The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 13 January 2015

Session 4

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HEALTH AND SPORT COMMITTEE
1st Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Alison Britton (Law Society of Scotland)
Aileen Bryson (Royal Pharmaceutical Society in Scotland)
Dr Francis Dunn (Royal College of Physicians and Surgeons of Glasgow)
Detective Chief Superintendent Gary Flannigan (Police Scotland)
Patrick Harvie (Glasgow) (Green)
Stephen McGowan (Crown Office and Procurator Fiscal Service)
Dr Stephen Potts (Royal College of Psychiatrists in Scotland)
Coral Riddell (Law Society of Scotland)
David Stephenson QC (Faculty of Advocates)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health and Sport Committee

Tuesday 13 January 2015

[The Convener opened the meeting at 09:52]

Decisions on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the first meeting in 2015 of the Health and Sport Committee—a good new year to you all.

I ask everyone who does not require them to switch off mobile phones, tablet devices or other electronic equipment, because they can sometimes interfere with the broadcasting system. However, people will notice that committee members, clerks and others are using electronic devices instead of hard copies of our papers.

I welcome Patrick Harvie MSP, who joins us for agenda item 4.

Item 1 is a decision on taking business in private. I invite the committee to agree to take item 5 in private today and at future meetings. Item 5 is consideration of the themes that emerge from our evidence sessions on the Assisted Suicide (Scotland) Bill. Are we agreed?

Members *indicated agreement.*

The Convener: Secondly, I invite members to agree to take item 6 in private today and at future meetings. Item 6 is our consideration of a draft stage 1 report on the Mental Health (Scotland) Bill. Are we agreed?

Members *indicated agreement.*

Assisted Suicide (Scotland) Bill (Witness Expenses)

09:54

The Convener: Item 2 is on witness expenses in connection with the committee’s scrutiny of the Assisted Suicide (Scotland) Bill. I invite the committee to agree to delegate to me, as convener, responsibility for arranging for the Scottish Parliamentary Corporate Body to pay under rule 12.4.3 any expenses to witnesses on the bill. Do I have the committee’s agreement?

Members *indicated agreement.*

Health and Social Care (Safety and Quality) Bill

09:54

The Convener: Item 3 is consideration of a legislative consent memorandum from the Scottish Government on the Health and Social Care (Safety and Quality) Bill, which is a private member's bill in the United Kingdom Parliament. The committee previously agreed not to take evidence on the LCM. The memorandum is in the members' papers.

As no member wants to comment, is the committee content with the LCM and with the Scottish Government's view that the Scottish Parliament should consent to the UK Parliament legislating in this area?

Members *indicated agreement.*

Assisted Suicide (Scotland) Bill: Stage 1

09:55

The Convener: Item 4 is the start of our stage 1 scrutiny of the Assisted Suicide (Scotland) Bill.

On our first witness panel are David Stephenson QC, Faculty of Advocates; Professor Alison Britton, convener of the health and medical law sub-committee, and Coral Riddell, head of professional practice, both Law Society of Scotland; Detective Chief Superintendent Gary Flannigan, Police Scotland; and Stephen McGowan, procurator fiscal, major crime and fatalities investigation, Crown Office and Procurator Fiscal Service. Welcome to you all.

I remind members that Mr McGowan has written to provide us with details of the matters on which he may not speak because of judicial review.

Patrick Harvie is here not as a witness but as the member in charge of the bill. He may ask questions of the witnesses through me, as convener.

I will go straight to questions. Dr Richard Simpson has the first one.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): The fact that the majority of the public appear to support the bill is wholly understandable if one looks at it from the point of view that all of us want to have autonomy over our own life, including when we end it. However, as a doctor who was a founding member of a hospice and as a general practitioner who dealt with a number of difficult terminal stage cases, I have great difficulties with the bill in one respect.

It was my experience that the patients who sought most to end their lives were the ones who had reached the point where they are unable to do anything about that themselves. I am particularly thinking of people with motor neurone diseases who have reached the point where they are being ventilated mechanically and they are being percutaneous endoscopic gastrostomy—PEG—fed. I may be wrong, but my understanding of the bill is that the individual would be assisted but the person providing the assistance would not perform the act of ending a person's life. Therefore, that group of people would be excluded. The other excluded group is people with impaired cognition. I am not quite sure how that is tackled in the bill, but I want witnesses' comments on the situation.

The bill excludes people who are severely demented, because they cannot make an informed choice. However, an increasing number of people will make advance statements or living wills. In a case in America, a person expressed in an advance statement their wish not to continue living in certain circumstances, such as a stroke. However, the doctors ignored their wish. When the person recovered, they were grateful that the doctors had done so.

I realise that the issues are extremely difficult. The two issues on which I want the panel's views are cognitive capacity in cases of terminal illness and situations where people are so physically disabled that they are unable to perform the final act to commit suicide themselves.

10:00

The Convener: Who would like to respond first?

Professor Alison Britton (Law Society of Scotland): Good morning. I would like to start with the issue of the individual who is unable to take their own life without some form of assistance, which highlights the importance of having a clear definition of what constitutes assistance. As Richard Simpson rightly points out, those who have a progressive neurological disease or some other form of impairment may not be able to end their life by use of drugs or other substances, or by other means, without some form of assistance. The bill talks of the licensed facilitator using "best endeavours" to assist in the process but, given that section 1 is about criminal liability, we need to be very clear about what such assistance encompasses. We also need to be clear at what point there is a demarcation between giving assistance and being complicit in homicide; we need to know where the former crosses over into the latter.

The Convener: Does anyone else want to respond to Richard Simpson's question?

Stephen McGowan (Crown Office and Procurator Fiscal Service): In section 18 of the bill, no one is authorised to do anything that, in itself, causes the death of the person concerned. Causation is a rich vein of case law in Scots law, both criminal and civil. It is still the subject of argument in the courts on a regular basis. I support Alison Britton's point—the line between assisting someone and taking the act out of that person's hands is a fine one.

There are also difficulties in relation to what support is and when support becomes encouragement. The key aspect is that there is no definition of what assistance is and what it is to assist someone with suicide. Given that causation is often a matter of controversy in the law, the provision of a specific definition of what assisted suicide is should probably be considered; otherwise those who might seek to assist others will be exposed to criminal prosecution, which is obviously not desirable.

Coral Riddell (Law Society of Scotland): In relation to the first point, about physical assistance, I agree with Alison Britton—a challenge that the Law Society has identified is the absence from the bill of a definition of assistance. The Assisted Dying Bill, by comparison, includes some description of assistance. For example, it would include assisting a person to ingest or self-administer medicine. There is recognition in that bill that there might be a further degree of assistance, but in the bill that we are considering we do not even have that spectrum. That is an area that should be further fleshed out.

I have a comment to make in relation to the second point, about impaired cognition, but I could come back to that if you would rather deal with physical assistance first.

The Convener: Yes, we will come back to that.

Professor Britton: I have a brief follow-up point. I know that the member in charge of the bill has pointed out that the spirit of what is proposed is that it should be taken as a process, but the nature of our criminal law relies so heavily on causation that that is what will be the focus. Given that the action, the mens rea—the intention—and then whether it is in the public interest for any prosecution to go forward will be the focus, it is very difficult to treat what the bill proposes as an entire process. We must focus on what the assistance is in isolation, because it will be the person who provides it who will have to take the ultimate responsibility for the consequences of their act.

Detective Chief Superintendent Gary Flannigan (Police Scotland): Just to reiterate what the other witnesses have said, I think that any confusion is likely to lead to what most people are seeking to avoid: a police investigation. That would be the consequence of a lack of clarity on this issue.

David Stephenson QC (Faculty of Advocates): Section 18 tries to deal with this issue by seeking to draw a distinction between assisted suicide and an act of euthanasia. Section 18(3) says that the requirement referred to earlier in the section

> "is that the cause of the other person's death must be ... that person's own deliberate act."

In the interests of clarity, it might be better to provide that the final act, or final cause, is the "person's own deliberate act" instead of simply referring to the matter as "the cause". There might be multiple causes; indeed, in an assisted suicide, a person's death will certainly have multiple causes, because different people will come together to contribute to that end. Making such a change to section 18 would be helpful and make matters clearer than they are.

The Convener: Thank you. Dr Simpson, do you want to come back on that?

Dr Simpson: With regard to Mr Stephenson's final point, it would be very helpful to have some indication in writing of the changes that might be appropriate to clarify an area that I have to say is giving me considerable difficulty. I can see situations arising in which the relative or friend who assisted might have to procure drugs from a doctor, who, by providing the means by which the act would occur, would also be assisting. The fact that multiple assistants could be involved certainly gives me, as a doctor, some cause for concern.

David Stephenson: As far as the practicalities are concerned, the act does not specify any means of committing suicide, and it is not clear what exactly is envisaged as the means of death. At an international level, people have claimed to have developed machines that might be capable of dealing with the situation envisaged by Dr Simpson involving someone who is substantially disabled and is not physically in a position to ingest drugs. For example, an Australian doctor claims to have developed a machine that, on the use of a coded password triggered through a computer by someone who can move only their eyes, will inject lethal drugs. There are practical and technical ways around some of the difficulties that have been indicated.

The Convener: Is this a particularly Scottish issue that relates to Scots law, or are there other jurisdictions across the world that have supported assisted suicide and have overcome such problems?

Professor Britton: When the state of Oregon introduced its assisted dying bill in 1995, one of the strongest arguments was made by lobby groups representing the interests of the parts of society that have been highlighted—in other words, individuals with progressive neurological disease or some impairment that would make it very difficult for them to bring about their own death. I do not think that the situation is unique to Scots law at all.

The Convener: I am quite happy to hear from Patrick Harvie on this matter, but do members have any other supplementaries on this theme?

Rhoda Grant (Highlands and Islands) (Lab): I seek some clarity, convener. At the moment, we want to stop it being the case that someone commits a criminal act by assisting someone else's suicide. Of course, suicide itself is not a criminal act, but has anyone been prosecuted for knowing that someone else was about to commit suicide and, rather than assisting or encouraging the act, providing moral support or whatever? I am not awfully sure whether that is the case.

Stephen McGowan: The last prosecution for such an offence was in 2006, when a man whose brother had Huntington's disease was prosecuted in the High Court for the assistance that he gave. He was convicted and admonished. There have not been many such prosecutions, but there have been some and they were all for homicide.

Rhoda Grant: That was although the person who was prosecuted did not carry out the act that led to the death.

Stephen McGowan: These cases are very fact sensitive. Under the current law, it depends on what precise action was taken to assist the suicide. Perhaps the key point is that consent is not a defence in terms of assault or homicide. Any act that has been taken to assist in the dying process can be looked at in the context of the law of homicide as a whole. Because a person cannot consent to die in that way under the current law, if someone assists that, that potentially becomes homicide. However, it is difficult to come up with a precise rule, because the cases are all very fact sensitive. It depends on the circumstances of each case, what the condition is, what level of understanding the person who died had, and the intention of the person who assisted.

The Convener: I think that Bob Doris wants to follow up on that.

Bob Doris (Glasgow) (SNP): Yes. I was going to read out my question anyway, but it links into the issue of when a crime has been committed and what assistance means.

My understanding is that no specific penalties are highlighted in the bill as the consequences if a crime is committed or the process is not followed. Under Scots law, would that put the default position back to homicide rather than something else? Should there be provisions in the bill to say what the penalties would be?

That probably links into another matter that has been raised. No one wants to talk about prosecutions in cases involving vulnerable people. That is not the reason for asking this question; it is to ensure that the process is as watertight as possible. A safeguard or savings clause in the bill is that anyone who acts outwith the processes that are outlined in it and does not act carelessly or acts in good faith—whatever those things mean—will not be prosecutable either. Where does the balance sit in law? What does "acting in good faith" or not acting carelessly mean in the provision? Is that too broad? There are no penalties in the bill if the process is not followed and there is a savings provision that seems to extend protection for when the process is not followed. That compounds the lack of clarity when we talk about what it means to assist someone to end their life.

That question links into the current line of questioning, and I would like opinions on it.

Stephen McGowan: To answer the first part of the question first, the default position under the bill if it is passed will be that, if the procedure in it is not followed, the person who has assisted will be liable to investigation under the law of homicide.

It is really a matter for Parliament whether it thinks that, instead of the law of homicide, other offences could be put into the bill to cover what happens if someone does not follow the procedure. The English Suicide Act 1961, for instance, has specific offences in it and specific penalties that attach to them.

Section 24 of the bill has the savings provision. As you said, it talks about carelessness and “acting in good faith”. There is a lack of definition of what that means and what the standard of carelessness is. The standard of carelessness is not defined in the bill. Are we looking at that on an objective or subjective basis? What is “acting in good faith”? There is a spectrum of potential behaviour.

I understand that the intention behind section 24 of the bill is to safeguard those who go through the process from being liable for prosecution if some of the paperwork is not correctly filled in, for example. The intention is not to expose them for prosecution under the law of homicide. However, I am not sure that section 24 as it is currently drafted restricts protection to those types of situation—which is what was envisaged; the provision was not intended to be too technical.

The bill sets out a statutory scheme of checks and balances, some of which could be blunted—I can perhaps use that word—by the effect of section 24. That means that it might be difficult to bring a prosecution in circumstances beyond a mere failure to fill in the paperwork properly, for example.

Section 24 would restrict the ability to prosecute people in circumstances beyond those of a mere technical failure to complete the paperwork properly or those in which they have gone ahead with the final act a day before or a day after the timescale envisaged in the bill. I think that the drafters’ intention behind the provision was different, but that is not necessarily the effect that the provision would have.

10:15

The Convener: Is your question on this issue, Colin? I would like to bring in Patrick Harvie to respond to this issue.

Colin Keir (Edinburgh Western) (SNP): It is—my question is about the final act. I take it that we all agree that the final act must be initiated by the person themselves. In my eyes, anything else is not an option in law, because it would be euthanasia. Am I reading that correctly?

Stephen McGowan: Yes.

Coral Riddell: Yes.

Colin Keir: Let us assume that we reach the final stage of the bill—a vote and all the rest of it—and that we agree a bill that actually fits in with the general plan of movement, in terms of what should be provided to initiate such an act. At the moment, in law, anybody who helps someone go through the act of suicide is liable for prosecution. Am I correct in assuming that?

Stephen McGowan: Yes.

Colin Keir: Taking that away, I am a bit woolly regarding how we get to the point at which someone is able to commit suicide in a dignified manner, if there is such a thing. Because of the different illnesses, the different abilities to commit suicide and the different forms that suicide might take, is it better that the bill is drafted very specifically or kept open, in terms of the procurement, the people who are allowed to assist and how they go about it?

I think that those are the difficulties that you are talking about. The question in my mind is: if we accept those difficulties, will drafting open legislation as opposed to very prescriptive legislation become a hindrance or a help?

Professor Britton: As you have pointed out, we are dealing with assistance to end another person’s life. To me, a simple distinction between euthanasia and assistance in dying is who takes responsibility. In the bill, the responsibility for the deliberate act of taking one’s life must remain with the person. As soon as the responsibility is moved to another person, we are dealing with euthanasia. There is nothing in the bill that would allow any interpretation of that whatsoever.

Colin Keir: That takes me back to the question itself: how difficult is it to draft legislation? Because of the different forms of taking one’s life, is it easier to keep the legislation open, to allow those who are helping to go about it in different ways? I am not talking about weeks and time periods, but the more practical methods of help. Because of the differences, is it better for the bill to be open or more prescriptive?

Professor Britton: That is a matter for the Parliament. All that I can say is that other jurisdictions have taken different approaches. Some focus only on assistance to die and others focus only on physician-assisted assistance to die. The Netherlands, for example, incorporates both euthanasia and physician-assisted suicide. The end result has been brought about by different means in different jurisdictions.

David Stephenson: The more general and open the legislative provisions are, the more risk there is of uncertainty and somebody falling foul of, or failing to comply with, what would ultimately be the courts' interpretation of what the legislation means and intends.

There is clearly a tension—you must be right—between an open, permissive system and a heavily regulated one. Where the balance is struck is essentially a political matter, but the consequences must be that, the more flexible the system is, the more open it will be to different interpretations, and the more uncertain the procedure is, the greater the difficulty that people will have in knowing that they are protected when they act to assist with bringing about the end of a life.

Coral Riddell: I agree. There are challenges at both ends—heavily prescribing and defining, and leaving the legislation open—but personally I believe that, because we are dealing with people at a vulnerable stage in their lives, we should err more on the side of definition and have some reassurance. Otherwise, we will constantly rely on the courts to interpret the legislation, and that will not get us to the position of having a process and a system, which is what the bill seeks to achieve.

For example, section 18 is entitled:

> "Nature of assistance: no euthanasia etc."

The bill could go further to define the "etc" part. What would assistance look like, or not look like? The UK Assisted Dying Bill takes that question a little further. It is not necessarily the answer, but it is an example of how further definition and clarification would benefit all the parties.

Professor Britton: One of the other witnesses alluded to the concern that a lack of clarity would also mean that there was more invasive investigation at the end of the process. The aim of the bill is to allow some autonomy, respect for the individual and value for the individual. If we leave some things to chance or uncertainty, we leave them open for increased investigation—necessary investigation—at the end of the process.

Detective Chief Superintendent Flannigan: If it is open to interpretation, it is possibly open to investigation. The Parliament has the option to try to prevent that.

The Convener: Mike, do you want to come in on that?

Mike MacKenzie (Highlands and Islands) (SNP): I am relaxed, convener. I can come in now or later—whatever suits.

The Convener: If committee members agree, I will give Patrick Harvie, the member in charge of the bill, an opportunity to ask some questions at this point.

Patrick Harvie (Glasgow) (Green): Thank you, convener, for giving me the opportunity, as a non-member of the committee, to ask some questions.

As I did to the Justice Committee when it took evidence on the bill, I highlight that I am happy to explore constructive amendments that might seek to change the level of detail in the bill. Obviously, it is for members, both of the committee and of the full Parliament, to decide on the matter of principle—whether to move towards a more codified system.

In response to Mr Stephenson's comment that a more open legislative framework leaves people with a lack of clarity about what might be subject to prosecution and Mr McGowan's comment that we are talking about a spectrum or range of behaviours, I put it to you all that the position that we are in is the most open, undefined legislative framework in the policy area—an area that is inherently complex and in which we will probably never have crystal clarity about every theoretical scenario in any legislative context.

A paper from the office of the solicitor to the Scottish Parliament has been circulated to members. It outlines the current context, which is different from that for the Assisted Dying Bill, which amends the Suicide Act 1961. The paper says:

> "In Scotland, an individual"

assisting a suicide could

> "be prosecuted under the common law for murder or culpable homicide, or some lesser offence such as culpable and reckless conduct."

For example, someone might take steps to ensure that someone who they care for has access to the means to end their own life in the room where they are being cared for, might prop the person up in bed when they take the action to end their life or might simply make practical arrangements for the person to travel to Geneva and end their life in that way. At present, all those scenarios give rise to a great lack of clarity about what offences might be prosecuted and under what circumstances.

Is the position that we are in not the most open and ill-defined legislative framework that we could possibly have in the policy area? Is an attempt to outline a process that would be protected from those forms of prosecution not a positive step that increases the clarity that is available to people?

Stephen McGowan: In relation to answering that question, my hands are tied to some extent by the continuing judicial review.

Patrick Harvie: That perhaps underlines the point.

Stephen McGowan: My hands are tied and I cannot really comment on it. I am not sure that there is anything that I can usefully add.

The Convener: We respect your position. Professor Britton will respond.

Professor Britton: Perhaps I can help a little.

What you said, Mr Harvie, has some resonance. Prior to recent events and the current judicial review, the reply to that was that the law in Scotland was absolutely clear that assisting in the death of another person would incur some form of investigation and possibly some sanction.

As you know, the position in England was subject to similar consideration, and the Director of Public Prosecutions issued guidelines following the case involving Ms Purdy. That has not yet happened in Scotland so, at the moment, we rely on existing law, which—the argument is—is clear. England has tried to be a bit more specific but there is clearly a limit to how specific any rules or guidelines can be, because we would be usurping the role of Parliament. Therefore, I acknowledge that this might be the time for a challenge.

Patrick Harvie: Is the current law in Scotland clear about whether someone who made all the practical arrangements for someone else to travel to Geneva, travelled with them and ensured that they were able to go through the process would be subject to prosecution?

Professor Britton: We have not had sufficient case law in Scotland to be able to answer that.

Patrick Harvie: Exactly.

I will follow that up with a point about the line between support and encouragement. In relation to the role of the facilitator as defined in the bill, the issue was raised as to whether and in what context the provision of practical and emotional support might cross the line into encouraging someone to take an action. Is that not another situation that exists at present?

That judgment would probably have to be made in any legislative context, whether that is the Assisted Suicide (Scotland) Bill that we are considering, the Assisted Dying Bill south of the border or the frameworks in Switzerland, Oregon, Belgium or wherever. A judgment will always have to be made about whether support has crossed the line into encouragement. Is that not an aspect that is inherent to the subject rather than one that is specific to the bill?

10:30

Professor Britton: The only point that I would make is that the bill authorises somebody to undertake that role. There will be a specific appointed person—the licensed facilitator. That new role is very responsible and, indeed, onerous, so the definitions of what that person can and cannot do have to be clear. To revert to section 1, that is because, if those definitions are not clear, the person may be subject to criminal or civil liability.

David Stephenson: Patrick Harvie's point that the current situation is uncertain and therefore unhappy is a good one. However, that does not mean that, if we are introducing legislation to create a system, we should not do the best that we can to reduce and remove uncertainty. If we criticise the existing system for uncertainty, we should do our best to remove uncertainty when creating a legislative regime.

The Convener: I have misled Mike MacKenzie a wee bit, because Dennis Robertson is first on my list. I will go to him first and then come back to Mr MacKenzie.

Dennis Robertson (Aberdeenshire West) (SNP): We have looked at some carelessness aspects in relation to section 24. We are talking about a person making a decision for himself or herself—an autonomous decision. However, are such decisions always fully autonomous or are people influenced by the will of others? I am thinking about more vulnerable people. People probably have an idea of how they want to live their life or end their life, but for vulnerable people, could that be influenced by the will of others, which would mean that autonomy was removed?

Professor Britton: Medical jurisprudence has acknowledged the individual's right to make decisions about his or her healthcare. Vulnerability and capacity to make decisions will always be challenging issues and there will never be a completely watertight way to address them. However, the law on adults with incapacity and on mental health, for example, consider the ability of the individual to understand the decision that they are about to make and whether they have the commensurate knowledge and reason to make the decision. That is perhaps the best provision that can be in place in relation to the issue. For people who have no capacity or who are highly vulnerable, we have a duty to put in place mechanisms to ensure that they are protected and treated equally in society. Where people can articulate preferences about, for example, healthcare or how they are to be treated at the end of their lives, their ability to articulate that has to be worked out and measured against the difficulty of the decision.

Dennis Robertson: My problem, or difficulty, with that is that the vulnerable individual needs to be identified in the first instance. There are groups of people in society who could be influenced, perhaps as a result of changes in society, but who are not known to the medical profession as being particularly vulnerable, although they might be known to other people—for example, social care services.

It is a question not of capacity but of vulnerability, and I am concerned about groups in society who are particularly vulnerable and are influenced by external influences—what they read in the media, or encouragement from families.

Coral Riddell: I appreciate that this comes later in the process, but I think that the bill might benefit from additional safeguards in circumstances in which a person were to cancel their declaration. Unlike the declaration itself, that would not, under the bill, be done through a formal document. If recording of declarations and their subsequent cancellation were subject to a more formal process, that might provide a trigger for allowing the individual to meet, say, someone from a support service to discuss the decision and the reasons behind it. At the moment, however, there will be capacity only to make the declaration; the fact that a very limited number of people will be aware of that might leave the vulnerable people in question more vulnerable.

Dennis Robertson: That is my point. Quite a number of groups in society are known as "vulnerable", but under this bill they would become even more vulnerable to the influence of other people's thoughts and decisions, and would follow those lines in decision making. Autonomy would be removed: even though it would be the individual themselves following things through, they would be doing so because of the influence of others.

The Convener: I think that the gaps in that respect have been acknowledged.

Mike MacKenzie: Much of the territory that we are covering this morning has already been covered by the Justice Committee, and Mr Harvie's response to at least some of—if not all—the points that have been made is that he is perfectly willing to consider amendments to deal with difficulties that have been highlighted. I am not suggesting for a moment that we do not have a duty to get as close to perfection as we can, but given that the law is not a perfect instrument and does not always function perfectly, might it be possible to deal with some concerns through amendments, statutory guidance or subordinate legislation, or is the bill itself irredeemably flawed in its general approach?

The Convener: That was a pretty straightforward and direct question.

Professor Britton: I cannot comment on every aspect of the bill, but if I had to choose areas that I think need to be firmed up, I would choose the role of the licenced facilitator and—I am sorry to go back to this—the definition of "assistance". After all, we cannot identify criminal or civil liability without knowing what constitutes assistance.

Stephen McGowan: I agree. We also need clarity on section 24, which relates to the savings provision, and the effect that that would have. I understand what is intended, but I think that the drafting goes beyond that intention.

David Stephenson: I agree with the comments about section 24; indeed, it was one of the points that I wanted to make myself.

The other point I want to pick up on is the need to clarify the role of the facilitator. At present, the bill contains no expressed requirement that a facilitator be engaged or that he or she be involved to any extent in the process of assisted suicide. It is necessary for the person who is applying for assisted suicide to make a statement in their second application to the effect that they have engaged the services of a facilitator, but no requirement on them to use the facilitator is expressed.

The facilitator is given certain duties. The facilitator

> "is to use best endeavours"

to do a number of things that include being present at the death, but there is no actual requirement that the facilitator be present at the death. The facilitator has no powers to force himself on the person who is seeking assisted suicide.

When I spoke at a symposium on the bill in April last year, a member of the audience suggested that the bill's late promoter had made a deliberate policy choice not to require specifically that a facilitator be present at the death, because a facilitator should not be forced on the individual suicide at the time of the act. Such an act is obviously deeply personal, and one can understand why that might not be desirable.

If that is correct, and if I am reading the bill correctly, it raises the question why the facilitator is described in the supporting papers as a "safeguard". If he or she is a safeguard, he or she is not a necessary safeguard, yet the facilitator is the only person who has obligations in relation to reporting the death or the attempted suicide. If the facilitator is not to be involved in the practicalities of every suicide or attempt at suicide, there is a gap in the reporting provisions. If the facilitator is not there and does not know what has happened, who is to report the suicide or attempted suicide?

The facilitator is given no powers whatever in the bill to support their function and enable them to compel the applicant for assisted suicide to participate and co-operate with them. There may be very good policy reasons for that; it may be decided that that is undesirable, or that the facilitator should not have to be involved at all stages of the procedure. However, if that is the case, it ought to be understood that the facilitator's role is not as involved and all-encompassing as some of the bill's supporting documents suggest.

The Convener: Rhoda Grant is next on my list.

Mike MacKenzie: I was hoping to tease out some further elucidation on the point that I raised. Perhaps I can rephrase my question.

The Convener: Certainly.

Mike MacKenzie: I absolutely accept, as I think Patrick Harvie does, that the bill could be improved by amendments as it goes through Parliament.

I am not certain, but I take it that Mr Stephenson's point—and, indeed, any one of the other points that have been made—is not an absolute showstopper, and that it should not be beyond the wit of Parliament to address such issues. Is that correct?

Stephen McGowan: That question is difficult to answer, because it is for Parliament to decide how it takes the matter forward. It is not for me to comment on; I can comment only on my position and experiences. If Parliament wants to progress with the bill, there are areas that could be fleshed out and given increased definition. That is what we are trying to do this morning. Does Parliament as a body want to legislate in this area?

10:45

Mike MacKenzie: I am grateful to you for making that point, which is a very interesting one, because the tension that you describe could apply to the functioning of any piece of legislation. You touched on the possibility that the lack of perfect clarity might give rise to the need to investigate. I am sorry—it might have been your colleague Mr Flannigan who did so. Is that tension—that moral hazard—not a benefit rather than a disbenefit, in as much as the possibility of prosecution exists in all our criminal law if we do not get things right?

David Stephenson: That is a political issue—you and your political colleagues must make a decision about what sort of system you want and its likely consequences. For my part, I am representing an organisation. Whatever personal views I might have, I am not able to advance specific suggested amendments to individual sections of the bill.

Mike MacKenzie: I am sorry—I think that you have misunderstood me. I am not suggesting that it is your responsibility to suggest amendments, or that you ought to do so. I am talking just about the broad principles. In theory, could the matters that you have raised be dealt with by amendments as part of the parliamentary process, or is the bill irredeemable and cannot be made satisfactory through the normal parliamentary process? I am not asking you to write amendments or, indeed, to suggest any.

The Convener: I think that you are trying to elicit a response that you are not going to get. We are at stage 1 of the parliamentary process and our witnesses are assisting us in identifying problems or issues that they believe, from their expertise, will act as barriers to moving forward. The bill will be refined at stage 2, when we expect all those who are interested in promotion of the bill to take into consideration the expert evidence that we will have received and the criticisms that will have been made of the bill. That will be followed by a debate in the chamber, in which all the evidence and the committee's report will be considered. There will be subsequent amendments, which may or may not gain the support of Parliament. We are now in the very early stages of stage 1.

Rhoda Grant: If a licensed facilitator needed to register or report a death as a suicide—there would obviously be paperwork attached to that—would there be any formal investigation of that? Would that paperwork be enough to indicate that the process had been carried out under the law and that no investigation of the circumstances surrounding the death was necessary?

Stephen McGowan: That question assumes that the facilitator would have all the paperwork and that all the paperwork would be in the one place. You are correct to say that, were the bill to be passed, the nature of any investigation would depend on the circumstances, but it is crucial that all the paperwork would be available in the correct place so that it could be gone through. That would be the starting point, but it might or might not be the end point.

As I understand the bill, the various declarations and pieces of paperwork would have to be noted on the medical records of the person who had expressed the will to take advantage of the legislation, but there is no central repository for all the relevant paperwork. Therefore, there is a potential issue with in-gathering all the paperwork, which means—given how the bill is drafted—that there might be an investigation. The policy intention behind the bill is to minimise the intrusiveness of any investigation—in other words, the purpose of an investigation would be to allow the authorities to satisfy themselves that things had been done in accordance with the legislation. Something could be done about having a central repository for the documents. At the moment, the bill envisages that endorsement will be in medical records, but I am not sure that the bill is quite as tight as your question suggests. I hope that that is helpful.

Professor Britton: I fully support that. In our written submission, we suggest that there be something similar to the Office of the Public Guardian, where documentation could be held centrally and securely for monitoring purposes, data purposes and security, when it is collated. I agree that it might not be a case of simply producing it, and that it might take a bit of time. The licenced facilitator has to be given reasonable time to pull the paperwork together.

Detective Chief Superintendent Flannigan: As we have suggested previously, the bill suggests that the mechanism for reporting would be to report to the police. There is a precedent in respect of medical deaths, which are reported directly to the procurator fiscal’s office. We would wholly support that approach, because such consistency would make things smoother for everyone concerned.

Rhoda Grant: Dennis Robertson asked about vulnerable people. If a family member who was not aware of the declaration of intention took issue with the situation, for example because they did not believe that the decision had been taken by the deceased, what steps could they take to have that investigated?

Detective Chief Superintendent Flannigan: That would be consistent with any concerns that anyone had in any other aspect of their life. If someone is concerned that a criminal act might have taken place, they are freely able to report that to the police or to the procurator fiscal and an investigation will be conducted. I do not imagine that that is likely to change.

Everyone has a right to express a concern. I do not think that anything in the legislation would alter that ability to report. Does that make sense? If someone raises a concern, the police or the procurator fiscal would have an interest in what that concern was and, if the situation required more than just dialogue, a full investigation would be likely to follow.

Stephen McGowan: If there was a concern that all was not as it appeared to be on the face of the paperwork, that would be investigated. It would have to be investigated. I do not think that, in the face of a concern being expressed that not all was as it seemed, the paperwork could be accepted at face value. There would have to be some kind of investigation into that. Obviously, the extent of that would depend upon the circumstances but if there was a suggestion that there was no consent, there would definitely have to be investigation into that.

Rhoda Grant: What if a family member thought that someone had been coerced into making those declarations? In such a circumstance, the paperwork would be properly filled out—and registered, if that were required by an amendment to the bill—but someone might still think that an individual had exercised their influence over a person in order to make them reach that decision and had encouraged them to fill out the paperwork. The person might have stated that view in front of witnesses, but they might have done so only in order to get the approval or whatever of the other person.

Stephen McGowan: That would have to be investigated. Under the terms of the bill at the moment, that might take the investigation into something like an investigation of homicide rather than something that would be dealt with within the parameters of the assisted suicide legislation. It would have to investigated, and it would be.

The Convener: This may not be the right time to ask this question, but specific penalties in relation to assisted suicide have been mentioned. Would specific penalties require a specific offence, which is the case in England and Wales?

Stephen McGowan: Yes. In order for there to be a penalty there has to be an offence. At the moment, the default position is that, if the bill became law and was not complied with, the common law would apply. The position in England and Wales is that there are statutory offences in this area, with specific penalties attached. The bill that is before the United Kingdom Parliament—the Assisted Dying Bill—contains various offences relating to fraud and so on, which also have specific penalties. If the bill that we are discussing is passed, the default position would go back to common law.

The Convener: How do you create a specific offence?

Stephen McGowan: Parliament would have to define the offence. In relation to the UK bill, things such as fraudulent entries in the documents are being made an offence.

Nanette Milne (North East Scotland) (Con): We have been talking a lot about the practicalities of the bill. The Law Society’s written submission raises the possibility that to legislate at all in this field could be incompatible with article 2 of the European convention on human rights. Does the Law Society still have that concern?

Professor Britton: I think that our intention was to flag up matters of interpretation. As you say, article 2 confers a right to life. That is interpreted by member states broadly to enforce and protect that right to life. The European Court of Human Rights tends to leave interpretation of article 2 up to each member state. A right to life does not automatically confer a right to die.

However, article 2 must also be considered in relation to article 8 and a right to a private life. There has been far more case law around that. There are English cases involving Ms Pretty and Ms Purdy. The issue of the private life is whether one can make decisions about one's death and the processes leading up to that. Is that an integral part of life? Lord Hope in Purdy acknowledged that it was.

Article 2 is a right to life, which will not, under current interpretation, confer a right to die. However, within the confines of the bill, we are not looking for a personal right to die. What has been proposed in the bill is that, under certain circumstances, assistance can be provided.

Nanette Milne: Has this issue arisen with other jurisdictions that are signatories to the ECHR and which also have laws that allow assisted suicide?

Professor Britton: Case law has started to be developed only in more recent years. Many states were relying on a common law development within their own member state. As I said, the European Court talks about a margin of appreciation that has to be applied in each and every circumstance. The court is reluctant to interfere in what a right to life might mean; for example, a right to life might include evaluations of personhood. When does life begin? Each and every member state will have religious, cultural and legal influences that will determine that.

The jurisprudence in case law has been developing, particularly in recent years. Some of it will have had some impact, but it is having an increasing impact. We are looking to the European Court of Human Rights but, more so, to article 8 and the notion of a right to a private life and what that means for our decision making about death and the dying process.

Nanette Milne: Have those issues been taken into consideration south of the border in the legislation that is before the House of Lords?

Professor Britton: I imagine that they have been, particularly with such recent case law. As well as Ms Purdy and Ms Pretty, just last year the Supreme Court issued the judgment in the case of Mr Tony Nicklinson and others. I would find it very surprising if that was not to the fore in any deliberations relating to Lord Falconer's Assisted Dying Bill. The Supreme Court made it very clear that any decision taken on whether assisted suicide was to be endorsed was strictly a matter for Parliament and not for the courts.

11:00

The Convener: That was a good summary from Professor Britton.

Bob Doris is next, and I think that Patrick Harvie has a few additional questions. I see other hands going up, so I will also bring in Richard Simpson and Colin Keir.

Bob Doris: I wanted to ask two questions, convener. I will be as concise as I can.

We have had some discussion about what it means to assist in an assisted suicide. I am interested in the role of medical professionals in this matter, because before people can exercise this right—if that is what is decided or agreed to by this place—they will have to know about it. An individual might find out about it from their GP, and GPs might well have a variety of views on the matter; after all, they are individuals in their own right and have their own regulatory system. What balance should be struck with regard to GPs, unsolicited, informing patients about this treatment option? Indeed, would it be seen as a treatment option? Would such an approach be valid, or could it be interpreted as promoting or encouraging the practice? How would that be defined in the bill or indeed in other law?

I know that this must be frustrating for the member who is promoting the bill, but we as members have to think about potential scenarios in the event that the bill is passed. In one scenario, for example, the family might disagree with the right to assisted suicide being exercised and might challenge on a variety of fronts, one of which might be the advice or information that had been given by a medical professional or anyone else. Where are the protections in the bill in relation to such a scenario?

I see Professor Britton leaning forward—she seems to be mopping up all the curveball questions. Perhaps I should take a slightly more tangential approach and ask whether, if you have not considered such a scenario, you consider it to be relevant. Perhaps it is not; on the other hand, it might be very relevant, but you have just not considered it. Have you done so? If not—and you are allowed not to—do you think that the matter needs to be considered and fleshed out?

Coral Riddell: We have not considered the matter directly in relation to the medical profession, but we have certainly considered it from a legal standpoint. For example, a solicitor might give a client advice about different options such as testamentary matters and executries. On the question whether the scenario that you have outlined should be considered, I think that solicitors, who have professional obligations with regard to integrity, honesty and their client's best interests, would face huge ethical challenges about what they might do. At what point does assistance or encouragement seep beyond the immediate parties envisaged in the legislation? I do not know what that would mean. You would not be able to compel a solicitor—or, I assume, a medical practitioner—to disseminate or promote this information, but I certainly think that this is a difficulty with the bill.

David Stephenson: Given that, if the bill were to be passed, there would be a law in Scotland making assisted suicide legal in certain circumstances, it would be very difficult to see how someone who was simply imparting information about an existing legal regime that had been approved by the Scottish Parliament would be contravening some other law. However, any doctor who promoted such information would, in addition to the legal position, have to consider their ethical position, which would be largely determined by the General Medical Council's guidelines. At present, the GMC's face is set against assisted suicide and euthanasia or assisted dying. If a legal regime were to be introduced, the GMC might have to look at the issue again—clearly I am not in a position to speak for it—but at the moment the role of the doctor would be subject to professional regulation by the doctors' professional bodies and, in particular, the body that defines doctors' ethical obligations: the GMC.

Bob Doris: That is helpful. I was not suggesting that doctors should encourage or promote a pathway towards assisted suicide; I am just trying to see where challenges might arise. That question may be more relevant for the next panel, in addition to considering the legal position.

The Convener: On that point, I presume that GPs would be subject to the same concerns that you warned us about earlier with regard to the bill's current lack of clarity. Those issues would apply to anyone—doctors, friends, family or whoever—who was assisting someone to die.

I see that the witnesses are all nodding.

Professor Britton: Yes. The proposals would apply equally to any member of society.

David Stephenson: The bill seems to envisage that the service in question would be supplied under the auspices of the national health service. It does not say so in specific terms, but it mentions registration, the keeping of documents in the patient's medical records and the use of registered medical practitioners, so I think that it anticipates that a system for supporting documents would operate within the NHS.

If the service is to be regarded as an NHS service, doctors who work in the NHS might be concerned about the need to have specific protection or an opt-out. Dr Potts, from whom the committee will hear evidence later today, deals nicely with that issue in his submission, which is appended to the committee's documents. He says:

> "if participation is considered a part of NHS duties, there is a strong case for an opt-out provision"

so that a doctor knows that he or she is not considered by their NHS employer to be obliged to participate if, for conscience reasons, they do not feel able to do so. Perhaps the inclusion of a "conscience clause", to which the Faculty of Advocates refers in its submission, should be considered.

Bob Doris: I want to develop that point further. The medical profession would have to make significant ethical and practical judgment calls. For instance, if a patient was unaware of assisted suicide and a doctor deemed that that patient qualified in theory to go down that pathway, when would it be appropriate to inform their patient of that option, and would that be deemed to be encouragement? It is difficult to tease out what is or is not appropriate, and how the system could provide checks and balances without compromising doctor-patient confidentiality.

I also want to explore two medical areas. I may have got this wrong, but I understand that the End of Life Assistance (Scotland) Bill referred, with regard to determining whether an individual has capacity, to a psychiatric assessment. That assessment would not, under the provisions in the current bill, necessarily have to take place.

I will try to roll my points together for brevity. There could be various medical opinions with regard to the qualification that the person must have capacity but must also have a terminal or a life-limiting illness. I am thinking about what might happen after the event itself. If, for instance, an assisted-suicide case was challenged because an individual believed that the person who had made the decision did not have capacity and a full psychiatric assessment had not been carried out, or if a case was challenged on medical grounds because an individual did not believe that the patient's condition qualified them, what would be the legal position? Have we got right the checks and balances and the protections in the bill?

We have almost gone full circle, as we are coming back to clarity in the bill. I am trying to tease out that issue with some specific examples.

Professor Britton: On your last point about the definition of terms such as "terminally ill" and "life-shortening", all legislation that I am aware of has struggled with issues such as how to encapsulate a person's illness and how to define the stage that it must be at to enable the person to fall within the provisions of the law in question.

There will be reliance on medical diagnosis in the first and second consultation as part of the process, but the Law Society believes that the process should not rely only on medical diagnosis. If the bill is about an individual's autonomy to request assistance at the end of their life, we believe that their subjective view should also play a part in the process. It should be about their opinion of the quality of their life and not just about medical opinion; it should be about what they value and what they think is important to them at the end stages of their life.

In respect of medical diagnosis, we believe that good communication between doctor and patient should always be encouraged and that each party's viewpoint should be respected. We would hope that that would go some way towards painting a fuller picture through linking medical diagnosis with the person's value system, beliefs and view of their quality of life at the time.

David Stephenson: The approach that is outlined in sections 8 and 10 of the bill starts with medical diagnosis, but section 10(3)(c) states that it is necessary for the applicant to have reflected "on the consequences" of the medical condition and to have "concluded that the quality" of their life "is unacceptable." The words "is unacceptable" suggest that the quality of their life is currently unacceptable. In addition, section 10(4)(b) states that the person must see

"no prospect of any improvement"

in their quality of life. Therefore, quite a high hurdle is added to the need for medical diagnosis of a life-shortening condition or a terminal condition that might be life shortening but will still leave the person with decades to live. For someone to qualify under the bill's provisions, they must perceive their current life quality to be "unacceptable" and to have

"no prospect of any improvement".

I think that that is quite a high hurdle and a subjective one.

Bob Doris: In terms of capacity, I am just wondering about—

Dr Simpson: Can I deal first with the definition of "life-shortening", convener?

The Convener: Yes. You can ask a supplementary question on that, then we will go back to Bob Doris.

Dr Simpson: Bob Doris asked the two questions that I was going to ask, but I would like to ask supplementaries on both. First, to take a rather extreme example, a significant number of people with schizophrenia commit suicide—such people see no prospect of their life improving. During periods of control, or while their symptoms are diminished, they might in those better states become aware that there is no long-term prospect of their managing with the medicines that they are required to take, and so on. Would such people qualify under the bill? There are also people who have learning disabilities that are not severe, but are significant, and there are people with epilepsy. All those people tend to have much shorter life expectancy. I do not have difficulties with the terminal-illness group or the progressive-illness group, but I have significant difficulties with what constitutes a "life-shortening" condition. Can the witnesses comment on that?

David Stephenson: "Life-shortening" is not defined. It therefore seems to follow that any illness that shortens a person's expectancy of life is life shortening. The Faculty of Advocates' submission pointed out that many everyday conditions are likely to be life shortening. For example, type 2 diabetes can shorten life; it might do so by only a relatively short time, but it could nonetheless be argued that it is a life-shortening condition.

Dr Simpson: Indeed. It was stated in *The BMJ* last week that type 2 diabetes could shorten life by 15 years, so we have a problem.

My other point is on the words

"no prospect of any improvement".

A recent case that really disturbed me was that of a young man who as a result of a rugby injury became paraplegic and so went to Switzerland. Even as we speak, exoskeletons that provide movement, and treatments such as the transplanting of stem cells into the spinal cord, are being developed. As a result, what constitutes

"no prospect of any improvement"?

Who will decide that there is no such prospect? Who will decide that assisting someone is the course of action to be taken and that there is no prospect of improvement when, in fact, such a prospect might exist?

11:15

Professor Britton: I think that you are referring to the case of Daniel James, who was a very young man. It is a good example of the need for more than just a medical diagnosis, and for the need to look at the broader picture. Mr James tried to take his own life—once by overdose and once by trying to stab himself to death—and I believe that family members had done everything possible to encourage a decent quality of life. At the end of the day, his family—very reluctantly, I am sure—reached the view that going to Switzerland was what Mr James wanted at that time. I do not think that we have any way of knowing whether Mr James would have wanted to take that course of action, had he lived, but his quality of life at the time was such that his family and friends were willing to offer support to allow the man to end his own life.

Dr Simpson: And yet a natural reaction—

The Convener: Richard, you have asked a supplementary. Mr Stephenson wants to come back in, and two or three other members want to ask questions. I must point out that we are under a bit of time pressure.

David Stephenson: On who will decide that a person's quality of life is unacceptable, it will in the first instance be the person who applies under sections 8 and 10 of the bill. However, medical practitioners would then have to be satisfied that the facts that were available to them were "not inconsistent"—you will note the double negative—with the individual's conclusion about the unacceptable quality of their life. It is not clear to me what degree of scrutiny would be required, because the medical practitioner would be required to come to a conclusion based on the information that he has. I suspect that the information that the practitioner would have would vary in individual circumstances. The process does not seem to involve an objective review of the patient's subjective conclusion that his life is unacceptable—although, of course, that might not be possible or realistic. One might say that that should not be an aim of the bill, but that seems to be what is anticipated at present.

Dr Simpson: Thank you.

The Convener: Bob Doris wants to conclude his questions, Richard Lyle has not asked any questions yet and I want to give Patrick Harvie the opportunity to come back in—and we are going to do all of that within the next 15 minutes.

Bob Doris: I had asked about capacity, and I think that witnesses' comments have fleshed out certain issues about the individual's subjective views overriding medical considerations. That is a political and ethical judgment call as much as it is a legal issue, but I think that capacity is clearly a legal as well as a medical issue. For example, the person in question might not have had a psychiatric review; of course, the medical professional might not deem such a review to be appropriate, but a lot of psychiatric conditions can go undiagnosed and undetected. I also note that the previous bill on the subject made provision for such a review. Could there be a legal challenge on the ground that the medical professional had got things wrong or, on balance, should have referred the individual for a psychiatric review?

Coral Riddell: Such a situation would certainly be open to challenge. Concerns about capacity are raised in the Law Society's submission, simply because different degrees of capacity are required for different decisions. I will not labour the point, but the Law Society has a particular view about solicitors acting as proxies. The decision would, after all, be significant, so we must be sure that the person has capacity that is commensurate with the decision's significance. I suspect that a solicitor who took the role of proxy would look for some form of psychiatric or medical reassurance and for confidence that the person understood the effect of the decision.

As far as solicitors are concerned, there is certainly a difference between determining whether someone has the capacity to purchase a property or transact a basic contract and whether they have the capacity to understand the nature of an assisted suicide decision and its consequences, to understand that they can change their mind and to cancel the declaration, and so on.

There are lots of areas to consider. This goes back to Dr Simpson's original point about impaired cognisance. How do you determine whether capacity continues—whether a decision that was valid at one point in time would not now differ? There is difficulty in ensuring that capacity exists, so there has, because of the significance of the effect of the bill, to be a high test.

David Stephenson: The endorsing medical practitioners in respect of both the first and the second request will need to be satisfied that the person who is making the request has capacity under the definition in section 12. Section 12 introduces a two-stage approach to testing for capacity. The first stage involves reference to the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 12 states that

> "a person has capacity to make a request if the person—
>
> (a) is not suffering from any mental disorder ... within the meaning of ... the Mental Health (Care and Treatment) (Scotland) Act 2003 ... which might affect the making of the request".

For the purposes of section 328 of the 2003 act, mental disorder is any "mental illness", "personality disorder" or "learning disability", "however caused or manifested". Therefore, if somebody had a mental illness that

> "might affect the making of the request",

their request would fail at the first of the two stages in the test of capacity. The Faculty of Advocates is concerned that that part of the test of capacity involves a medical decision that looks like a psychiatric decision. If a cancer patient, for example, already has a diagnosed mental illness, the GP or a consultant who is dealing with them might know that they have a mental disorder. However, section 12 suggests a psychiatric diagnosis, and who is capable of making a psychiatric diagnosis? A psychiatrist is another medical practitioner, so we are concerned that the practical effect of section 12 might be to require a psychiatric diagnosis at the first stage of the two-stage test. If the medical practitioner has to be a psychiatrist at that stage, will he be capable of making a diagnosis about the terminal or life-shortening condition? I leave that with the committee.

What does the phrase

“which might affect the making of the request”

mean? I know that Mr Harvie’s view on the matter is different from mine. The word “might” suggests that the mere possibility of such an illness would be enough, but what does

“affect the making of the request”

mean? Does it mean “influence the making of the decision behind the request”? To my mind, the provision is not clearly expressed and might be improved on.

The second stage of the test relates to capability in a more practical sense—the ability to make a decision, remember a decision and so on—and it may not require a medical or expert psychiatric decision. The psychiatrists who have responded to the committee—you have a copy of their paper—say that it would not. However, I think that the first stage would require a psychiatric decision.

The Convener: We can explore that later.

Richard Lyle (Central Scotland) (SNP): I have sat and listened to the questions this morning, most of which have been on points that I was going to raise, but there is one issue that I still have to raise. The Parliament makes laws, the police enforce them, procurators fiscal charge people and lawyers defend people in court and look at all the circumstances. What we have heard today is that, to cover all the bases, the bill will require hundreds of amendments. People have the right to live—we all agree on that. Do they not also have the right to die when they choose?

Stephen McGowan: I think that that is essentially a matter for the Parliament. It goes to the heart of the legislative purpose of the bill. It is not really something that I can comment on.

Richard Lyle: With the greatest respect, you said earlier that it is homicide, not suicide. I do not want to go back over all that you have said this morning, but if people want to die, why should we not respect that? That is the question that I want answered.

Stephen McGowan: I talked about the law of homicide, which currently applies to the situation where anyone assists someone else. That is the current law. If the Parliament wants that not to be the situation, it can legislate to that effect, but that is a matter for the Parliament.

David Stephenson: The dead are beyond the reach of the law. If somebody commits suicide, their troubles in this life are over and they will not be prosecuted. They are dead. The point of the bill is to protect those they leave behind who may have been complicit in their act of suicide, and to prevent them from being prosecuted or found civilly liable. Our focus has been very much on the criminal side, but there is also the removal of civil liability in section 2. The focus is not so much on somebody’s right to die or to kill themselves if they choose. It is on protecting those they leave behind.

Coral Riddell: I agree. The issue is not so much the person’s autonomy or the decision to die but the fact that the bill requires the assistance of a number of different professionals to bring that about, such as doctors, solicitors and those in the new role of facilitator. Many of them already have professional codes of conduct and obligations, which have not necessarily been accounted for within the process that is set out in the bill. That is why the professionals are keen to safeguard things and highlight those conflicts.

The Convener: The bill does not propose a right to die.

Professor Britton: We do not need a right to die. We are all going to die. What we are looking at here is that, under certain conditions, that help is provided.

Richard Lyle: None of us wants to lose any of our loved ones. We have all gone through the pain at some time, with grandfathers, mothers or whoever. Mr Stephenson is correct, but what I am saying is that, given all the points that you have made this morning, we would need hundreds of amendments to cover the person who is left, who knows that their loved one wanted to go. That is the point that I am trying to make. Thanks, convener.

Patrick Harvie: On that last point, I do not think that I have ever seen a bill introduced to Parliament that was not capable of improvement through the amendment process to some extent. As I said, during the process, I will be happy to engage with any proposed amendments that are constructive and intended to improve the bill.

I strongly agree with some of the comments that were made about the purpose and intention of the bill, so I will not go over them again. I will also leave the issues to do with psychiatric assessment and so on to the next panel, where I think they might be more usefully explored.

However, I want to pick up on two issues that came up more recently. One is a conscience clause or opt-out clause. Given that the regulation of the professions is currently a reserved function, it seems possible that that could be implemented either through guidance or perhaps through ministerial regulations. I ask the witnesses who raised the issue whether those are appropriate means of introducing a degree of protection for those who do not wish to participate in assisted suicide and want to be sure that they will not be required to do so. If not, is it possible for the bill to address that by other means?

11:30

David Stephenson: I think that I raised the issue of a conscience clause. From my point of view, it does not matter much where the provision is found, as long as it is there, is effective and gives those who have conscientious objection to participation in the process an ability to opt out. As I said on another occasion, it would be appropriate and necessary to include in the conscience clause a provision so that somebody who declined involvement on the grounds of conscience would be under a duty to advise the person who was seeking assisted suicide of that fact. That person would then know why they were being refused assistance and would have the option of going to somebody else who might be prepared to supply them with the assistance that they were seeking. It is not enough for somebody to say that they will not get involved and then leave a person with the impression that they somehow do not qualify, when they do or might.

Patrick Harvie: Whether people agree or disagree with the basic principle that is at stake, I have not discussed the issue with anybody who would not welcome a clear conscience clause. Apart from anything else, that would give individuals the ability to register with a GP who agreed or disagreed with the issue in principle and to know that they would be given treatment by someone with a view that was compatible with their own.

Some of the issues to do with qualifying conditions were discussed. In what seemed to me a fairly extensive list of conditions that in my view would be unlikely to qualify, you included type 2 diabetes. Although it might be described as a life-shortening condition and would thereby meet the test of section 8(5)(a), in the absence of other factors it certainly would not meet the whole test in the bill, which you described as a high bar. Type 2 diabetes in its own right would not meet that high test, would it?

David Stephenson: It is difficult to envisage somebody concluding that the quality of their life was unacceptable and that there was no prospect of any improvement simply because they had type 2 diabetes. That is why I tried—perhaps unsuccessfully—to get across the fact that there has to be an objective medical diagnosis but there then has to be a subjective impact on the person's life. It is at that point where, it seems to me, the bar is set quite high because, on reflecting on their condition, the person has to conclude that they have an "unacceptable" quality of life with

> "no prospect of any improvement".

There would have to be some relation between the two, because that conclusion has to be as a consequence of reflecting on the condition. Existential angst on its own is not enough.

Patrick Harvie: Indeed. The medical practitioners who would then endorse the individual's request would have to be satisfied that the person's conclusion about their quality of life was

> "not inconsistent with the facts then known"

to those practitioners. There is that double level.

David Stephenson: There is a check, although I am not sure whether the check is strong enough or whether the use of the double negative is appropriate. Perhaps there should be an additional requirement of investigation or inquiry—I do not mean an extensive investigation—rather than leaving the medical practitioners' decision based on such material as they currently have, which could be not very much.

Patrick Harvie: That is helpful—thank you. Again, I am happy to explore the details further.

My final point relates to the earlier question on compatibility with the ECHR. To clarify what was said, it seems clear at present that, as with other issues that the Scottish Parliament has legislated on recently, such as same-sex marriage, the ECHR neither compels a jurisdiction to provide assisted suicide nor forbids it from doing so. That is the case, whether we look at the decisions that have been reached at European level or in the Supreme Court in this country.

Professor Britton: Yes. Under the interpretation of article 2 of the ECHR, it does not confer a right to die. The European Court of Human Rights is keen to allow that margin of appreciation to be given to each member state. However, article 2 cannot be read on its own. It has to be read in conjunction with other articles—primarily article 8.

Patrick Harvie: As far as I understand it, the decision of the Supreme Court makes it clear that the question of whether article 8 has been breached is one for domestic courts.

Professor Britton: Yes, it is an issue of proportionality for the domestic courts.

The Convener: On behalf of the committee, I thank all the members of the panel for attending. We are grateful for your written evidence and for the precious and valuable time that you have given.

We will pause to set up the next panel.

11:35

Meeting suspended.

11:42

On resuming—

The Convener: We continue agenda item 4, which is our stage 1 scrutiny of the Assisted Suicide (Scotland) Bill. Our second panel of witnesses is Dr Francis Dunn, from the Royal College of Physicians and Surgeons of Glasgow; Dr Stephen Potts, a consultant psychiatrist, from the Royal College of Psychiatrists in Scotland; and Aileen Bryson, practice and policy lead at the Royal Pharmaceutical Society in Scotland. I welcome them all. We will go directly to Bob Doris for our first question.

Bob Doris: Towards the end of our last evidence-taking session, we teased out some of the potential issues or challenges for the medical profession should the bill be passed into statute. One was whether there should be a conscience clause in the bill, whether it would be acceptable to have something at a later date in guidance or secondary legislation or whether existing codes on medical practice provide suitable protection for medical professionals, be they GPs at the local practice or others who might at some point be involved in the assisted suicide pathway—I am not sure whether that is the correct terminology.

Some of my earlier questioning concerned at what stage it would be appropriate for a medical professional to say to one of their patients that they should perhaps be aware of assisted suicide. I imagine that saying to someone that they should be aware of it could tacitly move them towards considering it. As the bill stands, is that something that medical professionals would feel comfortable with? Is there suitable protection for their individual views and for them to work in their patients' best interests?

Dr Stephen Potts (Royal College of Psychiatrists in Scotland): It would be an unusual position for psychiatrists to suggest or advocate the possibility of suicide to any of the patients that they see, but we would not expect to be the clinicians in the front line who might raise the question, so I defer to the views of my colleagues.

11:45

Dr Francis Dunn (Royal College of Physicians and Surgeons of Glasgow): The Royal College of Physicians and Surgeons of Glasgow represents a huge constituency, with varying views on the subject. I would say that the majority view is that there is a relationship of trust between doctor and patient. Having the option of discussing assisted suicide with a patient is a new and, to many doctors, alien concept so, if the bill were to proceed, it would be important to have a conscience clause. One would be concerned about the patient having to go to different doctors to find one who agreed with assisted suicide. We need to think of our duty of care to the patient from that point of view.

The conscience clause is important, and it is important to emphasise that there are diverse views within the profession. Within my organisation, the majority view is very much that the proposals impinge on the trust relationship between doctor and patient.

Aileen Bryson (Royal Pharmaceutical Society in Scotland): Pharmacists would like a conscience clause to be in statute rather than in professional guidance. We, too, represent members with a wide range of views on the subject, but even among those who would be willing to dispense a prescription for the procedure if the legislation goes through, a conscience clause was an absolute must in order to protect everyone involved in the procedure.

Bob Doris: I note that a variety of professionals seek the assurance or comfort of a conscience clause. I mentioned front-line doctors and GP practices as a potential first point of contact for patients, and that is why I started with them. An interesting point has been made about the trust dynamic between doctors and patients.

Is it still the case that many family members have the same GP or the same GP practice? An individual may seek to go down a road that family members may or may not agree with, so I wonder whether there is a trust issue not just between doctors and individuals but also between doctors and the wider family network. I know that things have moved on a lot and that people move between GP practices a lot more, but traditionally families had the same family doctor or GP practice. Does that have any bearing on the issue?

Dr Dunn: The relationship between the patient and the doctor is the prime relationship and nowadays we take a much more positive view. In days gone by, doctors sometimes excluded the patient from discussions about their prognosis and outcome, because they thought that the patient would be affected, but thankfully those days are gone now. Clearly, there is family involvement as the patient dictates, but it is important that the patient decides how much involvement they want their family to have with the general practitioner.

Bob Doris: Does Dr Potts want to come in?

Dr Potts: On a conscience clause in so far as it affects psychiatrists, I represented the college in responding to the End of Life Assistance (Scotland) Bill in 2010, and I surveyed the sub-specialities in psychiatry that might wish to avail themselves of an opt-out or conscience clause. It was important to do so then because that bill built in many requirements or duties for psychiatrists, and two thirds of the psychiatrists who responded said that they would wish to opt out of all or some of the provisions of that bill.

I suspect that if the current bill is passed, a proportion of psychiatrists will also want to opt out. It probably will not be as high as two thirds, but it might well be a substantial proportion and it could be a majority. We would need to poll again to know that.

Bob Doris: There seems to be unity on the panel on having a conscience clause for pharmacists, psychiatrists and GPs. Are there other professionals in the field and on the front line who could come within the scope of a conscience clause? Will the panel give the committee a flavour of the potential extent of such a clause?

Dr Potts: If the person who is seeking assisted suicide is in a palliative care residential placement or on a hospital ward, the nursing staff who are attending to them might wish to avail themselves of a conscience clause. If such a request is made in an institutional setting and nurses are involved, they might ask why they cannot avail themselves of a conscience clause when pharmacists, doctors, psychiatrists and GPs can.

Bob Doris: There might not be any other professionals who would need a conscience clause. Are there any others that you wish to identify, Ms Bryson?

Aileen Bryson: No—off the top of my head, I think that that covers it.

Bob Doris: I have a final question. Mr Harvie said before that people might wish to register with a GP who supports assisted suicide or with one who does not support it—I might be taking that out of context, but I am sure that Mr Harvie will provide clarification. I was concerned by that, because I would like to think that that would not be the overriding factor in someone’s choice of a GP or a particular health practice. The relationship ought to be built on a variety of health needs.

Would you be concerned if people registering with particular GPs on the basis of their ethical views on such matters became a pattern?

Dr Potts: None of us represents GPs, so we would hesitate to speak for them. As a psychiatrist, I am not in a position to express a view on that.

Dr Dunn: It could become an issue, but it is very difficult to know how much of an issue it would be. As you mentioned, people are registered with the family GP from the early stages of their life and many would not want to raise the issue, but if the bill comes in, it could be an issue for some individuals when they register with a GP.

The Convener: You talked about the relationship of trust that exists between patient and doctor. You seemed to indicate that the bill would be likely to alter that relationship. In what way would that relationship be altered? If, as a medical professional, you had a discussion with a patient who brought up the subject, would the approach be described as a therapeutic one or a medical one? In what way would the relationship of trust change? What is the fear or concern?

Dr Dunn: There would be an additional dimension. Doctors are absolutely committed to ensuring the best health for their patients and that, when the time comes for them to die, they have as peaceful and dignified a death as possible. Up until now, the great majority of doctors have been uncomfortable about participating in a process that would lead directly to the patient’s death. That is alien to how we are developed and our careers.

There is also a feeling that if assisted suicide was an option, it could affect other options, such as further development of the palliative care movement. If it had come in 20 years ago, it would have diminished the impetus for the palliative care movement. There are still many further developments that could be made in palliative care, particularly for non-malignant conditions. If assisted suicide were an option on the table, it would not be possible to explore the other options in the same way. That is a real issue.

We have already heard about the developments that are being made in relation to conditions such as quadriplegia, which were previously reckoned to be incurable. Even 70 years ago, there was a feeling that a patient with tuberculous meningitis could be considered for euthanasia because it was believed that there was no way that the condition could ever be anything but fatal and a very uncomfortable way for the patient to die. However, as a result of that option not being available, people started to discover methods of treatment. As I have said, today neurodegenerative conditions are the ones that are creating tremendous interest in research into what can be done about them. That is the other dimension: assisted suicide might reduce the incentive to find better cures and better palliative care treatments.

The Convener: However, as you said yourself, times have changed from the days when the patient was not consulted but the family was. We now have patient choice and empowerment. Why would patient choice to take the road of assisted suicide be contradictory to having good hospice and end-of-life care, given the new relationships that we have between doctors and patients? Patient choice would be the top priority in end-of-life care.

Dr Dunn: Another component is the unpredictability of the situation. Even in relation to malignant conditions, doctors find it difficult to estimate the remaining part of the patient's life and whether the quality of it will continue to be level or will deteriorate further. That is a question for doctors when they give patients advice.

We respect the autonomy of the patient, but there is the greater picture of what impact the decision will have on the greater body of patients. We get tragic individual cases with which everybody sympathises, but whether those cases should lead to a major change for the whole population is a question that doctors find very difficult.

The Convener: I am sorry to press you, but the committee has considered access to new medicines and new drugs. Sometimes there are aggressive treatments whose outcome is uncertain. Sometimes they lead to betterment and sometimes they lead to severe and unpleasant end-of-life situations; it is all uncertain but people are encouraged and are allowed to make the choice to access such medicines. We have a hospice movement of which we are very proud, in Inverclyde and elsewhere, and we might have assisted suicide as part of patient choice. If a patient's choice was to be assisted to end their life, to access new medicines or, indeed, to have palliative care, would doctors not support having all those choices sitting side by side?

Dr Dunn: The issue is the fundamental nature of the decision for a doctor or a facilitator to provide assistance to death. Obviously, the general practitioner or doctors in other environments would have to have a role in that, and a significant proportion—a majority—of the doctors in my organisation find that difficult. As we have emphasised, there are contrasting views, which I respect. Clearly, some people hold the view that they could move to the stage of being a facilitator who could assist, but the majority still feel that that is a bridge too far.

Dr Potts: I will venture a speculative answer to the question. As a psychiatrist, I am not in the front line of those decisions, but I work alongside doctors who are.

Part of the fear in the medical profession is that if they mention the option of assisted suicide or discontinuing life-sustaining treatment, the patient might think, "He's not fighting for me any more. He's not pushing for me. He's given up on me." That is part of the fear of a loss of trust that some doctors might express. I have observed that as a possibility, but I stress that I am not in the front line of those decisions.

Rhoda Grant: I will ask about the 14-day time limit between the second request and the act of committing suicide. I have two concerns. First, why do the witnesses think that that time limit is in the bill? My thoughts are that it has been included because medication is not always available in the community.

Secondly, is there another way of doing it? If a person who had made the second request and had received their medication knew that they had only 14 days to use it before the second request expired, could that time limit force their hand in respect of the decision whether to use it or not?

12:00

Aileen Bryson: As colleagues have suggested, the timing issue is difficult with regard to prognosis and other matters. I understand the difficulty of putting numbers in the bill. If the legislation went down the road of having medication as an option, the likelihood is that that medication would not be readily available in the community and would need to be specially ordered for the individual. It would certainly take a few days to acquire and to be delivered.

We had a working group of pharmacists from right across the sector looking at this issue, and it was felt that 14 days was a fairly reasonable number to plump for, given that the prescriptions would be valid for only 28 days and that any time limit longer than 28 days would require a new prescription to be issued. However, we feel that the bill as it stands does not put enough emphasis on the fact that this is the person's own decision and that they can change their mind at any time. Even if they had made the second request and were in the final 14-day period, they would still be able to change their mind; indeed, the whole premise is that someone can change their mind right up to the very last instant and that the decision is theirs. The issuing of a prescription and entering the final 14-day period do not preclude a change of mind at any point; in fact, there has been some anxiety about that, because that has not been made very clear in the way the bill has been written.

Does that answer your question?

Rhoda Grant: It helps, but what if a prescription lasts 28 days and the person in question, having made their second request, has received it but has decided not to draw it down or is swithering about whether the time is right? If they present the prescription on day 12 or 13, they might discover that it takes three or four days for the medication to arrive and their second request might be cancelled. On the other hand, they might feel that, having made the second request, they need to draw down the prescription right away because the time limit is so tight. The limit might not give them time to reflect on things properly and assess whether or not the time is right.

Aileen Bryson: Part of the reason for developing our policy, which we have submitted to the committee, was to examine what the practicalities would be if the legislation were to be passed, and we thank the committee for recognising that, if the legislation were to go through, pharmacists would play an important role.

Having looked at all the possibilities, we suggested a framework in which there would be a triangular agreement between the medical practitioner, the pharmacist and the facilitator. We took a slightly different tack in suggesting that if a person requested an assisted suicide procedure the medical practitioner would have a conversation with the pharmacist and the prescription would be issued at the beginning of the 14-day period to allow the medication to be acquired. However, there would be conversations, dialogue and close working with professionals to ensure that patients were not put under undue distress.

This would not be a normal prescription in any shape or form—it would be quite different—and we would want to avoid exactly the kind of scenario that you have described of someone presenting with the prescription in the normal way. The procedure in question would have to be quite different, which is why we have also advocated the formation of a professional advisory panel that would produce national guidance and protocols. We would not expect prescribers to do this work alone; we feel that they would need to be supported and that robust procedures would need to be put in place.

I find that when we start to look at this we see more questions than answers. It raises a lot of issues. We have asked for a multidisciplinary professional advisory panel to be written into statute; the details of that could be set out in subsequent regulations, but the panel would be able to look at these kinds of decisions and iron out a suitable national framework.

Dr Potts: I think that there has to be a minimum and maximum time limit, but quite how those limits are set depends on a number of factors. A short minimum will allow those who are deteriorating rapidly and suffering intensely to avail themselves of the possibility if it is there, but it might not allow enough room for the decision to be reviewed and the possibility of somebody changing their mind. On the other hand, a long maximum allows plenty of room for somebody changing their mind and reviewing their decision, but it might mean that somebody whose mental capacity is deteriorating loses capacity and therefore cannot avail themselves of the opportunity.

I do not have a view about a 14-day time limit versus a 28-day time limit but I believe that another European jurisdiction—the Netherlands, I think—has two time limits of 14 days and six days written into its legislation, one of which is for those who are deteriorating rapidly. It might be worth looking at amending the bill in that way.

Colin Keir: The issue of trust was mentioned earlier. I believe that Dr Potts suggested that, if doctors discuss this issue with the person involved, they might be seen as not fighting for patients any more. I would not expect anyone in the palliative care environment to even mention suicide; indeed, I would expect the issue not to come from anyone in the professions but to be discussed when the patient himself had decided that this was the final straw. If he had already received palliative care, he would, I suggest, have gone past the point at which professionals would be fighting for him.

I am trying to get my head around this. Given that these people would have reached what they would see as the point of no return, how would the professionals be letting them down through whatever action they take?

Dr Potts: My point was in response to Mr Doris's question about whether doctors should or should not raise the question of assisted suicide with a patient as one of a number of options.

Colin Keir: Is that not the crux of the matter as far as professional involvement is concerned? I think that the issue has to be raised by the patient. Thinking about the palliative care movement, the trust issues that you have highlighted and people's awareness of assisted suicide, I think that if people are quite happy to go through the end-of-life process in the palliative care system, that is fine, but I suggest that the issue is for them to bring up.

Dr Potts: I tend to agree with you, but I am not sure that that answers Mr Doris's question.

Colin Keir: But if the patient, not the doctor, is determined to bring the issue up, it highlights a different aspect with regard to the issue of trust between professionals and patients.

Dr Dunn: In my medical career, I have frequently heard patients saying, "I've had enough." In my own area of heart disease, patients can have very disabling symptoms, and at times it might seem like the end of the road for them. If a patient were to say as much, we would, if the bill were to come in, have to explore the matter with them. At the moment, that option is not available, which means that we have to explore others, and on many occasions—indeed, in the vast majority of situations—we can make the patient comfortable and give them a continuing quality of life. Interestingly, quite a significant percentage of the "Do not resuscitate" notices that patients put on themselves are reversed as time goes on and they see the effects of treatment kicking in. It is important to understand when patients have had enough, but at the moment they have the opportunity to review that and there is concern within the profession that, if assisted suicide were to be brought in, that option might not be explored as thoroughly as it is at the moment.

Aileen Bryson: On the subject of professional trust, our group included palliative care specialist pharmacists, who were adamant that the two procedures are completely different and that there is a conflict of interests. The procedure for palliative care and established end-of-life pathways is totally separate from, and should not be confused with, an assisted suicide procedure. We feel strongly that patients should always be given information about all the palliative care options that are available to them. I agree with my colleague that people are sometimes not aware of even some quite simple options.

My understanding is that some people who register with Dignitas have simple inquiries that we would say are pharmaceutical care issues that should be dealt with, and when those inquiries are explored and dealt with, the patient does not then request an assisted suicide procedure. That happens often and it highlights what was mentioned before—the need to resource palliative care adequately across the country, to have it across the different therapeutic areas and to have equity of access. The committee might want to explore more about that when it speaks to the palliative care specialists in a few weeks.

I agree that there are two completely separate pathways. The hospice pharmacists and palliative care specialist pharmacists did not want to have their roles confused with an assisted suicide procedure because they felt that that would take away patients' trust.

Dennis Robertson: A comment was made about when patients say, "I've had enough. It's the end of the line and I can't cope with this any more," and with their agreement, a DNR goes ahead. In how many cases do people change their minds? Whether it is the individual or the families or carers that go through the discussion, are we aware of how many people opt out of the DNR choice once they have made it?

Dr Dunn: Studies—mainly from the United States—suggest something around the 30 per cent mark, I think. I would have to check that as I last looked at it a number of years ago.

The DNR is a different situation altogether and it is one in which we would support the patient. In the vast majority of cases, the decision is appropriate, but people can decide—for whatever reason—that they want the DNR to be lifted. If their carers feel that that is appropriate, that is what would happen.

Dennis Robertson: Under a DNR, there is probably still the possibility of making a patient comfortable and continuing their life, whatever its quality. I am not trying to establish a parallel with ending a life through assisted suicide, but it strikes me that patients already make decisions not to continue their life, and those decisions are respected by the medical profession. Is not that the case?

Dr Dunn: There are situations in which the patient may want to reverse the decision, but the ultimate decision in that regard would be for the medical professionals. If, for example, a patient said, "I want to go on a ventilator whatever happens here," we would have to counsel them and advise them that, given their situation, that would not improve their quality of life or give them a better outcome. In that situation, the professional would have to make a decision, with the patient and their family, as always, so that the DNR order would be appropriate.

The Convener: Patrick Harvie wants to come in on this point. I will then call Richard Simpson on the capacity issue that he raised with the first panel.

Patrick Harvie: Like other members, I am keen to explore the question of trust. Dr Dunn began by talking about a trust relationship in the context of describing assisted suicide as a "new concept". I suggest that it is not and that it goes beyond the fact that medical professionals might, as you say, have excluded patients from decisions. It might not have been legislated for in days gone by, but there is good historical evidence that it has been fairly common practice for doctors to decide when was the right time to end someone's life and to administer a dose of medication with that intention. With this proposed legislation, we are continuing a trend away from the authoritarian approach in which an authority figure imposes decisions on individuals, and towards empowerment and the ability for individuals to make their own choices. Is that not the basis of a healthier trust relationship?

The bill includes the mechanism of the preliminary declaration, which a person might lodge in their medical records at any time in their life, perhaps when they are fit and well and do not anticipate an imminent need to make a request for assistance. A person's ability to have that conversation with the doctor about their general attitude to questions of life and death could surely give rise to a stronger trust relationship between patient and doctor in which the patient knows that the doctor understands and respects their approach to such questions.

12:15

Dr Dunn: Yes. When I said that assisted dying is a new concept, I meant that if the bill were to be passed, doctors would have a new issue in dealing with patients. You are absolutely right that the issue has been around for many years; I cited the fact that euthanasia was discussed in the early part of the 20th century. It is not a new issue.

I take the point about the importance of patient autonomy and the fact that, in days gone by, doctors hid information from patients—even about things such as their blood pressure.

The issue is fundamental for many people in the profession because it is about assisting the process of ending the patient's life, which is a difficult concept for many doctors. Many of us feel that pursuing other avenues, such as palliative care, is the way forward and that the bill would diminish the chances of that. There are other issues, such as the fact that even extremely disabled patients can be huge contributors, through continuation of their lives, not just for themselves but for their families and the wider world. There is an issue about that contribution and the fact that patients can reflect and decide that they are glad that they did not take the decision to end their life because of the contribution that they have made. We know of many examples of that among people who have motor neurone disease. People who have such conditions have, towards the end of their lives, made huge contributions to society through their attitude to their life-ending condition. That door would be closed if there was widespread introduction of assisted suicide.

Patrick Harvie: I agree with your comments about the positive contribution that people make to society as well as to their families' lives. I suspect that everybody would agree with that, although it has to happen on people's own terms.

You have again suggested that the introduction of assisted suicide would lead to a diminution of palliative care. What evidence do you have for that? A significant body of research—I can provide the committee with research references if that would be helpful—demonstrates that in jurisdictions that have a form of legalised assisted suicide, we do not see that; we see the opposite. Since such legislation was passed in Belgium and the Netherlands, investment in palliative care has increased. There is also evidence that demonstrates the high quality of palliative care in Oregon compared with its neighbours, and that the use of assisted dying legislation is relatively low.

We are not talking about a large number of people; it is expected that a relatively small number of people would take up the option. That also slightly conflicts with your suggestion that we would see a reduction in research into treatment or cures.

Dr Dunn: That is the concern. If we take the example of intractable pain or nausea, and if there is an option to relieve that pain through assisted suicide, the incentive to try other measures to control that pain would be diminished.

Patrick Harvie: Is there evidence that that has happened in other jurisdictions?

Dr Dunn: It is difficult to get that evidence because we do not have the option of not pursuing palliative care. At the moment, the palliative care team is doing everything that it can to further develop methods of controlling pain.

Patrick Harvie: There is strong evidence that, in jurisdictions that have a form of assisted suicide, we actually see an increase in investment in palliative care and other alternatives, and not a reduction.

Dr Dunn: Do we know that that investment includes those intractable issues? That is the thing that we would need to look at.

Patrick Harvie: I see no reason to imagine that the investment would not include those issues. There is a high level of palliative care provision in Oregon and there has been an increase in investment in and provision of palliative care in Belgium and the Netherlands. Those are some of the jurisdictions that we cite most regularly as comparators.

Dr Dunn: The palliative care movement worldwide is being invested in, so it is difficult to know what the relationship is between that investment and the situation in those three particular constituencies.

The Convener: We will have representatives from the palliative care movement at future evidence sessions, so we will be able to explore that issue further.

Dr Simpson: Cognitive impairment and capacity is a difficult area. I gather from what Dr Potts is saying that his members may be relieved that the psychiatrist's assessment that was specifically required by the previous bill is not required under the bill that we are considering. However, my concern would be about whether all my colleagues in general practice would have the ability, in those delicate circumstances, to assess mental capacity, and whether the matter needs some more specific determination involving either a lawyer or a medical practitioner with specific qualifications, such as those that are required for detention under mental health legislation. To sign detention orders under those acts, one is required to be registered for that purpose. I want to explore the matter a little further, because cognition seems to me to be hugely important in determining whether individuals may be vulnerable in ways that mean that they would not make appropriate determinations.

Dr Potts: You are right to say that my colleagues and I are relieved to be relieved of the potential burden of deciding on capacity routinely in all cases. We accept that we may well be involved in assessing capacity in a subset of cases.

The best way to answer the point is by reference to the renal units up and down the country. They have large numbers of people on dialysis, only a small proportion of whom will decide that they have had enough of dialysis and want to stop. They do so in the full knowledge that they will die within a matter of weeks or, perhaps, days afterwards. Renal physicians are in the main very capable of assessing patients' capacity, but if there is a question of cognitive impairment or lowering of mood, or if there is a history of psychotic symptoms, they may well call in psychiatrists to assist with the assessment of capacity and, therefore, with the decision making.

That is the model that I and my colleagues would have in mind for the bill, if it is passed. We would expect to be involved in a proportion of cases. It is hard to judge how many, but we would not expect to be involved as a matter of routine in all cases in which there is no question of mental disorder or impaired cognition, even though the result of such decisions would, by definition, be fatal, as with decisions to withdraw dialysis.

Dr Simpson: That is very helpful.

Dr Dunn: Such questions take us into a delicate area in which palliative care physicians clearly have the expertise. It may well be that many general practitioners do not have that level of expertise, but the onus will in many situations fall on them, at the end of the day. The question is whether we have enough individuals to deal with that; there would need to be specific training for primary care doctors so that they could enter into discussions on palliative care. I know from my specialty that cardiologists' abilities in palliative care were weak before we spoke to palliative care doctors and learned all that can be done to relieve patients' symptoms. In cases involving non-malignant conditions, cardiologists can now provide expertise that they did not previously have. It has become evident that there is a real art in the whole palliative care environment.

Rhoda Grant: I return to a question that was raised earlier. When people who are losing physical capacity and suffering from difficult conditions say, "I've had enough," what assessment could be done, under the bill, to show that they have options, if the right support and palliative care or new treatments are available? All such patients may become sick and fed up of their condition, but if they were allowed to pursue an assisted suicide rather than explore options, how would you stop them falling through the net? I am thinking of people who are depressed by their condition; people who are getting older get depressed because they know that their strength will not return and that they will continue to decline. How can GPs and other doctors make that assessment and determine whether it is a passing phase in coming to terms with an illness or with declining abilities, rather than an opinion that the patient will continue to hold?

Dr Potts: That is the everyday work of psychiatrists in the liaison psychiatry specialty in a general hospital. They try to help patients and treating doctors to come to a judgment about whether such as opinion is a passing phase or a settled view. It is not easy; it is not an exact science, and we will get it wrong.

In preparation for this meeting, I reviewed case records from my department over the past 10 years or so. During that time, 25,000 to 30,000 cases were referred to us; in only two was part of the referral an explicit request for assisted suicide—at a time, obviously, when it was not legal. In both cases, the patients were seriously ill. Both would have qualified for assisted suicide under the terms of the bill, and both had depressive illnesses. However, after assessment, we were as clear as we could be that their depression was not influencing their decision making. If assisted suicide had been available at the time, they would have availed themselves of it.

That assessment is not easy, and it takes time and consultation with others, but it would follow as the clinical work that would be required if the bill were to be passed, and we would have to develop our skills further, in accepting Parliament's will, for the benefit of the patients whom we are trying to help.

Bob Doris: Having heard some of those answers, I wonder about the relationship between the doctor and the patient, which could be affected by a number of factors besides the mental state of the patient. For example, palliative care frameworks could be better in one part of the country than in another, or for one condition compared with another. Some individuals' pharmaceutical management may be better than others', and the social care that local authorities provide could vary. Are there concerns that the likelihood of some individuals seeking assisted suicide may be determined by social factors such as the quality of care provision or the level of investment in palliative care for life-limiting or terminal conditions?

Dr Dunn: That is a fair question. I am sure that there are differences throughout the country on all those issues. The patients who are best looked after and who have access to optimal palliative care are obviously the ones who are likely to continue down that road. Patients who do not have access to such care would be more discouraged and might consider assisted suicide, if that were available. That emphasises the importance of services being equal throughout the country. I know that we are all aiming for that, but I agree that such factors could well influence patients' decisions.

Bob Doris: I have another supplementary question relating to whether a psychiatrist should determine capacity on every occasion or on some occasions. A witness on the previous panel suggested that there could be a legal necessity at the first stage for a psychiatrist to make a determination. Whether Dr Potts thinks that it is always necessary or desirable, in legal terms it might or might not be required.

I am also thinking about the proposed law being challenged when doctors do not refer patients for a psychiatric assessment and their family members or others seek to challenge the validity of the decision when the patient goes ahead with an assisted suicide. I take on board the points that you make, Dr Potts, but are there any concerns about protecting your profession or protecting doctors who do not make referrals for psychiatric assessment?

12:30

Dr Potts: There does not need to be automatic recourse to psychiatric assessment at any stage, but the doctors must have it available for their patients at every stage.

It is probably better for a lawyer to comment on whether a decision is open to legal challenge. At the moment, when a patient says, "I want to stop dialysis," and their doctor agrees, we do not have a concern that that decision is open to legal challenge. We do not require that doctor always to refer every such patient to a psychiatrist.

Probably half of the patients in my hospital who are in that condition do not get referred to my department and I accept that. I do not see any reason clinically—and with an amateur's understanding of the law—why it would be necessary to make such referral automatic.

The Convener: Would changing the law make it more likely that people who are caught within that process, such as the GP or other medical persons who are involved, would seek that reassurance to ensure that they would not be held liable in the future? I suppose that that was what was being said this morning.

Dr Potts: In advance of legislation, a code of practice and the idea being seen to work, it is hard to know what proportion of cases would trigger a referral to psychiatry. I suspect that cautious GPs and doctors would refer quite a high proportion of patients. If the practice is bedded in, that proportion might go down over time but that is pure speculation on my part.

The Convener: Yes, but there is a high level of anxiety among the professions about capacity.

Dr Potts: I would expect a psychiatric referral for any person who requests assisted suicide when they appear to be significantly depressed at the time, if there is a history of depression, if there is evidence of cognitive impairment, and if they are on antidepressants or antipsychotic drugs. That might account for most people but not automatically for everybody.

The Convener: You would not want there to be a blanket ban on people who have mental health problems getting access to the law, if the bill becomes law.

Dr Potts: The difficulty there is potentially significant. My psychiatric colleagues will have the everyday experience of seeing people who have depressive illnesses saying things like, "My life is intolerable. I can't go on. I would be better off dead. Please let me die." I am talking about people who do not have qualifying physical conditions and the everyday job of psychiatrists is to treat such people, sometimes against their will, under mental health legislation, in the full expectation that they will recover from the episode as they have recovered from all their previous episodes.

If psychiatrists are asked in those circumstances to enforce treatment on people who have depressive illnesses, and to essentially authorise assisted suicide in other cases when the patient has a physical disorder, that would be an acute dilemma and I do not know how the profession would resolve it. I am prepared to assist in that process if the legislation is passed and a code of practice needs to be written, but it might need some time.

The Convener: Do you all believe that there needs to be enhancement of the protection?

Dr Potts: A lot would depend on the code of practice. I and my college are undecided about whether it would be necessary to build protections into statute.

Dr Dunn: That is a huge dilemma, particularly for colleagues who have patients who have major psychotic illnesses and have to be treated against their will. We are preventing those patients from taking their own lives but, in other situations, we would be asked to assist in the process. That is part of our dilemma.

The Convener: As there are no other questions from committee members at this point, I will give Patrick Harvie the opportunity to ask some questions before we close the meeting.

Patrick Harvie: I am grateful, convener. I will pick up on your last point, Dr Potts. I assume that you would acknowledge that there could be many patients with a diagnosis of mental illness and a history of episodes that have not recurred for some considerable time. If the Parliament was to agree the principle of legislation in this area, such circumstances would mean that a blanket ban on patients with mental illness in general would not be appropriate.

Dr Potts: It would be unsustainable and inappropriate.

Patrick Harvie: Evidence from jurisdictions such as Oregon shows that under the Death with Dignity Act 1997, a high proportion of people who acquire a prescription for a lethal dose of medication with the intention of taking it, should they reach that point, do not do so. In other jurisdictions the experience is that people knowing that they have the option helps them to face the experience that they are going through. Do you recognise that evidence?

Dr Potts: I am familiar with that evidence and I recognise it.

Patrick Harvie: I ask Dr Dunn to reflect on the argument that, for some patients, should they reach that point, knowing that they have the option to ask for assistance benefits them and helps them to deal with the experience that they are going through.

Dr Dunn: If patients let us know that that helps them to get through the process, it will have to be acknowledged. It is just a question of balancing that against those who make the decision. We will never know whether they reflected on it or not. I certainly acknowledge that such evidence exists and having the choice, if they are faced with it, helps some people to say that it is not the route for them.

Patrick Harvie: Thank you. I want to pick up on the point that Bob Doris made about social factors and circumstances and look at the bill’s definition of a life-shortening condition. Should a condition itself be required to lead to the shortening of somebody’s life expectancy, or should the social circumstances, such as the discrimination that they might encounter or the likelihood that they will have to live in poverty or be unable to work, be considered? There is a distinction to be made between whether the condition directly shortens somebody’s life or whether it is associated with social circumstances that might have the same effect. Would a slightly clearer definition be helpful in determining which conditions meet that test?

Dr Dunn: It is all part of a package. How a patient responds to an illness will depend on the support they receive, their social circumstances and many other factors. It is difficult to focus purely on the condition. It is about the whole support network in which the patient finds themselves and how they cope with it. The coping strategies that they have formed down the years might be influenced by that support. The disease is at the centre of the issue but all those other factors will play a part in the patient’s decision-making.

Dr Potts: It is well recognised that it is life-shortening to live in certain deprived areas in Scotland. Few people of my age and older will not have at least one life-shortening condition, whether it be diabetes, hypertension, asthma, emphysema or, indeed, depression. That means that the term “life-shortening” is drawn so broadly that it will be difficult for it to work in the bill. The definition needs to be tightened and revised.

Patrick Harvie: Presumably it is open to amendment; the definition could be tightened.

Dr Potts: I hesitate to answer that without having tried to do so.

Patrick Harvie: I hope that we will get to that point.

Finally, Aileen Bryson mentioned time limits and talked about whether other jurisdictions might have two different time limits for different circumstances. The Assisted Dying Bill that is under consideration in the House of Lords includes the option to accelerate the timescale so that it could be shorter in certain appropriate circumstances, perhaps because of an individual patient’s prognosis. Is that the kind of approach that you seek from the bill?

Aileen Bryson: I think it was Dr Dunn who mentioned that. I talked in general about the difficulty of putting numbers into the bill but I was talking about practicalities and prescriptions. Dr Dunn mentioned the Netherlands and the six days.

Patrick Harvie: I beg your pardon. Does anyone want to respond on the point about the Assisted Dying Bill setting out a timescale but then defining circumstances in which it could be accelerated? Is that what you are seeking in the bill?

Dr Potts: I am not seeking anything in the bill. I am just pointing out a comparison with other jurisdictions where that is a provision and I think I understand the reasons why it is a provision. The question therefore needs to be raised about whether it is worth amending the bill to incorporate it.

Patrick Harvie: Thank you.

The Convener: Thank you, and I thank all the witnesses who have attended this morning. Your written evidence is also appreciated. Thank you for giving us your valuable time.

12:41

Meeting continued in private until 12:55.

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e-format first available
ISBN 978-1-78534-682-8

Revised e-format available
ISBN 978-1-78534-701-6

Printed in Scotland by APS Group Scotland