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Pàrlamaid na h-Alba

Official Report

END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE

Tuesday 5 October 2010

Session 3

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END OF LIFE ASSISTANCE (SCOTLAND) BILL COMMITTEE

9th 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 GAVE EVIDENCE:

David Cullum (Scottish Parliament Chamber Office)
Margo MacDonald (Lothians) (Ind)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 2

Scottish Parliament

End of Life Assistance (Scotland) Bill Committee

Tuesday 5 October 2010

[The Convener *opened the meeting at 10:16*]

End of Life Assistance (Scotland) Bill: Stage 1

The Convener (Ross Finnie): Good morning. Welcome to the ninth meeting of the End of Life Assistance (Scotland) Bill Committee. As usual, I remind everyone in the room to switch off any electronic equipment that might interfere with transmission. No apologies have been received. I apologise for the slight delay in commencing proceedings; traffic jams delayed members getting to the meeting.

There is only one item on the agenda. As a matter of courtesy, I note that members have received three communications since we last met. The first is from the Cabinet Secretary for Health and Wellbeing and relates to the applicability of the National Health Service (Scotland) Act 1978. The committee has also received a helpful letter from the bill's sponsor, Margo MacDonald, and a further letter from the Solicitor General for Scotland clarifying issues relating to the practice of procurators fiscal in respect of post-death certification and investigation.

This is the final oral evidence session, subject to the committee not requiring to call further witnesses. We welcome the bill's sponsor, Margo MacDonald, who is accompanied this morning by David Cullum, head of the non-Executive bills unit in the Scottish Parliament, and Peter Warren, who is a researcher for the member in charge. I invite questions from members.

Helen Eadie (Dunfermline East) (Lab): My question may be answered by any member of the panel. I thank Margo MacDonald and her team for their letter providing us with further clarification. At the bottom of the first page, it says:

> "there is no requirement on the requesting person to seek assisted dying from a doctor at the practice with which they are registered or to involve the practice in any other way in the processes set out under the Bill. There is also no requirement on the requesting person to have been registered with the designated practitioner for 18 months prior to seeking assistance. Section 4(1)(b) merely requires the requesting person to have been registered with any practice or series of practices in Scotland for this continuous period of time."

However, in the evidence that we have heard throughout stage 1, there has been considerable emphasis on the requirement for the practitioner to know the patient and to be able to distinguish whether there was any undue internal or external influence on the patient's choice. The clarification that Margo MacDonald has provided is at odds with the written evidence that we have received from various respondents to our call for evidence, who believe that it is important for practitioners to have detailed knowledge of patients so that they can determine whether there has been undue internal or external pressure. I invite you to respond to that concern.

Margo MacDonald (Lothians) (Ind): First, the bill makes no reference to the medical practitioner in the practice with which the patient is registered. We have tried to be as flexible as possible. We went into detail for rather a negative reason: we anticipated that some people might think that there would be suicide tourism, or something like that. We wanted to ensure that the approach could not be regarded in that way, so we talked about the qualifying period and the need to be registered with an appropriate medical specialist and so on.

It might well be that a person's general practitioner would not want to take part in the procedure, so we did not want to be too prescriptive. However, we said that, if the person was unable to contact someone who was willing to help, the GP would have a duty to help them. There is an entirely reasonable supposition that the person would be known to one or other of the medical specialists, whether that was the person to whom they first mentioned the issue or the person to whom they were subsequently referred.

Helen Eadie: Do you think that the person to whom they were referred would be able to carry out checks via the other GPs? Would they know the patient well enough?

Margo MacDonald: We have said that the requesting person would have to have two witnesses, who would have to be able to say that the person was not being coerced and so on. There must also be recourse to specialist psychiatric or psychological advice. There would be a network of support, so the person would be unlikely to be unknown to everyone that they met.

Mr Cullum is reminding me that there are General Medical Council guidelines on how professionals should act.

Helen Eadie: Let us consider the bill's direction and purpose. It covers euthanasia and physician-assisted suicide. Professors Mason and Laurie said that the approach is

> "largely uncharted territory for any jurisdiction."

Is it practicable to cover euthanasia as well as physician-assisted suicide? If so, are the provisions applicable to both practices?

Margo MacDonald: The bill's intention must be weighed up in its entirety. There are two points to make. First, the bill talks about the autonomy of the patient. Secondly, the possibility of anyone else taking the decision for the patient would be prevented by provisions throughout the bill. If someone exercised their autonomy and decided that their life had come to an end for them and that they were left with just a shell of intolerability, the bill would give them the legal right to seek help, but no other person could instigate that process or make the decision.

That is why, when we were drawing up the bill, it was difficult to decide whether to use the word "euthanasia". This might be entirely personal, but I maintain that euthanasia is associated with someone else taking the decision, rather than the requesting patient. I accept that some people think that, in the final analysis, it is euthanasia if the requesting patient cannot self-administer the drug and a clinician gives assistance at the very end.

I am trying not to split hairs, but the intention was to ensure that people understand that no clinician can do as they can do at present and make the decision by giving a double-effect dose of medication near the end of life to shorten life. The bill says that the only person who can make that decision is the patient. When Professor McLean gave evidence, she said:

> "If we accept the fundamental principle of choice at the end of life, it would be illogical to limit the bill to assisted suicide ... If the bill were to cover only assisted suicide, those who want to die but who need the simple assistance of a doctor would be deprived of that assistance on the basis of a legal rule that even the highest judges in the land do not think is applicable in such circumstances." —[*Official Report, End of Life Assistance (Scotland) Bill Committee*, 14 September 2010; c 87.]

Helen Eadie: At last week's committee meeting, there was an exchange between you and John Deighan about the 10 or 11-year-old Remmelink report, which referred to 1,000 deaths. John Deighan said that, in the most up-to-date figures, it is estimated that 500 people have euthanasia imposed on them by doctors—I think that that was the point. It was inferred from that that there is a slippery slope. How do you respond to that criticism?

Margo MacDonald: I think that I am correct in saying that the Remmelink report was produced before the current legislation was adopted in the Netherlands. That is the first reason to question the material gleaned from it. John Deighan corrected his assertion, which I think has been made generally as part of the campaign against the bill.

Dutch doctors to whom I have spoken have all said the same thing: the reporting of deaths that were previously treated in the same way as deaths are here when a double-effect draught of whatever is given at the end of life has changed, and doctors now feel that they can declare what has happened much more freely. I think that it is a question of how deaths are reported rather than of more deaths being brought about by Dutch physicians.

The evidence is very shaky and it is questioned by the people in the Netherlands. The experience there seems to me to run in quite close parallel with the experience in Oregon, which has a completely different legal system, but the end result is that a very small percentage—let us say about 2 per cent—of deaths each year are brought about through assisted death.

Helen Eadie: So as not to hog the questioning, I have one last question for now, if that is okay with the convener.

If you have seen the letter that we have received from the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, you will be aware that she says that

> "The Scottish Government takes the view that the provisions of end of life assistance as set out in the Bill would not be within the powers as set out in the 1978 act and therefore is not within the powers of Health Boards in terms of that Act. It follows from this that the Scottish Government believes that NHS General Practitioners or any other health professionals who provide services through the NHS in Scotland could not provide such assistance while acting in that capacity."

That presents some difficulties for you. How would you see your bill operating when its provisions do not fall within the scope of the National Health Service (Scotland) Act 1978?

Margo MacDonald: It is not an unusual circumstance; in fact, it is very common to have a piece of legislation make another bit of legislation redundant or archaic. I therefore propose to lodge an amendment at stage 2 that will make a small amendment to the 1978 act to allow such assistance to be provided under the national health service in Scotland. Such a circumstance is not extraordinary given the way in which legislation is built and how one act can impact on another. In any case, the bill has a certificate of competence from our dear Presiding Officer.

10:30

The Convener: Before I come to Michael Matheson, I want to pick up on a small point—actually, no; it is quite a major point—that Helen Eadie raised. In explaining why the bill covers both physician-assisted suicide and voluntary euthanasia, you quoted Sheila McLean. However, in its report, the committee has to be absolutely clear that the bill seeks to decriminalise matters that are covered by the Homicide Act 1957. Of course, that is not your fault; that is the way in which the law is written. Legal precedent and interpretation distinguish between physician-assisted suicide and voluntary euthanasia in that assistance in dying is provided in the former and administered in the latter but, with all due respect, I do not think that that is what Sheila McLean said. The conflation of these two separate principles raises an important issue, and I invite you to expand a little on it.

Margo MacDonald: Philosophically, you have to look at the bill's intention. If you disagree with it, you will see the conflation of the two things as a major obstacle; if you agree, you are unlikely to find anything sinister in what Professor McLean and I are saying.

The Convener: I was not suggesting that there is anything sinister in what has been said. We are very properly being invited to consider a bill that would effectively decriminalise two matters that heretofore have been quite separately addressed. I am not saying that they should always be so addressed, but substantial arguments will have to be put forward for conflating the two and for suggesting that the principles are similar. Either one argues that the two sections in question support separate or potentially separate elements—which was the substance of Helen Eadie's question—or one accepts your argument that the previous position is erroneous and that the two issues should be run together as a single principle.

Margo MacDonald: I think that they are two routes to the same outcome. [*Interruption*.] My colleague Mr Cullum has reminded me that the safeguards are in place and are recognised and that all the other processes have been correctly observed. The two things are not at odds with each other.

The Convener: Well, voluntary euthanasia puts a very different responsibility on designated practitioners.

Margo MacDonald: I am sorry, but I have to disagree. If a practitioner who agrees to help someone to bring their life to an end has, in the final analysis, to give an injection or to help or allow someone to swallow something, that does not seem to me to be terribly different in principle from the same practitioner helping the person who has tried and failed to swallow a draught—say, by choking—to move forward to do so. The intention—or mens rea, as the Solicitor General called it—is all important in working out whether something is legal or illegal. If you intend to help someone to bring their life to an end, is that very much different from actually helping them to do so?

The Convener: Well, that is the question.

Margo MacDonald: With all due respect, it is one that I have given you my answer to. I think that there is no difference.

The Convener: Is it on this point, Ian?

Ian McKee (Lothians) (SNP): I was just going to say that Mr Cullum could give evidence himself.

The Convener: We will operate on the basis that all present are capable of contributing. It can avoid the writing of hasty notes in indecipherable handwriting.

Margo MacDonald: I promise you that I do not have a single indecipherable note in front of me, although my ears are nipping.

Michael Matheson (Falkirk West) (SNP): Margo, you mentioned earlier the importance of patient autonomy in the objectives of the bill. How far should patient autonomy go in decision making?

Margo MacDonald: We do not need to talk about patients as if they are different from any other person.

Michael Matheson: I was talking about personal autonomy.

Margo MacDonald: Any person's personal autonomy is just that, until it impinges on any other person's autonomy.

Michael Matheson: Should society put any limits on someone's personal autonomy? If so, what factors should be taken into consideration?

Margo MacDonald: To live in society together, we voluntarily agree to limit our autonomy in certain respects. The issue that we have addressed, the end of life, is not quite the same as driving on the same side of the road so that we do not have crashes. It is not even the same as getting yourself inoculated against a potentially fatal disease that can spread. There is a peculiarly singular quality to the decision that you take about your own life at its end. Therefore, I do not think that we can argue that personal autonomy is limited at the end of life because we agree to limit it in other aspects of life.

Michael Matheson: In the financial memorandum, you estimate the impact of the legislation, if it were enacted, and suggest that around 55 people per annum would make use of its provisions. How did you arrive at that figure?

Margo MacDonald: I will probably need to get my socks and shoes off to explain.

Michael Matheson: You do not have to if you do not want to. I will give you a loan of my hands.

Margo MacDonald: We looked mainly at Oregon—we thought that it was the best parallel for such a judgment. However, as I said previously, there appears to be some correlation from very different areas of jurisdiction, with different laws, as to the percentage of deaths per annum that are assisted. I do not see why Scotland should be any different.

Michael Matheson: So that figure of 55 is largely modelled on the Oregon approach.

Margo MacDonald: Yes.

Michael Matheson: If we take the Oregon approach, my calculation is that we are probably talking about a figure of nearer 110 on a population base, because Oregon has a smaller population than Scotland. However, that aside, the bill is more akin to the Dutch legislation, which provides for physician-administered suicide and physician-assisted suicide. Why have you modelled the figures for the bill on the Oregon legislation when the Oregon legislation is only part of the bill?

Margo MacDonald: We do not claim that it is an exact science—it is not. We can only look at parallels and make estimates of what we think is likely to be correct. There are a number of significant differences between what would be permitted under the bill and what is permitted in the Netherlands. We have drawn the bill much more tightly. The involvement of a psychiatrist to assess a person's competence is probably the most significant difference, because that would reduce the numbers, I think. We have included an extremely robust process that only the most determined would have the willpower to complete. In fact, that is one of the things that I sometimes wonder about. We are not making it easy for people.

We intend to ensure that everyone understands completely and understands that the procedure is not to be undertaken lightly. None of the people who are included in the numbers of people who were assisted to die without their knowledge or through advance directions or living wills could lose their lives under my bill. There are differences. We estimated in good faith, but I tell you honestly that, if there were 100 deaths per year in Scotland of people who found their life to be absolutely intolerable and followed the procedures in the bill faithfully, I am not going to argue about that. I am not going to argue either about people who decide that they could at the end of their life face a very distressing death and decide to come to live in Scotland for the last few years of it.

Michael Matheson: I accept that your proposals are not exactly parallel with the Dutch legislation, but they are even less parallel with the Oregon legislation. I want to get to the bottom of the figure on the number of people who might exercise their rights under the bill if it were enacted. I accept your point that the safeguards in your bill are different from those in the Dutch legislation, but it is difficult to quantify exactly what practical impact they would have, other than being legal safeguards. In the Netherlands, more than 3,000 people make use of the legislation annually. Working on the basis of the modelling that you used to compare with Oregon, that suggests that, if the bill was enacted in Scotland, closer to 1,000 people per year would make use of the legislation here. That is significantly higher than the figure of 55 in the financial memorandum.

Margo MacDonald: I explained that we do not claim that the figures are accurate to the last decimal point. It is impossible to do that. The Scottish Parliament information centre has queried the figures from the Netherlands, as we have done, because the reporting system is so different there that it is difficult to tabulate the figures. I thought that, roughly speaking, the rigour of the procedures in the bill is almost balanced out by the fact that in Oregon, a large percentage of people do not take advantage of the prescription that they receive—they use it as an insurance policy. It seemed to me that there is a similar social attitude towards the issue here.

Michael Matheson: I am not sure about the issue that SPICe has with the Dutch figures. The figures that I am using were provided to the House of Lords select committee that considered Lord Joffe's Assisted Dying for the Terminally Ill Bill. Those were national figures that were provided by the Government in Holland. I understand that it is difficult to tell whether the figure will be 55 or 110, but—

Margo MacDonald: Well, palliative care has improved so much—

Michael Matheson: Hold on, Margo, let me finish my point. I understand that it is not an exact science, but your bill is a much closer parallel to the Dutch legislation. If we take that parallel but use the same methodology that you used to calculate your figure in the financial memorandum on the number of people who might exercise the rights under the bill if it were enacted, the figure is closer to 1,000 rather than 55. That is significantly different.

Margo MacDonald: I do not think that we can make that leap of estimate because palliative care has changed so much since Lord Joffe's bill. The argument that I have heard from people who are opposed to the bill—that, if there were better and more easily available palliative care, fewer people would feel their lives to be intolerable—may be a factor, but I am not at all sure that the figures that are used are up to date enough for me to feel any security in them.

10:45

Michael Matheson: You ask me, as a committee member, to consider the bill and examine the figures that are related to it. I applied your modelling to the figures from a jurisdiction where the legislation is close to your bill—I am sure that you would agree with that because of the two provisions we have discussed—and the figure is significantly higher.

On the argument that palliative care may have had an impact, look at what has happened in Oregon. In the first 12 years from the passage of the Death with Dignity Act 1997, the number of people who exercised their rights under it increased fourfold, even with improvements in palliative care.

Margo MacDonald: Where does that figure come from?

Michael Matheson: It is Oregon's figure from when the act was passed until last year.

Margo MacDonald: You must excuse me: I have not come across that figure.

David Cullum (Scottish Parliament Chamber Office): Perhaps I, as the author of the original memorandum comparing the Oregon figures, could comment on the question. The comparison that produces the number for Scotland is a direct comparison with the number of deaths in Oregon. The number of people who die using the assisted suicide law there is simply extrapolated across to Scotland.

We considered the Netherlands but, as the SPICe report suggests, there is no accuracy in the reporting there. The Netherlands does not have the same system as Oregon, where the numbers are reported.

There are also some significant differences in the process. Margo MacDonald mentioned the involvement of a psychiatrist. Under the bill that is before the committee, there is no use of advance directives or living wills, both of which are applicable in the Netherlands. Under the bill, nobody could be killed without their knowledge or consent. Those are significant differences that we thought, when we produced the numbers, cast some doubt on what comes out of the Netherlands.

Margo MacDonald: I will go back to the figures from Oregon. My lovely young assistant has explained to me that, in the first year after the act was passed, there were 35 or 40 deaths and the figure now bumps around at between 60 and 80. That is why I did not understand where the fourfold increase came from. The number of deaths per annum is still not enormously high.

Michael Matheson: No, it is not, but even if we use those criteria, we arrive at a figure in Oregon that is almost double the one that you suggested. I understand what David Cullum said about the difference in the reporting mechanism in the Netherlands but, as a committee member, I am trying to understand the validity of the figures that are in the accompanying documents to your bill. I am afraid that that raises serious questions about their accuracy and the approach that has been taken in calculating them.

Your bill is very different from the Oregon act. It goes well beyond what is permitted in Oregon because it allows for physician-administered suicide. In places such as the Netherlands, 90 per cent of the people who exercise their rights under the legislation exercise them under the provisions for physician-administered suicide; only 10 per cent opt to go for physician-assisted suicide.

We are asked to consider what could be a highly significant shift in policy on the matter, so it is important to have a clear understanding of the figures for the number of people who may exercise their rights under the bill. I put it to you that the figure will be closer to the Dutch figure, which leads to an estimate that 900 to 1,000 people in Scotland per year would exercise their rights, not 55 people.

Margo MacDonald: I can only repeat the figures that we have given to the committee, which are a guide, as I said. In relation to the Netherlands, the Select Committee on the Assisted Dying for the Terminally Ill Bill reported:

> "We were told that some 9,700 requests for euthanasia are made annually. About 3,800 of these actually receive euthanasia, of which some 300 are assisted suicides. Euthanasia therefore accounts for around 2.5% and assisted suicide 0.2% of all deaths in The Netherlands. In addition to these, there are about 1,000 deaths a year (0.7% of all deaths) where physicians end a patient's life without an explicit request."

That is what the select committee was told. As I said, I think that there has been a change in reporting since the figures were compiled. There have also been changes in palliative care.

With all due respect, I think that you are splitting hairs if you are saying that there is a huge difference in intent between a physician being present at the very end of life and a physician helping to administer the fatal draught.

Michael Matheson: I do not think that a doctor administering medication to end someone's life can be classed as "splitting hairs". It is a significant act for an individual. Someone might choose to self-administer medication to end their life of their own free will, but to legislate to give doctors the power to do that is very different from splitting hairs.

Margo MacDonald: If you are objecting to the phrase that I used, I am sorry and I regret using it, because I do not take the matter lightly.

Are you your brother's keeper? Would you stand by and allow someone to take medication to end their life? Would you do nothing to prevent them from doing that, or would you try to persuade them not to do it?

Michael Matheson: I am putting the question to you—

Margo MacDonald: No, I must put the question to you, because I do not know where you are coming from. I have told you where I am coming from in terms of the morality and legality of what is proposed. I cannot say it more clearly. I believe that there is no difference morally between sitting beside someone as they self-inject or ingest medication and pressing the plunger yourself—you will have assisted the person in bringing their life to an end.

Michael Matheson: If the medical profession took that view it would not be objecting to the bill as it is.

Margo MacDonald: You cannot say that "the medical profession" objects to the bill. The committee heard from medical witnesses. The British Medical Association representative said that he could not say with hand on heart that all BMA members are against the bill, because there is wide variation in opinion—which I presume parallels the wide variations in the moral positions of different groups. The medical profession cannot be said to be against the bill. The Royal College of Physicians of Edinburgh said that it takes no position, the Royal College of Nursing said that it takes no position and the Royal College of General Practitioners said the same thing.

Michael Matheson: We can get into different doctors taking different positions on different matters, but the evidence that we received from the BMA was that it opposes the provisions in the bill. They do not think that they should support physician-assisted suicide.

Margo MacDonald: Here we go, splitting hairs again. Who are "they"? We have not just estimates but factual numbers on doctors and other medical professionals who support the bill—David Cullum can give them to the committee.

This week, a new committee was formed of medical professionals who say that it is about time there was a change to the law to permit the very thing that I am suggesting—I admit that that committee covers England and Wales, but I do not think that attitudes are all that different on this side of the border. The BMA representative testified to the committee that he could not say that all BMA members oppose the bill.

Michael Matheson: It would be unreasonable to expect him to be able to say that all BMA members oppose the bill.

Margo MacDonald: Nor could he say that the majority of BMA members oppose it.

Michael Matheson: The BMA has taken a policy position on the bill. It opposes it. That is the reality.

Margo MacDonald: It said that it accepts that its procedures might not be perfect, but that is the democracy that it has. The representative did not claim that a majority of doctors support the bill.

David Cullum: I would like to go back to the figures from the Netherlands that have been bandied around. The starting point for the respondents was around 1,000 people.

The Convener: For the benefit of the *Official Report* and so that we can collate what you say with the evidence that has been presented to the committee, I would like to be clear about what document that you are quoting from. We seem to be drifting around.

David Cullum: I am looking at the evidence that was sent to the committee as a result of its call for evidence. A number of respondents referred to the around 1,000 people per year who die in the Netherlands. I think that that is the order of figure that Michael Matheson suggested.

When we were putting together the policy memorandum, we had a good look at what happens in the Netherlands. As I mentioned earlier, we considered a number of factors and we noted two things: the numbers in Holland were dropping year on year, and the quality of palliative care was improving. We also looked at the suicide rates in Scotland, and wondered whether they could give a guide to the number of people who might to want to utilise the bill's provisions. It was quite clear that not all people who have committed suicide would have fulfilled the bill's eligibility requirements. Perhaps a number would have failed the capacity test, apart from the other tests in section 4 of the bill. Statistical evidence that supported our contention that such legislation reduces suicide rates was provided from Oregon. The committee has received evidence on that.

We considered the process that the bill envisaged, and it looked likely that not everybody who would start the process would complete it. Perhaps a number would withdraw once other assistance became available as a result of initiating the application. The expectation was that that would happen here. In particular, discussion of palliative care options might encourage people to accept other available support.

As I mentioned earlier, we considered the significant differences between the bill and the

Netherlands legislation, in particular on advance directives and living wills, neither of which could be utilised to access the provisions in the bill. That led us to believe that a comparison with the Netherlands simply would not be robust in any way, whereas the Oregon figures are precise.

The Convener: That is helpful. I do not wish to put words in your mouth, but you started with evidence from the Netherlands on numbers that were presented to the committee, and with numbers that were supplied to the committee from Oregon. You then applied a number of adjustments based on your interpretation of matters, including suicide rates and the existence of palliative care. Was anyone engaged in that process who had any statistical qualifications and was able to guide you on whether your assumptions on the evidence that you adduced were reasonable and fair and would stand up to objective scrutiny?

David Cullum: There was nobody external. We did not scrutinise the figure of 1,000 people or thereabouts that we knew was in the public domain for the Netherlands, other than to consider how robust that figure is. I fully accept that the starting point was shaky and that the assumptions that were made are not 100 per cent reliable. We would never say that they were.

11:00

The Convener: I am sorry for interrupting, but Margo may be right that we are splitting hairs. The evidence that has been put on record is extremely helpful. We all have to make estimates from time to time—that is just life—but the committee, I think, is clear about the basis on which information has been derived and on which you have made a best estimate. I hope that I am not being unkind in saying that, but the fact is that you started from a particular point and have quite reasonably built in a number of factors.

On the other hand, Michael Matheson is using quite different figures without any further extrapolation apart from pointing out the population difference, which means that, when the percentages are applied, a different number is produced. Perhaps we should simply put on record that we have pursued the figures on two different bases.

Margo MacDonald: Perhaps I can reassure members by saying that we had to make guesstimates, because things were changing in the way that I have already described to the committee, but none of them has been disowned by the witnesses we have heard from.

The Convener: I do not know whether Michael Matheson wishes to come back on that.

Michael Matheson: It might well be that no one picked up the point with the witnesses in oral evidence, but some of the figures have certainly been challenged in the written submissions.

Margo MacDonald: I cannot say any more. We had the witnesses here, asked them questions and got their answers.

Michael Matheson: The committee might not have questioned the witnesses on the figures, but that is not to say that we have not received evidence that questions them.

Helen Eadie: The evidence that we received in the videoconference and, indeed, in some of the written submissions, has raised for us real concerns about the level of reporting and monitoring in Oregon. For example, according to research that was undertaken in 2008 by Dr Hendin and Dr Foley, health division officials have no way of knowing the exact number of physician-assisted suicide cases due to some doctors' reluctance to report them. Moreover, a whole section of our SPICe briefing paper makes it clear how shaky the information from Oregon is.

Margo MacDonald: How shaky it was, you mean.

Helen Eadie: Well, it is. The SPICe briefing paper says that, according to the Hendin and Foley paper,

> "there is no enforcement mechanism for dealing with doctors who do not comply with guidelines"

on reporting.

> "These authors argue that the law would have to be amended in order to grant full immunity to physicians as in the Netherlands to get a"

full "picture of the situation" in Oregon. The briefing also states that, despite the publication of annual reports,

> "it is difficult to obtain the real rate of PAS in Oregon, or any data on those patients dying as a result of other end-of-life processes such as the withholding of treatment or intervening in such a way that a hastened death will be a known side-effect of the treatment."

It then goes on at some length—

Margo MacDonald: That is why we did not choose the Oregon style.

The Convener: What Helen Eadie has said is also valid, but we are now in danger of having the same argument from a slightly different standpoint. Given that we are now absolutely clear about how the figures have been compiled, I am not entirely sure that we are necessarily adding to the sum of our knowledge with these questions. If Margo MacDonald is content that, through David Cullum, she has had an adequate opportunity to state clearly for the record the basis of her figures, and if members are content that we will be able to consider that evidence, I would like to move on to Cathy Peattie.

Margo MacDonald: We will summarise and re-present the figures if it will help the committee's deliberations.

The Convener: That course of action is, of course, open to you.

Cathy Peattie (Falkirk East) (Lab): Before I start, convener, I should say that I hope that I am not giving members the impression that I am weeping. I have an eye infection.

I have a number of questions that have arisen from Helen Eadie's questioning. Ms MacDonald mentioned the possibility of a medical practitioner passing responsibility on to another. I am interested in the whole opting-out process; indeed, I believe that when you questioned the witnesses you said that under the bill practitioners would have to opt in. I wonder whether you can explain that concept a bit more, because I do not really understand it.

Margo MacDonald: No doctor, no medical professional and no social worker—in fact, no person at all who comes into professional contact with the requesting patient—will be obliged to take part in the process.

Cathy Peattie: How realistic is that? I would have thought that in a rural area, in a small practice or indeed in a nursing or caring situation involving someone who would not be part of the decision, it would be difficult for a practitioner either to opt in or to opt out.

Margo MacDonald: I would not expect anyone to do anything that was against their conscience or moral beliefs.

Cathy Peattie: Do you not think that it might put employers in a difficult situation?

Margo MacDonald: I do not think so. The experience of the Abortion Act 1967, for example, shows that people who have opted out from such procedures have not been excluded from jobs.

Cathy Peattie: There is a conscience clause in the abortion legislation, but there is no such clause in your bill. Why do you think that such a provision is not relevant?

Margo MacDonald: It is written in a different way.

Cathy Peattie: It is not clear.

Margo MacDonald: What I mean is that the abortion legislation is written in a different way from this bill. We did not want to make it obligatory for anyone—requesting patient, assisting psychiatrist or the doctor whose help has been requested—to take part in the procedure. As I have explained many times, I fully accept that the bill deals with the interface of private morality and public policy, which means that there is greater acknowledgement of the autonomy not just of the patient but of the person who might be qualified to take part in the procedure but objects on moral grounds.

According to the GMC's advice, doctors should, where practical, tell the patient in advance if they are not going to provide a particular procedure because of a conscientious objection. However, doctors must be careful to be respectful of the patient's dignity and views, whatever the doctor's personal beliefs about the procedure in question. The registered medical practitioner has a duty to advise the person that they can see another registered medical practitioner. If the person is unable to make such arrangements, the medical practitioner would be under a duty to do so. I suggest to Cathy Peattie that such advice already applies to medical care that is being given in some of our more remote areas. People will make arrangements that are suited to where they live, the facilities on hand and their own abilities and beliefs.

Cathy Peattie: So, you do not think that it is necessary to have a conscience clause in the bill.

Margo MacDonald: No.

Cathy Peattie: Do you not think that it might be easier for the people involved if there were such a clause?

Margo MacDonald: No, I do not think so. They do not need such a security blanket. After all, it has already been assumed that everyone, no matter whether they are the patient or the doctor, has a conscience and that they have an equal right to exercise it. Adrian Ward from the Law Society of Scotland said:

> "There is always a question, in dealing with any profession, about the extent to which you constrain that profession by law and the extent to which you leave matters to professional regulation. ...
>
> I am not really subject to any constraints of law if I decide to decline to act for someone or to cease to act for someone. ... If you are asking me for a view, it is that we are probably getting into the area of professional regulation and what a professional should do when his conscience is against doing something that he knows that other doctors might be willing to support".—[*Official Report*, *End of Life Assistance (Scotland) Bill Committee*, 7 September 2010; c 33.]

That bears out what I have said.

Nanette Milne (North East Scotland) (Con): We have heard what you said. However, we heard from the GMC that if a doctor does not want to take part in end of life assistance they must refer the patient to another doctor. If the patient cannot do it, the doctor has a duty to do it. I know of medical practitioners who would find even making such a referral very much against their consciences. I am sure that there are many such people. Would not a conscience clause in the bill help them?

Margo MacDonald: We resisted including a conscience clause for the reasons that I explained. It is possible that such an approach could be construed as determining how a medical professional carries out their work, which is not for us to decide. We thought that the correct approach was to put no obligation on anyone to take part, which seemed to me to be the moral way forward. We thought seriously about the issue.

I do not think that the bill would be the only legislation to give rise to such an issue. I am sure that in relation to terminations there are doctors who must wrestle with the same moral dilemma about how far their conscience allows them to go.

Nanette Milne: I do not know the Abortion Act 1967 in detail, but I think that there is a conscience clause. I understand that there is an opt-out.

Ian McKee: Doctors must still refer, though. They cannot just opt out.

Cathy Peattie: I am sure that Margo and other members have enormous mailbags, and I want to talk about some of the issues that people have raised with me. There is the idea that people might be regarded as a burden on their families. Margo said that the bill makes robust provision to ensure that that would not happen, but there are fears that less than scrupulous families or care homes might say things like, “Well, this is difficult. Are you better away?” Are there enough safeguards in the bill to ensure that people do not regard themselves as a burden?

You talked about autonomy. Would that autonomy be taken from people, who would feel that they were doing the right thing not for themselves but for other people? I am thinking in particular about people who might be regarded as being incapacitated.

Margo MacDonald: I hope that the convener will excuse me if I ask you a wee question. Do you think that people do not feel that way now?

Cathy Peattie: People have raised with me the issue of families encouraging people to end their lives. I am not saying that all families would go down that route, but there are concerns. Are you saying that you do not think that that could happen under the bill?

Margo MacDonald: There will always be bad and wicked people among us, and the bill will not get rid of them, unfortunately. However, the bill goes out of its way to ensure that trying to coerce someone into requesting assistance to die would be illegal. Someone who did that would be committing an offence.

Cathy Peattie: I am aware that it would be illegal, but that would not stop people going down that route.

Margo MacDonald: Are you suggesting that people will become less moral if the bill goes on to the statute book? That is the only implication that I can draw from what you are saying, and I heartily reject it. The legislation will not change people’s morality: it will not change a loving family into a rapacious family.

11:15

Cathy Peattie: I am not talking about loving families; I am talking about autonomy and the rights of the patient, or the members of the family.

David Cullum: We were alive to that issue when the policy was put together. The bill deliberately has a number of checks on that. Those start from the application, which must be witnessed by two witnesses, who are required to sign a statement that, to the best of their knowledge and belief, the request is being made voluntarily and the person is not acting under any undue influence. The same requirement is made of the designated practitioner for the first application and of the psychiatrist.

There is then a requirement for a second formal request to be made, which must also be witnessed, with exactly the same requirements. Two witnesses—they may be the same witnesses as before, but there will have been a passage of time—have to sign and say that, to the best of their knowledge and belief, the person is not being coerced and is acting without undue influence. The registered medical practitioner has to consider the same issue, as does the psychiatrist. Then, at the very end, the same requirement applies again. The registered medical practitioner has to be satisfied that, to the best of their knowledge and belief, there is no coercion and no undue influence. We looked around and found that those two tests are not uncommon. They apply in a range of other situations.

Margo MacDonald: I remind the committee of what Professor Ganzini said in evidence on the issue. She said:

> “When I interview patients about not wanting to be a burden, what frequently comes across is their lack of value of the dying period”.

It is not about their life or personality; it is about the dying period. She said that that was

> “because that is a period in which someone is dependent on other people to take care of them and they find that an ... appalling idea.”

She continued:

> "When I ask them whether they feel a burden, I frequently see the family in the background saying that they would be honoured to take care of them and would like the opportunity, but the individual does not want it."—[*Official Report*, *End of Life Assistance (Scotland) Bill Committee*, 7 September 2010; c 63.]

Remember that the bill rests on the autonomy of the person concerned and their feelings about their death and the period leading up to their death. I understand why Cathy Peattie voices those fears—that is what the committee is for—but I think that they are groundless.

Cathy Peattie: You have said that the bill is robust. I agree that it is in certain respects, but I am concerned about the slippery slope. The intentions of the bill are clear now, but if it is agreed to by the Parliament, the situation could easily develop so that we have higher numbers than predicted and decisions are made without involving patients, as has happened in other countries. Is there enough in the bill to stop that happening? That concern has been raised by a number of people.

Margo MacDonald: Professor Penney Lewis told the committee in evidence:

> "you need to be able to look at the evidence and establish that evidence of or an increase in termination of life without request is caused by legalisation."

She continued:

> "In Belgium, where we have a little bit more data from pre-legalisation, there does not seem to have been an increase in termination of life without request post-legalisation; in fact, there seems to have been a decrease."—[*Official Report*, *End of Life Assistance (Scotland) Bill Committee*, 7 September 2010; c 16.]

When we spoke to people in the Netherlands and Belgium, we heard that, when public attention was focused on end of life issues, palliative care improved and much more thought was given to policy making on that. So people who might have requested help previously because they felt that life was absolutely intolerable found a way of making life tolerable and so did not request help. The committee has already been told that in evidence.

Rob Jonquière, whom the committee will remember is an official of the World Federation of Right to Die Societies, said:

> "a slope is slippery when no light is shining on it—the surface is wet and you can slip away. One of the advantages of regulating euthanasia with legislation is that the sun shines on the slope, so we know what is happening."—[*Official Report*, *End of Life Assistance (Scotland) Bill Committee*, 7 September 2010; c 14.]

That is important.

We should set that against the situation in England, where the Director of Public Prosecutions has said that, if someone helps another person to commit suicide or commits the act that causes death, he will judge their intention. It does not matter what a good man and how well intentioned the DPP is—there is no guarantee of a consistent judgment on intent. The bill would be much healthier, as it would introduce standards, procedures, rules and laws that must be adhered to, rather than leave it all to a public official, no matter how humane and well intentioned, to search through the fog to find out the intention.

Nanette Milne: I will ask about the qualifications on the psychiatrists and designated practitioners. We have heard from psychiatrists that the psychiatrists who would be qualified and experienced in this area are liaison psychiatrists, of whom there are very few in Scotland. How would the lack of appropriate psychiatrists affect the implementation of the bill?

My other question is on designated practitioners. Medical practitioners are not currently trained to administer drugs to end life, and they say that, if the bill became law, there would need to be a training programme for them to develop the necessary expertise. Would that involve having to train medical students at university to expand their expertise into ending life? Those issues have been raised with me as of serious concern. What are your comments on them?

Margo MacDonald: The psychiatrists did not agree with the contention that only the liaison psychiatrists would be qualified—I think that they challenged that. The Royal College of Psychiatrists has told us that assessing mental capacity is

> "the stock in trade of psychiatry as a whole".

I do not think that there is as big a gap as we maybe imagined between the two arms of psychiatry as practised in Scotland. The other psychiatrist did not agree that such work would be the preserve of liaison psychiatrists.

I doubt whether a huge amount of extra training would be needed. I think that for a doctor, whether a GP or hospital consultant, who agrees to take part in procedures that bring about an end to life a bit prematurely it would be a question less of formal training and more of aptitude. I may be wrong in that, and I will be honest that I have not asked too many people, but I am going to the general practitioners annual general meeting in Harrogate on Friday and it is the sort of thing that I mean to ask ordinary, working GPs: how they feel about the issue, whether they would need extra training, and so on. I confess that I have not asked, but I will let you know as soon as I know. However, I do not think that much extra training would be needed because it will depend much more on the personality and aptitude of the doctor.

Nanette Milne: I look forward to your reporting back after your visit to Harrogate.

Margo MacDonald: That is what I have tried to do—I have tried to speak to as many people at the pointy end as possible.

The Convener: I will interrupt proceedings briefly. Peter Warren has the discomfort of the sun glaring at him. Can we bring the blind down? It makes a terrible noise, so we will suspend for a moment.

11:24

Meeting suspended.

11:25

On resuming—

The Convener: Right. Nanette, have you finished your questioning?

Nanette Milne: I was saying to Margo that I will be interested in what the GPs say to her.

The Convener: Indeed, but did you have a supplementary to that?

Nanette Milne: No, I will leave it at that.

Margo MacDonald: I can reassure Nanette—the GMC have said that you do not get away with chancing your arm.

The Convener: The gentlemen who made all that noise have managed to leave Peter Warren back in the sunshine, which I find absolutely astonishing, and to deprive me of any sunshine on my back, which is a minor matter. [*Interruption*.] I am sorry about this. We will suspend for the moment while we get the blind sorted out.

11:26

Meeting suspended.

11:27

On resuming—

The Convener: I think that we have finally sorted the problem. Peter, I apologise for the length of time that you had to put up with that.

Ian McKee: In some of the many written submissions that we received, there was a lot of concern about whether medical practitioners en masse would revolt against such legislation, which would therefore be difficult to put into practice. The evidence that we heard was rather confusing, and I would like your reaction to it, Margo.

We heard from BMA Scotland that the BMA is fundamentally opposed to the legislation, but the doctor who came to represent BMA Scotland in questioning was a Welsh GP who was referring to a British BMA meeting of four years ago, and he acknowledged that he did not know anything about the situation in Scotland. At the same evidence session, Dr Mathewson of the Royal College of General Practitioners said that the college was split 50:50 on the bill. Will you expand on the soundings that you have taken and what you feel is the reaction of the medical profession in Scotland to this Scottish bill?

Margo MacDonald: We have a file of correspondence, e-mails and so on—communications of various sorts—from medically qualified people, both practising and retired. As the BMA said right at the start that it is against the bill, we took the decision to ask those of our correspondents who raised particularly interesting or pertinent points whether they objected to our using their name publicly. For the rest of them, we have not used their names, and we have no intention of doing so because I disapprove of the way in which information has been tossed around by some, although not all, of the people who oppose the bill.

Having heard the oral evidence, and having had the chance to ask what people mean by “a consensus”, “firm majority” and so on, we are convinced that there is as wide a difference of opinion in the medical profession and the paramedical professions as there is in the general public.

We remain convinced that the matter cannot be decided purely on its technical merits, because for some people it is a question of faith. I fully accept that, and I have not insulted them by trying to persuade them away from their faith and its teachings, but I do not think that any one faith or any adherent of any one faith has the right to try to impose on others moral standards that they do not share. We have tried to be as open-minded as possible. The public opinion polling that has been done has convinced us that most people in Scotland support the principle behind the bill, even if they may have quibbles with some of the details. I am more than willing to change it to make it better, but we are convinced that we have the support of the majority of public opinion and that we probably have the support of the majority of medical opinion. It does not really matter exactly how much medical opinion is behind the bill, because there is enough medical opinion in favour of it to make it workable and to be in line with the majority of public opinion.

11:30

Ian McKee: I will move on to the detail of the bill. Section 11(2) says:

> “The end of life assistance must be provided before the expiry of 28 clear days”

et cetera. We received evidence from Oregon that a lot of people who met the end of life criteria there and received the prescription that enabled them to end their life chose not to do it. We were told that that was because the knowledge that it was available for them to use tended to make them live longer, as they knew that they did not have to fight for it. We also heard that in evidence from the Netherlands.

I am slightly concerned that by having an expiry period of 28 clear days, we might push people to terminate their lives after 26 or 27 days to avoid having to go through the whole process again.

Margo MacDonald: They will be able to do that if they decide not to comply within 28 days. I am with you on that, to be honest. In an effort to make the bill watertight by prescribing a certain period, we have perhaps erred on the side of safety. I would prefer it if, as we heard in evidence is the case in Oregon, people used the legal right to end their life before nature ended it as an insurance policy. A very high percentage of the people there do not cash in that insurance policy, and I would hope that that would be the case here.

We are willing to look at that whole area, but we must remember that competence would come into consideration if people did not have to comply with any time limit. We will try to find a better way of expressing the provision, because I agree with what you say—at present, it might be perceived to exert some sort of pressure.

However, people can repeat the process. As I think I told the committee on a previous occasion, someone who comes from West Lothian told us that their friend—who had gone to the Netherlands to live, had developed cancer of the oesophagus and had decided to take advantage of the Dutch law—invited his friends over to be with him at the end and then changed his mind on the due date, twice. The friends were nonplussed, but the Dutch doctors were not. They said that it just showed that the legislation was working and that it was the patient who was in the driving seat. A third date was set and this time the patient went ahead. I would like to feel that we had the same approach, whereby the person can always say no, right up to the end. They can change their mind because they are in the driving seat. The only slight niggle is to do with their competence if they were deteriorating fast.

Ian McKee: I suppose that the difference is that here, as a result of an understandable need to put in lots of hurdles that people must get over before they reach the stage when end of life assistance can be given, it might be a bit daunting to someone to think, after 26 or 27 days, that they would have to go through the whole process of getting the agreement of two doctors and seeing psychiatrists et cetera again, which might tempt them to push ahead earlier. Quite honestly, I think that that needs further consideration.

Margo MacDonald: I will welcome the committee looking at it. If you have any good ideas, I do not mind where they come from.

Ian McKee: No doubt we will do that in due course.

More than one person has suggested that palliative care physicians can do a lot to help people. They are concerned that people might choose end of life assistance, although palliative care could help them. It has been suggested that one of the hurdles in the bill could be a requirement for people seeking end of life assistance to have had some contact with some form of palliative care to see whether it would help them. As far as I can see, the bill does not require that. What do you think about that?

Margo MacDonald: The likelihood is that someone in that position will have had a more specialised form of nursing, whether it is called palliative care or palliative nursing. It should be remembered that the bill refers to people for whom palliative care does not provide the peaceful, dignified end to life that everybody hopes to have. It is for people who know that there is a strong possibility that the very end of their life will be very distressing and who want to stop before they get to that point. The likelihood of such a person having had no special care, whether or not it is called palliative care, is very slim.

The Convener: I have a couple of questions, Margo. In your helpful letter to us, you raise the issue of intolerability being not an entry-level requirement but an eligibility requirement. I am not going to dance on the head of that particular pin. I am not too fussed whether it is an entry-level requirement or an eligibility criterion; it is described as an eligibility requirement in section 4. I want to tease out the principles that apply here.

The invitation, as a matter of law, is to decriminalise those aspects of the Homicide Act 1957 that relate to physician-assisted suicide or euthanasia. Having got to that point, there is then the question whether eligibility is a matter to be determined by the individual who is seeking help or whether the state, which is decriminalising those aspects of the Homicide Act 1957, ought to be setting out the protections and guarantees. You have inclined to the view that eligibility should be determined by the individual, not the state. Can you expand on that? There seems to be a reasonable, statable case for saying that the state that is decriminalising an act of homicide should determine eligibility, which would require the matters that are referred to in section 4 to be tested objectively rather than subjectively, which is the line that you have pursued.

Margo MacDonald: I do not think so. The state determines what is and is not legal. If the requirements in the bill are not met, it has not been legally enforced. The law would be broken if there were not two witnesses who testified A, B and C—that the person had not been coerced, and so on. The law would be broken if no psychiatric assessment was made of the person's competence and state of mind. The law would be broken if the doctor whom they approached for help did not ensure, one way or another, that they were informed of the whole picture—including palliative care or a different form of such care, another assessment from another doctor, or whatever. The law would be broken if the terms as outlined were not kept to. In that case, the state would say, "You've broken the law, and there has to be a penalty for that." I am not sure that I completely understand what you are saying.

David Cullum: Can I develop that—

The Convener: I will allow you to do that, David, but with respect, Margo, I think that you do understand the point, because you have consistently drawn a distinction between a subjective test and an objective test. That is perfectly reasonable; I am not suggesting that it is the wrong assumption. You have justified the objective test on the ground that section 4 should be interpreted or applied in a way in which the individual puts themselves within the mischief of the bill. I am simply putting it to you—because I wish to tease out the point—that it is not unreasonable, when the state is decriminalising acts of homicide, to have a more objective test in order to give protection to the state.

Margo MacDonald: The word that we have used in relation to the exercise of autonomy, as opposed to the state's requirements and definitions, is "intolerable". We have said that the requesting patient has to feel life to be intolerable. No state has the right to determine for any one of its citizens whether what they feel is intolerable or tolerable as regards their ability to have their wishes respected and their priorities recognised. That is a question for the individual, and the state guarantees those rights.

The Convener: But that was not the position taken by the House of Lords committee and it is not the position taken, or put to us—that is why I am raising it; I wish to tease it out—by Lord Mackay of Clashfern.

Margo MacDonald: I do not think that he said anything other than what I have said. He might have used different words, but I think we agreed—

The Convener: With respect, he stated in paragraph 14 of his written evidence:

> "The select committee considered that the definition of an applicant's suffering needed more objectivity than was provided for in Lord Joffe's bill."

He clearly got into the question of requiring objectivity, and that was—

Margo MacDonald: Relating to suffering.

The Convener: I am trying not to be picky. I am taking the principles to be applied under section 4, and I am simply trying to get the balance of the argument between the clear view that you have expressed that it should be a subjective test and the witnesses' arguments that, by definition, it needs to be a more objective test.

Margo MacDonald: I do not see how the state can judge a person's thoughts and their personal estimation of what is tolerable or intolerable to them. I do not see how the state has any right to determine that.

The Convener: It does not matter how we do it. Even you are circumscribing the autonomy to some extent by the conditions and eligibility criteria that you set out in section 4.

Margo MacDonald: I ask David Cullum if he will take over because I do not think that I completely understand your line of questioning.

11:45

David Cullum: I hope that I do. I suggest at the outset that there is a combination of state objective tests as well as the subjective test. The state objective tests can be found in section 4(1), which contains the age requirement and the registration requirement, in section 4(2)(a), where the state's test is that the person must be diagnosed as terminally ill, and in section 4(2)(b), where the test that the state is imposing is that the person must be

> "permanently physically incapacitated to such an extent as not to be able to live independently".

If I understand the point correctly, the issue is around the subjectivity of "intolerable" and what the House of Lords had to say on the matter. Let us first consider the term "unrelievable", which comes as a suggestion from the House of Lords report. In one view, the bill already makes that an existing requirement. It has already been established that the applicant has been diagnosed either as terminally ill with no more than six months to live or is permanently physically incapacitated and unable to live independently. The earlier tests already establish unrelievability. The same argument applies to "intractable" and "unbearable"; the tests are already established. As Margo said, the suggestion from the House of Lords removes control. That undermines the policy of the bill.

The Convener: I follow that, although there is the complexity of running the argument of terminal illness against whether matters are tolerable, intolerable, relievable or unrelievable. The two things are not necessarily the same. Someone can be terminally ill but their pain can be relievable. One has to be careful and clear not to confuse the two arguments.

Margo MacDonald: That is why I mentioned suffering. In Lord Joffe's House of Lords evidence, he talked about suffering meaning pain. Suffering is not necessarily all about pain. In fact, most of the people who suffer from multiple sclerosis or Parkinsons or other progressive conditions who have spoken to us say that it is not pain that they fear but the loss of personality, will and—as they judge—dignity and autonomy right at the very end of life. That is what they fear. That is what they wish to avoid. I fail to see where the state has a role in forbidding someone from addressing that.

The Convener: I was not suggesting a forbidding. In terms of the construct of the bill, section 4 is explicit in setting eligibility criteria. The committee has to consider whether those criteria fall, on balance, on the side of subjectivity or objectivity. That is the argument that I wish to explore.

Margo MacDonald: I am glad that the committee will explore that, but not for that reason. I am glad that you will consider it because of the misunderstanding that has arisen that the bill applies to people who are permanently disabled, including those who may have been disabled from birth. It does not. That was never my intention. The intention was for the bill to apply to progressive degenerative conditions. It is inequitable to say that because a person is handicapped in their movement in some way, they have less autonomy than I have. I refer to will, beliefs and morals. I prefer to treat all people the same. If the committee can come up with a better wording, I will be grateful.

The Convener: My final question has been triggered by one of your earlier responses, Margo. You said that you had difficulty in accepting that a doctor—I think that "doctor" was the word that you used; I do not wish to misquote you—would not believe that providing assistance and administering the fatal draught did not run on. However, the final act does not have to be done by a doctor. Indeed, the final act does not need to be done by any of the persons who are named or specified in the bill. The explicit relief from criminal prosecution is that it is not a criminal offence or a delict for a person to give assistance providing that they are entirely satisfied that the conditions are met. If the person has not been involved in the process, how are they to be so satisfied, particularly given that there is no requirement for an audit trail of what happens throughout the process?

Margo MacDonald: It is the doctor who has to be satisfied. I think that we gave the example—

The Convener: Sorry if I am misunderstanding the situation, but let us say that I am the person present at the moment of death. All matters have been laid out and let us assume that they have been carried out in accordance with the provisions of the bill. How am I to be satisfied that both my presence and anything that I do while I am present satisfies the requirements of the legislation?

Margo MacDonald: The doctor has to be there. David Cullum will comment.

David Cullum: I think that we have identified that the bill might need to go a little bit further to protect others who are involved in the process, in case something in the process that they have no knowledge of is not 100 per cent compliant. We can look to lodge what I hope would be a small amendment, perhaps to section 1, at stage 2.

Margo MacDonald: But the doctor has to be there.

The Convener: That takes us so far, but my question, quite explicitly, is that if I am the person present, how do I satisfy myself—whether I am the designated practitioner or someone else—that I will be afforded the relief by the legislation that nothing that I do will be a criminal offence or a delict? How do I satisfy myself that the legislation has been complied with?

Margo MacDonald: The person administering the jag or whatever must make no gain from the death, so what would the mens rea be?

The Convener: The issue of mens rea is interesting in that, when the procurator fiscal seeks to investigate the death—in terms of the further advice that we have had from the Solicitor General for Scotland—the person who assisted in the administration of the death would be asked how they had satisfied themselves that they had complied with the legislation. My question to you is, how would they answer that question?

Margo MacDonald: I do not know why they would want to do it. What would be the reason if they would not gain in any way from the person's death?

The Convener: It is not necessarily a matter of financial gain. There is the issue that the procurator fiscal must satisfy themselves that all steps were taken in relation to the person who was present. I am not clear that the bill would establish an audit trail that would enable the procurator fiscal to make that link.

Margo MacDonald: There is a trail.

David Cullum: Perhaps I can talk about the audit trail. Going right back, the first application must be in writing and witnessed in writing. The psychiatrist—

The Convener: Sorry, David, I am not trying to be picky; I am genuinely interested. Sections of the bill tell me to do things and sections require things in writing. Can you point to the section that states where the matters that are committed to writing should be kept, the section that tells me where those matters could be inspected and the section that, if I were—heaven forbid—a procurator fiscal, I could point to and say, “David Cullum, here is the section—comply”?

David Cullum: I can do that, by and large, in three ways. There are a number of requirements in the bill for matters to be put in writing, including both applications and the psychiatrist’s report to the doctor. There is also a requirement for the agreement on the provision of assistance to be in writing. In addition, we have the GMC guidelines, which apply to doctors and require all treatment decisions to be recorded in the person’s notes. We can also look forward to some guidance from the Crown Office, as set out in the letter from the Solicitor General for Scotland to the committee that is dated 30 September. Those three aspects will provide a clear audit trail, and the person who is involved at the end—if they are not the doctor—will be able to access that clear audit trail in the same way that any investigating authority can.

Ian McKee: Let us consider a scenario in which a terminally ill person has gone through that process and end of life assistance would be legal. If a doctor calls in to see that patient at the weekend and they want help to take the action for which there is permission, will there be a bit of paper at the house? What evidence will there be of that permission? The doctor will not necessarily have access to the patient’s notes. What if they give the terminal injection and someone then says, “Oh, by the way, we did not go through the procedure. We just wanted it now”? The doctor will be guilty of a serious crime—a homicide. How will the person who is present at the end, who might not be party to all that has gone before, have that evidence easily to hand?

Margo MacDonald: There are two things to say about that. First, the requesting patient and the doctor—that is how I still refer to the medical person—must agree who is physically going to give the end of life assistance. Secondly, if the bill becomes law, we should all be guided by the professional bodies, which are better placed to say what is feasible and reasonable. I always have about my person a list of all the medication that I take. Similarly, it might be reasonable for a ready reckoner to be carried by the person.

You said that a locum might be requested to provide the assistance in extremis, but that would not happen the next day. You must remember that, after a person has made the final request, there is a period when their own doctor or someone who is part of the group that is looking after them steps in. A locum would not have to make the decision whether to assist someone in bringing their life to an end.

Helen Eadie: The point was covered by the witnesses from Dignity in Dying, who were concerned that some of the process in the explanatory notes that you have provided to accompany the bill is not referenced in the bill. That is also a concern for other organisations. What you are describing is referenced in the explanatory notes but not in the bill.

Margo MacDonald: No. There are lots of things that I would not want to put in the bill, as they might make it a bit restrictive and we want to offer people flexibility. This is where humanity comes into it. We must recognise that we are talking about professionals—we are not asking people to step outside their skins or their chosen professional area of operation. We can give an indication in the explanatory notes but, as I have said, the GMC is better qualified to say how effect could be given to the intention.

12:00

Helen Eadie: It was put to the committee that prior notice of the intention of any death should be given to the procurator fiscal. What do you say about that?

Margo MacDonald: I think that PFs do not want prior notice. What would they do with it? You have to remember that we want the patient to be able to change their mind. If PFs were given prior notice, what would they do with it?

Helen Eadie: The Royal College of Psychiatrists raised the issue of inadequate supervision of psychiatrists. The point relates to GPs, too. We were also told that it might be better for a review panel to consider each case prior to agreement being given for the patient’s death. Would that be too cumbersome?

Margo MacDonald: I honestly think so. It would be a bit bureaucratic.

Helen Eadie: But would it not provide the safeguard for the people whom Ian McKee talked about? We have to keep in mind that the GP will arrive at whatever time of day or night and have a discussion with the patient. How can we ensure that we are absolutely certain that the GP acts in compliance with the legislation?

Margo MacDonald: We have to remember that two formal requests have to be made and that there is a cooling-off period. We are not talking about a trauma patient suddenly deciding that they want to end their life because it is intolerable; we are talking about someone who has suffered from a degenerative condition that has got worse. There is a whole process and a period of time, which is referred to in section 10 on "Agreement on provision of assistance". In each case, the patient and the doctor have to agree on how the law will be applied.

Helen Eadie: What do you say to the Association of Chief Police Officers in Scotland, which believes that there will be an increase in the number of investigations and that there will be cost implications if the bill is passed?

Margo MacDonald: The cost implications are not all that big. If the bill becomes law, I would like there to be an investigation post mortem into how it is working. That should happen anyway.

Helen Eadie: One fundamental difference between your bill and the situation in Oregon and the Netherlands is the lack of any monitoring, reporting and oversight processes, which is of some concern.

Margo MacDonald: It does not concern me all that much. We have detailed the steps that must be taken. As we have discussed, there is an audit trail. On top of that, professional bodies such as the GMC issue guidance on how things should be done. Professionals stick to that guidance.

Helen Eadie: I think that I am safe in saying that the committee was advised that when the legislation was reviewed in the Netherlands, it was decided that there had to be a monitoring and reporting process, and various commissions were set up across the Netherlands to ensure that everything was done properly and within the law.

Margo MacDonald: Here is a bit of horse trading: if, after the committee considers the bill, you think that it would be a good idea to have what you suggest, we might well agree with you and add it to the bill by amendment.

Helen Eadie: I return to your assertion that the vast majority of people whom you have come across support the bill. In fact, in the written evidence that we received, 87 per cent of respondents held a position that was opposed to the bill and only 6.5 per cent were supportive of it. Almost 7 per cent had no position on the bill. I appreciate that when we call for written evidence the result can be controversial, but will you respond to the fact that an overwhelming number of people seem to be against the bill?

Margo MacDonald: That might seem to be the case, but I can quote you chapter and verse on the opinion polling that has been done during the past 20 years—I will not do so, because I am aware of the time.

I remind you that an organised campaign was conducted, in the way in which many political campaigns are conducted. The campaign's effectiveness and efficiency were demonstrated by all sorts of evidence that came into my office. Care not Killing, which is opposed to the bill, printed cards that were made available at the back of churches and church members were encouraged to fill them in and send them to us. I have no doubt that the same church members sent us other communications.

There was an organised lobby against the bill. People are perfectly entitled to organise lobbying—I am not complaining about that—but independent measurements of public opinion, including one from STV, show that the people who are most organised and most opposed to the bill are in the minority.

Michael Matheson: When we heard from witnesses from the hospice sector who have serious concerns about the bill, I tried to get to the bottom of the physical practicalities of what would happen if the bill were enacted. Our witnesses said that if a patient chose to end their life, their organisations would not be prepared to let that happen in their premises. We have also had a letter from the Cabinet Secretary for Health and Wellbeing, in which she said that end of life assistance is not in the national health service's remit.

How do you envisage things working out in practice for patients in hospices? Would they have to return home? What about someone in a long-stay ward in an NHS facility? Even if end of life assistance were permissible, how would people end their lives? How would that work in practice?

Margo MacDonald: If the bill were enacted, people would become aware of it over time. I think that people would know whether they might want to take advantage of the new law. I doubt very much that such people would go into a hospice that was run by one of the churches. Churches are perfectly entitled to run hospices according to their beliefs—

Michael Matheson: I do not think that our witnesses were talking just about religious hospices. The hospice in my constituency is not faith based, but it would not permit end of life assistance to be given on its premises.

Margo MacDonald: Why, if the National Health Service (Scotland) Act 1978 were to be amended and the bill became law?

Michael Matheson: There are organisations that are not covered by the 1978 act. They are independent.

Margo MacDonald: I think that an independent organisation would be entitled to say that its moral beliefs—you said that the organisations concerned were not faith based, but we must be talking about their moral beliefs—precluded its offering assistance to die. It would be perfectly entitled to do that.

Michael Matheson: That was not my question. My question was about the physical practicalities that you envisage if the bill were enacted. If someone was in an NHS facility, on a long-stay ward, what would happen? Would they have to leave the ward and go to another part of the hospital? If they were in a hospice that would not support them through end of life assistance, what would physically happen?

Margo MacDonald: I think that you are getting to a level of detail that it is the preserve of individuals who own or operate hospices to determine, if they are not part of the NHS. If the bill becomes law, the NHS must observe the law. Where is the difficulty?

Michael Matheson: I do not know whether we misunderstand one another.

Margo MacDonald: When I got home, I puzzled over what you were getting at. I thought that I had it cracked, but obviously not.

Michael Matheson: No. I am trying to work out what would physically happen. Even in an NHS facility, would you envisage the person having to leave the ward? Also, the vast majority of hospices in Scotland are independent.

Margo MacDonald: In an old-fashioned Nightingale ward—I do not know whether any such things are left in hospices—the curtain would discreetly be drawn round and the person's life would be brought to an end. Is that what you envisage?

Michael Matheson: I am just trying to work out practically what would happen when someone exercised their right to die.

Margo MacDonald: Well, that would not happen, because I am sure that nobody who runs any sort of hospice and is used to caring for people would bring about someone's end just like that.

Michael Matheson: And if the hospices did not participate in it?

Margo MacDonald: If they were faith based and it was against their teaching, they would be entitled not to, unless they were taking NHS referrals or had an NHS contract. If that were the case, they would have to abide by what the NHS had to abide by, and the NHS would have to abide by the law of the country.

Michael Matheson: I think that we have a misunderstanding about hospices. Hospices are independent establishments.

Margo MacDonald: As I have said, if they were independent they could—

Michael Matheson: They would not be covered by the National Health Service (Scotland) Act 1978. Even if it were amended, they would not be covered by it.

Margo MacDonald: I know.

Michael Matheson: If they refused to participate, what would we do?

Margo MacDonald: We would amend the 1978 act.

Michael Matheson: But they are not covered by it.

Margo MacDonald: We would find another way of amending it if that were the case. We cannot have an inequity across the national health service. The provision must be the same in any NHS facility.

Michael Matheson: But hospices are not NHS facilities—they are independent facilities and are not covered by the 1978 act.

David Cullum: Can I add a couple of things? The bill covers the issue, to an extent, in section 11(5), which states:

> "The place where the end of life assistance is to be provided must not be one to which the public has access at the time when the assistance is being provided."

It must be a private place. If the hospice did not want to provide the assistance, the person would have to make other arrangements as to where the assistance would be administered. Given the fact that the assisters require to be competent, the person would have the support of a doctor. That should be perfectly possible to arrange. The bill is deliberately not prescriptive about where the assistance should take place.

Michael Matheson: Okay. Thanks.

Margo MacDonald: I will see you after the meeting, Michael, to find out what you are worried about.

The Convener: I have received no intimation of any further questions, so I thank the member in charge of the bill, Margo MacDonald, and David Cullum and Peter Warren for their evidence this morning.

Item 2 on the agenda is consideration of the committee's stage 1 report. At a previous meeting of the committee we agreed that consideration of our report would be taken in private.

12:13

Meeting continued in private until 12:58.

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