is based is the concept of individual autonomy. That has already been touched on, but I would like to explore it a bit further, because the issue of individual autonomy within society is an interesting one. I note from John Bishop’s submission that one reason why the Humanist Society of Scotland supports the bill is:

> “It respects the dignity and autonomy of the individual competent adult.”

Do you place any limits on individual autonomy within society?

John Bishop: Yes, we do. Individual freedom is not limitless; it must be related to responsibility towards others, particularly to responsibility to future generations. That is our philosophy. We talk about the development and use of autonomy within an agreed or social framework. The interesting thing about the bill is that it is an attempt to get a new settlement on where autonomy sits, because we all, whatever our faith or non-faith, face changing technologies. Our

medicine, knowledge and science have changed, and we now have a new situation that was certainly not available to my grandfather. Doctors are being asked to handle new dilemmas.

I was here for the previous discussion. It seems to me that the discussion with the General Medical Council representative showed the essence of the difficulty of setting out the new settlement, but we must have a new settlement, and Margo MacDonald has made a remarkably brave and almost single attempt to try to sort that out in Scotland.

I return to the issue of autonomy. We support Margo MacDonald primarily because we feel that the balance of responsibility for individuals against the responsibility for doctors has got out of kilter, and we need to rebalance those things. I emphasise strongly that the Humanist Society of Scotland does not express such views on its own; we feel that we are a voice for much wider views, and a religious voice in part. There is a need to rebalance or reframe what is going on in society.

Members are dealing with an important bill. We believe that there should be more autonomy for individuals in choosing the timing of their death, either in the circumstances that Margo MacDonald has prescribed or in circumstances that are akin to them.

Ian Galloway: My understanding of my tradition's perspective is that life, including human life, is fundamentally relational. I have to be careful about using the word "fundamentally"; I will use the word "basically" instead. Life begins with the individual. How relationships get worked out has been a tension in the story of faith and in scripture right from the beginning. Human life has been described in relational terms right from the beginning. There is responsibility for the other in relationships. Autonomy exists within that relational framework, but limits to what an individual may desire have to be seen within that framework.

One of the difficulties that we have had in considering the bill is that it promotes the individual, but the potential effects of an individual's choice not only on the people around them but on the whole of our society and the expectations that people have of it are huge. I do not think that there has been a debate on the effect that there would be if the bill were enacted. The next morning, there would be a new set of parameters for everyone in the country, born or unborn, and a new relationship between the individual and society. I do not think that that has really been taken on board in a process that begins and ends with the individual.

11:15

Major Dixon: I would like to pick up on John Bishop's comment about the power going back to the individual to make the choice. I will compare that with the situation in the Netherlands, which has gone along the line that Margo MacDonald is trying to take with the bill. My understanding is that although it started off as being the individual's choice, in practice the power has not remained with the individual but has gone to the doctor. The medical profession in Holland has moved more and more to having the power of decision making at the end of life. Individuals have not made the decisions. From what I gather—this is anecdotal evidence—the doctors can sometimes make the decisions without any reference to the person whom they are caring for. For me, that is one of the dangers of going along the line in the bill. As I said, in Holland it seems that in practice the power lies not with the individual but with the medical profession.

Leah Granat: Following on from the previous speakers, I am thinking about what autonomy actually is in relation to society as a whole. None of us acts with complete autonomy; we all base our actions, beliefs and thoughts on society around us. The bill would change the views and actions of society around us to the extent that a patient would have to discuss with their practitioner

"the medical condition ... all feasible alternatives to end of life assistance ... the nature and consequences of the request ... and ... the forms of end of life assistance which may be provided".

In other words, the bill would change the view of society on the options for a person who is coming towards the end of their life, which is obviously what Ms MacDonald is looking for. However, it would also change our autonomy, our ability to act and our response to society's expectations if physician-assisted suicide became one of a range of possible treatments towards the end of life, which we would greatly regret. An individual's expectations, of themselves and of other people, would be changed.

Somebody's autonomy would be limited simply by the introduction of an act along the lines of the bill. That person would not have the same option to turn away from assisted suicide that they have at present if there was an expectation that it was one of a range of possible options. I said that we would very much regret that, but I would like to strengthen that: we would deplore that.

Dr Beltagui: In simple terms, autonomy means to me that we become more selfish in our relations. The bill would break a lot of the trust between the patient and the doctor and medical staff in general, and between the patient and family, because they would all be suspicious of

why the idea of ending life was being pushed—we have heard about examples from other countries. There would also be the commercial side. We know about the Swiss example—people go there for this procedure. All those things mean to me that we would be creating a society in which we were breaking the relations between individuals and their families and the wider society rather than bringing them together.

John Bishop said that we have a new society, medicine and technology. Like any other invention that has come to the world since the beginning, medical technologies can be used for good or for the not so good. As humans who believe in human life, we should use those technologies to improve the lives of everyone until they end in the natural way, not in a way that involves anyone interfering.

Dr Reid: In a sense the bill does not help individual autonomy, as it does not make us more autonomous. It mentions assistance, so there is a reliance on whoever or whatever is assisting. It does not help with regard to the autonomy of the people who must make judgments against the eligibility requirements that it sets out; in some ways, the requirements are quite ambiguous, or a line is drawn at a certain point with regard to age, therefore people are left to judge.

We must consider aspects of equality in relation to the bill. If people sit on one side or the other of a divide, where is the equality in that? Where is the autonomy and the choice for someone who is 14 rather than 16 or 18? How does one judge—and how does the professional judge—who fits the criterion of being "terminally ill" or someone who cannot "live independently"?

The bill does not offer autonomy for everyone, and certainly not for the people who have to make the judgments or those who do not fall under the criteria that the legislation sets out.

Donald MacDonald: I agree with most of what has been said with regard to the limitations on our human autonomy. I appeal to those who support the bill to consider whether the exercise of their autonomy infringes on the rights of other people and whether, as has been suggested, it would change society's attitudes towards death and dying, and support for those who are dying.

I appeal to those people to limit their own autonomy in a more selfless way. I know that we all tend to be selfish, but the idea is that we should always think of other people first rather than ourselves. The emphasis on saying, "It's my life, I want to do what I like with it" is okay as long as it does not infringe on the rights of other people, but if even one person ends their own life it diminishes us all.

What will one say to the young person who finds their life intolerable for various reasons? It may be temporary as far as we are concerned, but in their view it is really the end: they cannot cope. Should we allow them to exercise their autonomy, and go ahead and take their own life? We do not do that, and we have a parliamentary policy to try to reduce the number of young people who commit suicide.

If we go down the road of hastening the end of life by whatever means are chosen—the bill is rather vague on that—we push on the whole idea that life comes to a point at which it is not worth living any longer, and that people should have autonomy to end their lives. That conclusion may extend the reach of the bill beyond what its proponents would have us believe, but it is an inevitable, logical consequence of such thinking. If someone who is not covered by the criteria in the bill says, "I want to exercise my autonomy and end my life, or have it ended for me", how are we to say no?

I believe that there would be an inevitable slippage; we can discuss that later, but it would be the inevitable consequence of passing such a bill.

John Bishop: In a sense this is not an issue for the future—although the future is of concern—but an issue for now. A number of humane doctors already assist their terminally ill patients on their way while necessarily publicly denying that they do so. I quote Helen Watt of Callander, who wrote to us to say:

> "My father had motor neurone disease and did NOT want to go into hospital and have his life prolonged at the end. My mother and a very sympathetic GP ensured that his wishes were met. Had they not been there, who would have helped ensure that my father's wishes were fulfilled?"

Michael Matheson: One of the confusing aspects of the bill is that its central principle is autonomy but, as Major Dixon indicated, it places a lot of authority in the hands of doctors, who are the gatekeepers in the process. People have to approach a doctor who is willing to participate; there is then a competence test by psychiatrists. You are correct to say that in the Netherlands physician-assisted suicide is the preferred option by a significant margin. Again, that places a lot of authority in doctors' hands.

You have explained your position on the concept of autonomy. Like the Rev Dr MacDonald, I wonder why people should have to wait until they are terminally ill to exercise that right to end their life.

John Bishop: I was asked to address issues relating to the bill. Your question raises a number of issues that go beyond the bill. I do not wish to speculate; I wish to develop a practical answer to a current, very difficult problem.

Michael Matheson: With all due respect, the central principle on which the bill is based is that of

individual autonomy—the right for someone to be able to end their life when they are terminally ill. We have explored that. As you mentioned, the bill is trying to reset the way in which society views individual autonomy. On the basis of your definition of individual autonomy, why should someone have to wait until they are terminally ill to exercise that right?

John Bishop: It may be helpful if I say a little about the way in which we have approached this difficult ethical matter and in which we approach other ethical matters. We look at what science and reason say about a matter; we do not use a fixed creed or text to determine our position on it. I have come here today, after discussion with my colleagues in the Humanist Society of Scotland, to talk about the bill, and I have done so. I am happy to continue to talk about it, but the question that I am being asked to answer does not have the relevance that the questioner believes it to have.

Michael Matheson: That is something for the committee, rather than for you, to judge. I am surprised that you are trying to evade the question. If you believe in the central proposition of individual autonomy—which you have already recognised—why should someone have to wait until they are terminally ill to be allowed to exercise that right? I do not understand the intellectual logic of your position.

John Bishop: I will repeat my evidence, which is that we as humanists believe that our individual autonomy is constrained by our social responsibility to others.

Michael Matheson: Does that mean that someone should have the right of autonomy to end their life only when they are terminally ill?

John Bishop: We are talking about assisted death, voluntary euthanasia and assisted suicide. In that context, we are in favour of autonomy to make decisions with the support of medical practitioners.

The Convener: Both of you have made your points clearly.

11:30

Ian McKee: Those of you who represent religions or faith groups will correct me if I am wrong but, to put it in crude shorthand, I interpret the feeling among you, no matter which religion you come from, to be that God put you on this earth and God will decide when you leave it. I am sure that there are subtleties around that, but that is roughly the position.

One could say that those of you representing that point of view are all biased. The bill relates not only to people from faith groups, but to people who do not belong to faith groups and who do not share that view. One could argue—and I ask you to disagree and to explain why you do—that you are trying to impose your moral and religious beliefs on fellow citizens who do not hold them. In an attempt to do that, you are moving into the area of how an individual relates to the society that they are in and the question whether someone should put up with intense pain or total loss of autonomy because society would be upset if they did not put up with it. Those seem like side-effect arguments to me. Basically, you are against the bill because of your religious beliefs. Why do you want to impose those beliefs on people who do not hold them?

Dr Reid: I could turn that round and say that we are not trying to impose anything. Like the humanists, we are simply responding to a potential change in legislation that has been created over hundreds if not thousands of years. We are not evangelising here; all we are doing is addressing the status quo against this proposal.

Ian Galloway: Clearly, a view of how life is has developed over a long time within the faith traditions. It is not a view of how life is for me alone but of how life itself is, of the relationships within it and of how, in the midst of all that, we are our brother and sister's keeper. We are the inheritors of that faith tradition and its particular values and have to struggle and wrestle with how that tradition applies in today's society, which is not always an easy thing. Your faith is not about you and how you impose yourself on others; instead, it is about your understanding of the best ways for us all to live together.

That is one strand of our faith community's engagement with the proposed legislation. Another strand is the fact that the church and its practitioners are deeply involved in the care of people. In fact, some are nurses and doctors. After all, in dealing with the Christian church, you deal with not just religious professionals but people from all walks of life, who bring their own experience to that engagement. We have been dealing with people nearing the end of life for a long time and can bring to the table that huge well of experience of caring for and accompanying people who are dying—and, indeed, their families—through the whole process.

Your almost stereotypical question whether we are trying to impose a minority view on others simply pastiches faith communities' huge professional and personal engagement in caring for and accompanying people during what is a very difficult time for many, not just for a few. One of the things that we experience in the midst of that process is that people deal with things differently—they have a different relationship to the experience of dying and the circumstances in which they find themselves. People also change

their minds about their circumstances from time to time on that journey. Some of those things cause us concern about the proposed legislation.

Salah Beltagui: There is a simple quick legal answer to your question—according to human rights, people should have the right to live according to their faith. We are saying not that faith should be imposed on others, but "Don't impose this on us."

You mentioned side arguments, but they are for the whole community, not only for religious people. One such argument that has been mentioned is suicide. If life is intolerable and there is no hope because a young person has lost somebody, their job or their way in life, it is easy to just commit suicide. That young person does not need assistance. Some time ago it was taboo to talk about suicide, but now it is normal and it has become another option in life. Such side issues are not small things; they are really important in relation to our society.

Issues of life are not new. They are eternal since we were created. We cannot judge this issue of life, which is both before and after us, on the basis today's conditions only. We must look at how people have dealt with this in the past and consider the future. In the past, before the idea that there could be an assistance to die, I used to hear stories of older people who were active in many ways and would suddenly decide to sit at home and do nothing. In a few weeks they would be dead. If somebody looses the will to live he can die without interference. Interfering is the issue.

Leah Granat: To return to the question, it misrepresents Judaism and, far be it from me to speak for my colleagues, probably other religions too, to say that religion requires people to suffer great pain and anguish towards the end of their lives. Certainly in Judaism, although deliberately hastening death is not permitted, all measures to provide comfort and pain relief are not only permitted but encouraged in the awareness that there might sometimes be a double effect—for example, in providing pain relief. There is no obligation in Judaism to prolong life, either. A patient is completely an individual and at liberty to reject treatment even if it might be considered by a doctor a good chance for prolonging life. If an individual wishes not to accept that treatment, that is completely within their choice. Pain and anguish are not rejoiced in or encouraged by religions.

If we return to plain English, where I started earlier, real end of life assistance is the care and concern that is provided to people who are coming towards the end of their lives by the whole health care team—the medical professionals, auxiliary workers, social care workers and so on.

The Convener: Rev MacDonald?

Margo MacDonald: Thank you, convener—

The Convener: Sorry, Margo, but I said "Rev MacDonald", although I understand your wish to be so elevated.

Margo MacDonald: Keep it in the family.

Donald MacDonald: To answer Dr McKee's question, we are not imposing our views; rather we are stating what we believe is best for society. We have to persuade people and argue the case—it is not a question of imposing.

I again point to our great Judaeo-Christian heritage and to the fact that Christianity has been behind many modern medical advances. In this great city of ours, James Young Simpson first used chloroform to relieve the pain of childbirth, which was frowned upon by many people. He was a firm Christian and, I believe, a Free Churchman. I could mention many Christians who have made advances in medicine to relieve human suffering. There is a strain of Christianity that perhaps glorifies suffering in some way, but that is not the main strain. We are commissioned by God to relieve suffering and to prepare people for death. Death is the final enemy; it is not something that any of us wants to go through, but it is part of our human experience and we are to prepare for dying and to support people through it. However, it is unacceptable to take it into our own hands and say that we are going to end a life. I appeal to people to accept that.

I spent 15 years in rural India working as a doctor and I saw much suffering and death. I can say that the poor and needy who faced death never wanted their life to be ended. They hung on to life as long as they could. We did all that we could to help them and, often, we saved lives. It is very modern—almost post-modern—to try to end one's life. It is not true that, as is sometimes suggested, Christians are obscurantist and against advance. We are for advances in every way in medicine and the relief of suffering.

I point to the history of the humanistic strain, which perhaps includes things such as social Darwinism. There are parts of our history as a Christian church that we are not proud of and that we regret, but I ask those of humanistic faiths to be careful about thinking that they have a monopoly on the truth, because fashions will change, even within their tradition.

I hope that people do not think that we are imposing something that is harmful for people, but rather that we are doing what we believe is helpful for society as a whole.

The Convener: Major Dixon?

Major Dixon: I have nothing to add to what has been said.

Ian McKee: I apologise for the somewhat provocative nature of my questioning, but I was trying to elicit a response. I say for the record that I fully acknowledge the many good works that faith groups do in Scotland and beyond. I reassure Dr Beltagui that there is no intention in the bill to make people of his religion end their lives. The bill is permissive, rather than about making people do anything. I reassure the Rev Ian Galloway that I am well aware of the way in which his church and others have played a leading role in the development of hospices and palliative care. However, with that good lead, as things have developed, an awful lot of people who are involved in palliative care belong to different religions or to none at all.

A lot has been said in the evidence about the sanctity of life. Dr Beltagui was the most explicit on that. His submission uses phrases such as,

"Do not take a life",

and

"God decides how long each of us will live."

The evidence from Dr MacDonald's church talks about a "just war" in which a lot of people end up being killed. Correct me if I am wrong, but I think that most Muslim countries have the death penalty. America, which is probably far more inclined towards Christianity than our country, has the fourth highest number of people executed every year. How does the concept of the sanctity of life fit with the way in which countries throughout the world, many of which have a predominant religious element, set about so vigorously ending it prematurely?

11:45

Dr Beltagui: Sometimes you have to do something that you think is evil to stop something that is more evil. When we talk about just wars, we speak of people defending their country against, for example, invasion by others who want to occupy or take over the country. Nowadays, some countries do not approve of capital punishment, but it has always been in history. The idea is that it is a strong deterrent. It is traditional; it is part of the faith. We are saying not that we need to apply it every day and encourage it, but that we will apply it in difficult conditions. I am thinking of people having to defend their country or times of big mischief when the only way to stop things is to take strong action—action that becomes a deterrent. The sanctity of life remains.

I return to the point on prolonging life. Our tradition is that God created life. He also created disease and, for every disease, he created a remedy. Of course, the only thing that does not have a remedy is age. That means end of life. Medicine is part of this life. Of course, the advance of medicine in the 11th century and beyond was mainly in the Muslim countries, before we moved here.

Donald MacDonald: Life is not perfect. As our scriptures teach us, we are sinners. There is sin in the world. Unfortunately, it affects human behaviour, which means that there is evil. We account for that and try to explain it in our different ways. The Bible explains it by saying that, early on in human existence, there was a fall away from God's standard and since which time, there has been murder, war et cetera.

The concept of the just war began in ancient Greek and Roman society and was taken on by the church and refined over the centuries. In one sense, the concept of the just war, including self defence or defending the weaker country, can be seen as a good thing. Sadly, it always ends up doing more than that. That is the way life is; it is not perfect. Using controlled force to try to deal with evil can be justified along those lines, but it is never tidy; we always end up with suffering and evil of various kinds. We cannot extrapolate the concept of the just war to the situation of end of life. People in the latter situation are no more guilty than anyone else; they are just ordinary human beings and their life should not be taken from them judicially.

Personally, I am not in favour of the reintroduction of the death penalty for murder, although many in my church would be. The case is arguable, but it is far from the subject that we are discussing. We can debate issues such as using force to control violence and evil or punishing those who are irrevocably evil, but we must not confuse those debates with the debate on this issue. We cannot extrapolate from the first case that life can be taken easily in the other.

Ian McKee: If we were to go on for another two hours on the concept of the just war, it could be called a misuse of the committee's time. I just wanted to introduce the concept that the sanctity of life that many of you express is a qualified issue, not an absolute. Some of you have agreed that there are circumstances when life can be taken ahead of when God wanted it to be taken. I just wanted to introduce that point for discussion.

Ian Galloway: Yes. It would certainly not be very fruitful if I were to try to defend everything that had shown up in the name of the church in every society. In humility, we need to say that all our expressions—whether of faith or of church—are human and do not get us to where we would want to be.

Regardless of where people come from, human nature is involved in how they work and try to live together, and human nature is one of the areas in which the proposed legislation gives me concern.

My concern is about the opportunities that the bill gives, not for abuse of the proposed processes, but for nuanced cruelty. The more I have been involved with families over the years, the more I recognise that they are all different. Many have wonderful relationships in which people care for one another, but there are a lot of other families in which that is not the case and any opportunity for nuanced cruelty is taken. There are a great many elderly, frail people who are abused quietly and in ways that no one but their family would ever know about. I have a difficulty with the bill in that I think it creates another opportunity for that.

Dr MacDonald talked about sin. It is an unfashionable word, but it attempts to describe something of the reality of human nature in relationships.

Major Dixon: I am not sure that I fully understand the question, but my response is that there have been some societies in which suicide was accepted—in ancient Greece and in Japan, suicide was part of what life was all about. We have never taken that line in our society. Here, suicide has been tolerated, but it has never been encouraged. In Scotland, suicide has never been a criminal offence—although for a while it was in England; our attitude has been that although we have tolerated it, we have not encouraged it. For me, part of what the bill is about is encouraging suicide. That is a line that I do not want to go along.

Dr Reid: I am not much of a theologian, but we have not mentioned the basic Christian view that life is eternal and that death is only one part of that journey; that it is a transition point rather than a terminus. We all live our lives in different ways and we all reach different transition points through life. Life is sacred, but life as we live it is lived in parallel with many other people living their lives. When we look at life from a Christian point of view, how our lives impact on those of others is just as important as how we live our lives in their own single stream.

Nanette Milne: The intention of the bill is to allow people to maintain dignity up to and through the process of death. How do the witnesses see human dignity in the context of the bill?

Major Dixon: We have already referred to the fact that most of us, because of our faith and traditions—though not necessarily just because of those—have cared for people at the end of life.

The evidence in many of the establishments that the Salvation Army runs, not only in the UK but worldwide, is that, often, when a person faces the end of life on their own it seems very negative—that is an understatement of how they feel; intolerable, to use Margo MacDonald's phrase, is probably nearer the mark—but what happens to someone when they become part of a caring community? This is the palliative care issue again. In the context of caring for people at the end of their days, we often find that, because they are cared for, their attitude towards the end of their life changes. They may have felt, "I want it to end as soon as possible," but their attitude is changed because of something that is generated as a result of the ethos within that caring environment, which means that they do not want to end it; rather, they want it to be enriched through other people interacting with them.

Dr Beltagui: I think that dignity for the person who is in that situation and knows that he is about to die is about care, attention and compassion; it is about feeling that they are still wanted rather than that that is enough. That is real dignity at the end of life; the person is still wanted by his children, his relatives, his friends and so on. That is what we have been doing, as far as I know.

Leah Granat: Another word that is closely related to dignity is respect. Respect for an individual—every individual—means that their life and they themselves have an intrinsic value regardless of their external condition, whether we are talking about wealth or poverty, incapacity, intellectual attainment or whatever it may be. Respect for a person's life is closely tied up with dignity. If somebody feels respected and receives respect—there is an onus on us all as a society to give every individual respect—they are enabled to feel that they have dignity.

John Bishop: I share the sentiments of my colleagues in almost every respect in relation to their definition of dignity. It can be a subjective matter as well as, if you like, a commonly agreed term, but is it then disrespectful to follow the wishes of a competent adult who, in their own subjective judgment, decides that life has become undignified? Can I not define for myself when my dignity has gone? Who are we to dispute the interpretation of dignity by another human being who is facing death?

Ian Galloway: Over the years I have worried about the fact that our society too often leaves people with little dignity at the end of their life because the level of care that has been given in some settings has been far short of what we would want it to be. I have seen an enormous qualitative difference between death for some people and death for others in our society. Partly, it comes down to whether you are lucky, where resources are and who is on duty and that kind of thing—it is not an exact science—but it also shows up the social inequality in our society. If you are middle class—a professional—you are likely to get better care than if you are not. That is not a comment on individual GPs, but time and again I have seen how much longer it has taken other people to get

diagnoses, treatment plans and so on. Also, quite a lot of the people I have accompanied have not been easy patients—they have been difficult to work with—and the response to that is often not good enough.

12:00

This is a complex thing; whether there is dignity in these processes shows up in the fabric of our society. We have an awful lot more to do. Outreach services from hospices to hospitals and so on are endeavouring to get some of the values in there. That is important, but it is a mark of society, in some ways, where dignity does or does not show up. If someone has the resources, the wherewithal and the ways of thinking, they are much more likely to be able to achieve the things that we would associate with dignity. One of my worries is that, in passing the bill, we might think we have dealt with that when in fact we have not.

Dr Reid: I was going to say much the same as that.

Donald MacDonald: There is an inherent dignity that we cannot lose as human beings who are made in the image of God. If it just depended on our capacity—physical or mental or whatever—there would be unfortunate individuals who would perhaps be accounted worthy of less dignity. No—all we human beings have an innate human dignity that we cannot lose. We can perhaps lose our subjective sense of dignity. As someone who is disabled and getting more disabled because I have a progressive disease, I can envisage the day when I will lose many bodily functions and have to rely on other people more and more, but, perhaps because of my medical background, I do not find bodily functions undignified; they are just part of what it means to be human, in the same way that animals are dignified in the way they conduct themselves.

The moment we get into thinking that if we lose a certain amount of autonomy we lose our dignity and want to end our lives, human dignity for all of us is diminished. It is only as we learn to receive care from others when we begin to lose our strengths and we are suffering that that improves our human condition and the condition of society. Again, I appeal to those who support the bill to think again. The quick way out is not the dignified end. That is why I very much resent Oregon's Death with Dignity Act and the idea that the purpose of the bill is to enable people to die with dignity. To me, using language in that way is twisting language. Many people who are entirely helpless have dignified deaths: because of their spirit and the way in which they cope with suffering, they show tremendous human dignity, which enriches—rather than diminishes—us all.

I know that dignity is a slippery concept, but I believe that the bill places too much emphasis on the subjective aspect of dignity—the dignity that one thinks one has, or that society thinks one has. Please think again.

Cathy Peattie: Can I move us on a bit? Dr MacDonald talked about the rights of other people. Other people, such as family members, doctors and medical staff, will be involved. They will have, or should have, a right to opt out. Have you discussed that? What are your views on it? What support do you think churches or faith groups may be able to give people on the right to opt out of these decisions, or their role in caring?

Dr Beltagui: Putting that decision and that responsibility in the hands of medical staff is an unfair burden on them. It is such a huge issue, and asking them to make that decision makes things really difficult for them. The issue of abortion is another example. People could be forced to work against their ethical values or religious beliefs. As in other cases, they should have the right to opt out of practising this.

Leah Granat: There is a clear difficulty here for a lot of people who are involved in caring for those who are approaching the end of their life. As a society, it would be unfair of us to expect people to end the lives of their patients. The vast majority of medical professionals and those who work in the various welfare services did not go into those services to end life, but to care for people in all conditions and to provide dignity to those people, whatever condition they are in.

There are difficulties around a conscience clause. There would have to be a conscience clause that allowed people to opt out of ending life—of killing. There is a danger, however, that the people who do not use any conscience clause that is provided become professional end of lifers, or professional killers—providers of death, instead of support and care for a dignified life, of which death is a part.

Donald MacDonald: I know that the bill does not force any doctor to be involved, but with any medical procedure nowadays doctors have to be trained—and quite rightly so. Are we to introduce into medical schools training in killing people? That is the logic of the whole movement. We cannot separate it out from other things—people will have to be trained in it. Nowadays, people cannot perform any medical procedure or operation unless they have been fully trained, accredited and so on. I believe that that would have to happen in this case, which would change the whole way in which the medical profession—and the other caring professions—are viewed. As the committee has already heard, others, including nurses, paramedics and pharmacists, would be involved. There is no end of it—we should

consider the change that the bill would mean for society.

It will be argued by the proponents of the bill that only a very small number of people would be affected, but I believe that, over time, there would be a slippage effect, as has been said in previous evidence, such that society would gradually change to accept ending life deliberately as a medical role. We cannot afford even to allow the proposed small step to take place.

Ian Galloway: I was present at the evidence session earlier this morning. Professor Hazell was discussing the sort of pressures that nursing staff are under. I suspect that procedures for doctors would be made very clear, and it would work quite well—people would either participate or not, and that would be clear. One level down—for nurses—it would get slightly more complicated. Most of what they do they do because the doctor, the manager or whoever tells them to. In the case of most people who care for others in any kind of institutional context, there will not be any choice. Care assistants, for instance, do not have professional bodies looking after their interests or telling them that they can look after some patients but not others. People will go on caring because they do—as they should—but a great many will find it difficult. We would play that particular support role for people—the role of the church is to support anyone who wants its support in whatever difficulties they find themselves—but we would prefer not to.

Cathy Peattie: If someone in a first-class Church of Scotland care home that I know of in my constituency requested end of life assistance, what role would the home, the practitioners or those involved in the person's care play? Would that person be evicted? Have there been any discussions about what would happen in such circumstances?

Ian Galloway: I do not think such discussions have taken place—I have certainly not been involved in any. I point out, however, that people do not have to have a particular faith position to be accepted into a care home and that everyone has the same rights as everyone else. Of course, it would be very difficult for the people in that establishment to be involved in such activity, but people with a specific faith commitment work only in reserved occupations and would have their own conscience procedure. For most people who care, what they do is care and they simply have to deal with whatever comes their way.

Dr Reid: I agree with most of what has been said about conscience, but one point that has not been made is that most of us hold our conscience deep inside us and do not always express it. When people seek a doctor's advice on such matters, they do not know at what level of conscience he or she is working when giving advice. Depending on what their conscience says—something, I repeat, they might never publicly express—there might well be an imbalance in the advice and direction that GPs give.

Major Dixon: We need to differentiate between the bill's provisions and the care that the churches provide. In most of our homes for the elderly, we provide care; however, the bill is about those who need medical care, which most of our homes are not set up to deal with. Some homes provide that kind of care but most of us are involved in the general care of people. Yes, people die in our homes but the big difference is that they are not the intolerably ill people who are the focus of this bill.

Cathy Peattie: But people of a particular age in one of those care homes might well find themselves with a terminal illness.

Major Dixon: When people come into our homes, most of them are capable of looking after themselves but it is true that, after 10 years, the situation can change. Nevertheless, that is more about the provision of professional medical care than it is about the provision of general care for people. There is a subtle difference between the two.

Dr Beltagui: This brings us back to the first question about the percentage of people who practise religion. There is a difference between those who go to church, mosque and so on and those who believe in a certain religion but do not practise it. A lot of people are now in the latter category but, when faced with a difficult moral situation, they will go back to the religion on which their life and moral values are based. There are more believers than the statistics show and, again, it would be unfair to ask those people to do something that would be against their values even though they might not actively practise their religion.

12:15

The Convener: The final questions this morning will be put—for the avoidance of doubt—by Not the Rev Margo MacDonald. [*Laughter*.]

Margo MacDonald: Although we agree—I hope—to differ on this issue, I am glad to live in a society that pays such attention to faith and the part that it plays in society. I may not share it—I am not required to—but I like the fact that we still listen to churchy men. That was until this morning—we have heard quite a lot this morning.

I want to establish one thing. Do all the faiths that are represented here believe the bill to be morally repugnant and ethically unacceptable?

Donald MacDonald: I agree with that.

Margo MacDonald: Does anyone disagree?

Dr Reid: I would not express it in that way.

Margo MacDonald: That is the choice that is before you—is the bill morally repugnant and ethically unacceptable?

Dr Reid: It is ethically unacceptable, but it is not necessarily morally repugnant.

Margo MacDonald: Your acceptance of even one of the phrases suggests that you could never accept legislation such as this.

Donald MacDonald: No.

Margo MacDonald: So we know where we are starting from. There are one or two delicious philosophical points for debate, but I will not deave the committee.

The Convener: The chair will be most grateful.

Margo MacDonald: I hope that I will get the chance to do it at some other time.

I have a question for Dr Beltagui. Does the Qur'an decree that capital punishment is morally acceptable?

Dr Beltagui: Yes, because it is a deterrent—not just in this society at this time, but for humanity in general.

Margo MacDonald: I am talking about the instructions that the Qur'an gives to people of the Muslim faith. I am thinking about how people react when they are faced with a dilemma.

Dr Beltagui: The issue is not straightforward. The difference is that capital punishment is in the hands of the authority that makes the decision. The people who suffered as a result of the killing have the right to forgive—they are always asked to forgive and to do something different. However, the Qur'an provides for capital punishment, because it is a deterrent.

Margo MacDonald: So it is difficult to say that life is sacrosanct in all circumstances.

Dr Beltagui: The punishment is carried out not on an individual basis but by the whole of society. If one or two members of society are causing a problem to the whole of society, you can get rid of them. Such punishment is not carried out on an individual basis and is completely different from the case that we are discussing. If an individual wants to take his own life, it is a sin. In addition, no one else is allowed to interfere with his life.

Margo MacDonald: One of the witnesses said that every human life was worthy of respect. Is that true of a suicide bomber?

Dr Beltagui: We do not condone suicide bombing.

Margo MacDonald: I am not asking you to do that. I am trying to get to the root of the issue.

Dr Beltagui: Islam does not condone suicide bombing. Suicide bombers' aim is not to commit suicide but to do something active—that is their understanding.

Margo MacDonald: Is motivation important in judging the effect?

Dr Beltagui: No. Capital punishment may be used only where someone has killed another person—cold-blooded murder—and where society decides that it is the appropriate punishment. In such cases, the benefit to the whole of society supersedes the benefit to the individual.

Margo MacDonald: At present, doctors are enabled under the law to prescribe an opiate that has the double effect of both relieving pain and hastening death. Is that permitted by the Jewish religion? Leah Granat's comments suggested that it is not.

Leah Granat: The intention is very important. If an opiate or any other form of pain relief is administered with the intention of providing pain relief and comfort to the patient, that is permitted, regardless of any double effect.

Margo MacDonald: Does that mean that, if the patient requests that of the doctor, the patient has autonomy?

Leah Granat: Obviously, the patient's medical care must be discussed with the doctor. The intent is very important. If the patient's intent in asking for something and the doctor's intent in administering it are purely to relieve pain, even with the knowledge that there may be a double effect, that is permissible.

Margo MacDonald: How is the doctor to judge what the patient truly believes? What if a patient actually wants to finish their life at that point for whatever reason and requests a double dose of an opiate for the relief of pain? In other words, how is the doctor to know whether the patient is lying? You wanted plain language.

Leah Granat: The doctor will use his or her professional judgment to determine what dose is appropriate for any patient. Obviously, we are in a society in which some people have a faith and some do not, but a patient may want to involve a religious leader in their discussions on their care towards the end of their life. They could ask for assistance to convey their views to the doctor, but the doctor and the other medical professionals will use their professional judgment.

Margo MacDonald: Right. In your evidence, you seem to say that the bill will make murder

easier. Can you indicate the part of the bill that will make murder easier?

Leah Granat: If there is greater acceptance of the taking away of life, it is difficult to limit that acceptance to a particular field and to put barriers or borders around the acceptability of one form of taking life. The slippery slope that has been referred to in previous evidence could lead to a doctor thinking that he knows that a patient wants to die, even though they have not told him so.

Margo MacDonald: Can you show me the part of the bill that would allow for the doctor to take the decision?

Leah Granat: The doctor's obligation to include "end of life assistance" as one treatment in a range of treatments would take away the patient's autonomy to a great extent. We talked about autonomy earlier. The bill frequently refers to patients making decisions "voluntarily". We referred to that in our written evidence. Somebody may well do something entirely voluntarily, but that does not mean that it is being done without pressure or fear of the expectation of society.

If it becomes acceptable for people to be killed towards the end of their life, that immediately puts pressure and expectation on everybody who comes towards the end of their life. They think, "Will I be a burden on my family or the health care system?" They wonder, "Will I cost my family money and prevent them from carrying on with their lives because they have to care for me?" Therefore, people will request help with dying earlier. That is a voluntary request, but it is not an uncompelled request.

Margo MacDonald: If your fears—they are only suppositions, because you have led no proof to that effect—are to be taken seriously, should we not see that effect in the jurisdictions in which assisted death has been the norm for a decade, say?

Leah Granat: There are many different experiences in those jurisdictions.

Margo MacDonald: Research has been done on that. There is evidence, and it does not support your fear.

Leah Granat: As I said, the fact that a request for hastening death is voluntary does not mean that it is a completely free choice. In jurisdictions in which hastening death is permitted, people might be asking for their death to be hastened without somebody standing at their shoulder saying, "You will do this." However, legislating and saying that that is permissible changes the view of society and the view of an individual who is in that position of their duty and what is expected of them.

Margo MacDonald: Do you have an explanation as to why death rates in Oregon, for example, have not gone up and have not followed the pattern that you describe?

Leah Granat: I do not have enough knowledge of the situation in Oregon to be able to comment on that.

Margo MacDonald: But would you agree that we learn from one another and that, if Oregon has experience, and not merely a theory, perhaps we should place more reliance on that?

Leah Granat: I certainly agree that we learn from one another and therefore that we learn from the expectations of others towards us. If we believe that people's expectations are that we will request an early death, we might do so when that would not be our choice.

Margo MacDonald: We will need to disagree on that.

Dr Reid raised an interesting point when he said that he feared the effect that the measure would have on society and the country. Has allowing assisted death in other countries brutalised those countries and demeaned humanity? What effect has it had in other countries?

Dr Reid: It changes society. Once we make a fundamental change and cross the rubicon, that undoubtedly changes the way in which societies view the issues of life and death.

Margo MacDonald: Are Dutch reformed church people any less pious than you?

Dr Reid: I cannot speak for the Dutch reformed church.

Margo MacDonald: Before you say that society is changed by legislation such as I am proposing, should you not be aware of what it has done in those societies?

Dr Reid: There is evidence in those societies. I believe that since the introduction of such legislation in Holland, there has been a certain amount of pressure on physicians. As one of my colleagues has said, there has been a movement towards more and more physician-assisted death and what is effectively almost euthanasia.

Margo MacDonald: Do you believe that no effective euthanasia is practised legally in this country?

Dr Reid: In this country?

Margo MacDonald: Yes.

Dr Reid: Euthanasia is not legal in this country.

Margo MacDonald: I asked about effective euthanasia being practised legally.

12:30

Dr Reid: I am sorry, but I do not understand the question. You are saying that there is effective euthanasia in this country.

Margo MacDonald: Well, we heard from the pharmacists yesterday about the double effect of giving a large amount of opiates. Do you agree that that happens?

Dr Reid: I take the point. Undoubtedly, there is a grey area where people are being assisted to die in the sense that the level of medication probably hastens it.

Margo MacDonald: Yes.

Dr Reid: But it would be illegal if that were the conscious intent.

Margo MacDonald: No. It would be illegal if someone admitted to it.

Donald MacDonald: Good palliative care practice shows us that, in gradually incremental doses, morphine or another opiate does not hasten death and, in fact, prolongs life, provided that it is used skilfully and in the proper way. Obviously, if someone is given a sudden massive dose, it will bring about early death. Proper usage does not hasten death.

The situations in Oregon and the Netherlands are very different from each other. Oregon allows only for assisted suicide and has a rather loose reporting system, with a lot of underreporting of cases. As the committee knows, end of life assistance was allowed in the Netherlands long before the law was changed; the situation there came about gradually and incrementally. It has been shown over many years that there are cases of involuntary and non-voluntary euthanasia. It was interesting to note that those from the Netherlands and Oregon from whom the committee took evidence were enthusiasts for their respective pieces of legislation; no critical voices were heard from those jurisdictions. I was surprised at how complacent they were about the operation of their law. I believe that there is evidence already from the Netherlands that babies who are born with severe spina bifida are having their lives terminated. That is non-voluntary euthanasia.

I will illustrate the slippage that can occur. Some years ago, Baroness Warnock, one of the foremost ethicists in Britain, changed her mind about euthanasia, saying that it should be introduced. In *The Times* in 2004, she was reported as saying that older people should sacrifice themselves for their family and that they should not become a burden on society. I know that the bill does not cover that—it does not cover those who are demented and so forth—but there will be those who will push for that in future. Already, we have Sir Terry Pratchett, who knows that he is getting dementia and who wants to see a committee set up that would allow him to end his life when he feels that it is no longer worth living. It is inevitable that there will be changes.

We also know that a lot depends on context. I think that the witnesses from Oregon said that Oregonians are tough and resilient people who want to do their own thing. Scotland is a different country from Oregon; we have a different tradition. It would be much easier for slippage to occur in this country than it would in any other country. That is my opinion.

Margo MacDonald: We all have our crosses to bear and I do not want to be a

"Wee, sleekit, cowrin, tim'rous beastie".

I realise that we will not agree on the bill, but I have a question about how it is drafted. The Rev MacDonald has said that he thinks it is poorly drafted—in fact, he has been very uncomplimentary about us. Do other members share that opinion, or is it your view that we have tried to follow much of the good practice that the GMC and British Medical Association have outlined? Do you see room for improvement in the practicalities of the bill, or is it simply a case, as I put in my first question, that you cannot accept the bill because it is ethically unacceptable?

Dr Beltagui: I made my point earlier when I said that I would not comment on the details of the bill. That is a reflection of what I heard from people whom I know and to whom I spoke. They do not want to discuss it.

Margo MacDonald: I have one last question—

The Convener: No, we must try to contain the discussion. You have asked the question, and we must try to get the answers. John Bishop can go next.

John Bishop: I want to make it clear that we support the bill in principle, and we look forward to providing support by suggesting amendments. I thank the committee for allowing us to present evidence; it is quite rare that a Bishop provides evidence next to his religious colleagues.

Dr Beltagui: I was talking only about the principle, and not the details, of the bill. That is not my own personal opinion but a reflection of the way in which the people from my tradition to whom I have spoken have presented their value that life is life, full stop. They do not want to go into the details of the bill.

Margo MacDonald: What does the Qur'an say about abortion?

The Convener: No, I am sorry—I cannot allow three questions to run. We have had a fair run already.

Leah Granat: It would be very difficult to draft a bill that did not open the door much wider than was intended. I appreciate that Margo MacDonald's intention is limited, and that she seeks to permit death to be hastened in certain circumstances and not in others. However, we cannot support the bill in principle and we would deplore its passage into legislation.

Dr Reid: Margo MacDonald pointed out that some doctors have perhaps been hastening death intentionally. It would be unfortunate if the bill was seen as retrospectively legitimising the actions of people who break the law and who have carried out things that are, in principle, against the ethics of their profession.

Margo MacDonald: I agree.

Major Dixon: I think Margo MacDonald will have a copy of our written evidence. The opening sentence in response to question 1 simply says that we

"disagree with the proposed legislation, which represents ... more than simply a tinkering with the law. Such legislation, breaching as it does the societal prohibition on the taking of human life, carries implications for attitudes to many aspects of health and social care, not simply for the determined few who are pushing for change."

That clearly states our position, as she has acknowledged.

Margo MacDonald: I have one query on that. We award medals to soldiers who kill other soldiers, and that is the taking of human life.

Major Dixon: We have already discussed the concept of a just war, and the rest of that argument, and we do not need to go there again. That is a different context.

Ian Galloway: On that point, I do not think it is a good idea that we do that. It is terrible and we should change it.

Margo MacDonald: What—no medals?

Ian Galloway: Absolutely.

Margo MacDonald: Like Colonel Jones in the Falklands.

Ian Galloway: Killing in war is tragic, and the fact that wars happen is tragic. If it is a societal necessity that we do those things, I have a problem with the way in which our value system holds them up.

Margo MacDonald: I said that I would not indulge, although I would love to pursue those questions.

The Convener: We are getting close to being overindulgent, so I will bring the session to a close.

I must make it clear to the Rev Donald MacDonald that, although I value his personal views on the witnesses whom we invited from Oregon and the Netherlands, there was no question of the committee selecting witnesses who had a particular point of view—they were here to represent from an academic point of view the factual position, as was presented. I appreciate that he is entitled to his view, but there was a slight implication about the way in which the witnesses had been selected.

I draw this morning's session to a close, and remind the public and members of the committee that we meet again next Tuesday for a further evidence session. I thank all our witnesses this morning for their contributions.

Meeting closed at 12:40.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

Members who wish to suggest corrections for the archive edition should mark them clearly in the report or send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP.

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by RR Donnelley and is available from:

Scottish Parliament

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

For more information on the Parliament, or if you have an inquiry about information in languages other than English or in alternative formats (for example, Braille, large print or audio), please contact:

Public Information Service
The Scottish Parliament
Edinburgh EH99 1SP

Telephone: 0131 348 5000
Fòn: 0131 348 5395 (Gàidhlig)
Textphone users may contact us on **0800 092 7100**.
We also welcome calls using the Text Relay service.
Fax: 0131 348 5601
E-mail: sp.info@scottish.parliament.uk

We welcome written correspondence in any language.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders, subscriptions and standing orders
business.edinburgh@blackwell.co.uk

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Accredited Agents
(see Yellow Pages)

and through other good booksellers

e-format first available
ISBN 978-1-4061-6757-3

Revised e-format available
ISBN 978-0-85758-113-6

Revised e-format ISBN 978-0-85758-113-6