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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 20 January 2015

Session 4

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HEALTH AND SPORT COMMITTEE
2nd 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:

Graeme Dey (Angus South) (SNP) (Committee Substitute)
Patrick Harvie (Glasgow) (Green)
Professor David Albert Jones (Anscombe Bioethics Centre)
Professor Graeme Laurie (University of Edinburgh)
Dr Calum MacKellar (Scottish Council on Human Bioethics)
Robert Preston (Living and Dying Well)
Dr Stephen Smith (University of Birmingham)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Health and Sport Committee

Tuesday 20 January 2015

[The Convener opened the meeting at 09:48]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning, and welcome to the second meeting of the Health and Sport Committee in 2015. I ask everyone in the room to switch off mobile phones, because they sometimes interfere with the sound system. You will note, however, that some committee members and clerks are using tablets instead of hard copies of our papers.

I have received apologies from Richard Lyle. I welcome back Graeme Dey as a Scottish National Party substitute. I have also received apologies from Richard Simpson, who unavoidably cannot be here this morning. Patrick Harvie joins us for agenda item 3 and I welcome him.

The first item on the agenda today is a decision on taking an item in private. I invite the committee to agree to take in private item 5, which is consideration of our work programme, which we would normally take in private. Is the committee agreed on that?

Members *indicated agreement.*

Subordinate Legislation

Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2014 (SSI 2014/374)

09:49

The Convener: Agenda item 2 is subordinate legislation. We have one negative instrument before us today. There has been no motion to annul, and the Delegated Powers and Law Reform Committee has not made any comments on the order.

I do not see any committee member wishing to make comments on the order. Does the committee therefore agree to make no recommendations?

Members *indicated agreement.*

Assisted Suicide (Scotland) Bill: Stage 1

09:50

The Convener: We move to agenda item 3, under which we continue our stage 1 scrutiny of the Assisted Suicide (Scotland) Bill. This morning, we have a round-table discussion on ethical issues. As usual with round-table discussions, I invite the witnesses and committee members to introduce themselves.

To my right is Dr Mary Neal, the committee's adviser on the bill.

Bob Doris (Glasgow) (SNP): I am deputy convener of the committee.

Robert Preston (Living and Dying Well): I am director of the think tank Living and Dying Well.

Mike MacKenzie (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands region.

Professor David Albert Jones (Anscombe Bioethics Centre): I am director of the Anscombe Bioethics Centre.

Dennis Robertson (Aberdeenshire West) (SNP): I am the SNP member for Aberdeenshire West.

Dr Calum MacKellar (Scottish Council on Human Bioethics): I am the director of research at the Scottish Council on Human Bioethics.

Colin Keir (Edinburgh Western) (SNP): I am the MSP for Edinburgh Western.

Dr Stephen Smith (University of Birmingham): I am a lecturer in law at the University of Birmingham.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Graeme Dey (Angus South) (SNP): I am the MSP for Angus South.

Professor Graeme Laurie (University of Edinburgh): Good morning. I am from the Edinburgh law school.

Rhoda Grant (Highlands and Islands) (Lab): I am an MSP for the Highlands and Islands.

Patrick Harvie (Glasgow) (Green): I am an MSP for Glasgow, and I am the member in charge of the bill.

The Convener: I am Duncan McNeil, MSP for Greenock and Inverclyde and convener of the Health and Sport Committee.

I should point out that Professor Sheila McLean was unable to be here this morning but we are hopeful that she will participate at some future stage.

I ask Bob Doris to kick us off with some general questions, please, which I hope will encourage the participation of the panellists.

Bob Doris: I will indeed keep this question deliberately general, although I might come back in later with some specific questions about the bill.

Among the themes running through our briefings in preparation for today's evidence session were: how we determine autonomy or independence for the individual within society and the choices that individuals make; the balance between those individual freedoms and choices and the role of the state in protecting people; whether any individual can be truly autonomous and free from family or financial pressures in respect of their treatment choices; people's autonomy to make a full choice based on the treatment options available; and the level of palliative care. The question is where the individual sits in exercising what would be their rights in the bill to autonomy, or whether interference, intervention or protection by the state in relation to the individual are reasonable. There are constraints on autonomy and freedoms, which seem to be central to the ethical issues.

It would be helpful if we could hear some initial thoughts on those themes before we start to consider the details and the framework in the bill. I have deliberately not used the word "moral", but I appreciate that, for many people, moral considerations will be a factor.

Professor Laurie: Thank you very much for the question. It is crucial to ask what it means to take an autonomy approach to assisted dying. The existing legal and ethical framework in Scotland and in the wider European context is very much centred on the respect agenda and the notion that individuals are autonomous and have the right to self-determine.

Back in 2002, in the case of Diane Pretty, the European Court of Human Rights recognised that decisions about when and how to die engage people's human rights. The onus is on the state to show why it must interfere in those and it must be able to demonstrate that it is necessary and proportionate for it to do so. For example, in the Pretty case, the United Kingdom Government was able to argue that it was necessary and proportionate in order to protect vulnerable persons.

The important issue for Scotland is that the onus is on the Scottish state to justify its current position. We do not have the Suicide Act 1961, for example. The legal position with respect to assisted dying is not clear. Scotland will have to take a decision one way or the other on how it approaches assisted dying.

If Scotland were to move forward with a bill such as the one that we are discussing, protection of the autonomous nature of the decision is absolutely crucial. The safeguards that are in place—the three-step approach—are helpful, but arguably the approach might be too onerous. Might the first stage—the idea of having to make a declaration and then two subsequent requests—be too much to ask of an individual? The fact that medical colleagues would be involved in assessing capacity is important, but we would also want to ensure that the definition of capacity is the same as we find in other legislation in Scotland so that we are not dealing with two different systems for assessing autonomy.

Finally, if the bill goes forward, I would like to see in it a provision that makes it clear that if somebody is subject to undue coercion from a family member or somebody else with a financial interest, that will be the subject of a criminal prosecution in due course. That is not currently a feature of the bill.

Robert Preston: No one can be truly autonomous in a society unless they live on a desert island. The autonomy of the individual has to be balanced against the rights of other people, not necessarily the majority.

That brings the question down very much to one of safeguards. If one is to license certain people in certain circumstances to assist the suicide of other people, other people have to be protected. At once, that brings the debate on to the question of safeguards. The bill is quite conspicuously lacking in any serious safeguards—it is very long on bureaucracy, but quite short on safeguards. For example, a lot of form filling and witnessing of form filling are needed, and two doctors have to be of the opinion that, to the best of their knowledge, certain conditions apply, but no processes are prescribed that those doctors have to go through to establish as objectively as they can whether those robust safeguards are in place. The bill is full of aspirations on that, but it does not prescribe any processes to ensure that the safeguards are met.

Professor Jones: On the autonomy question, in thinking about assisted suicide, it is important to think about the assisting, which is what we are dealing with; we are not dealing with the question of suicide. This is not a discussion about the legality of suicide; it is a discussion about the legality of assisting suicide. Therefore, it is not simply about the autonomy of the individual; it is about the responsibilities of someone who is not that individual towards the individual and their decision-making process.

We are talking about somebody going to somebody else with a suicidal request and how that person responds to that, and the implications of how people are responded to more generally. Therefore, the issue is already outside the individual. We have already moved from the individual to thinking in general, “If a person responds to a person in this way and to another person in another way, why have they responded differently and what are the implications for society generally of how they respond?” The bill is about the assisting person and about legalising something that the assisting person could do. Therefore, if we are talking about autonomy, it is the autonomy of the assister that is in question and whether they should have the right to assist somebody else to kill themselves. That is what we are dealing with.

The right to assist somebody else to kill themselves is already relational. The move to the relational is not artificial; it is already there. The question to ask is: what are the decision-making processes that people must go through in assessing that, in these circumstances, it is unreasonable for someone to want to kill themselves and we should adopt a suicide prevention strategy and choose life and, in those circumstances, it is reasonable for someone to want to end their life and so assistance will take a different form? It is not about what the individual is doing; it is about what the assister is doing, and that has implications for society and what it is doing and the values that it puts on different people. Therefore, we have already gone beyond autonomy.

10:00

Dr MacKellar: In medical ethics and medical law, we spend a lot of our time trying to defend the autonomy of patients. We do that in biomedical research, surgery and so on. We try to ensure that the person knows what is happening and can make decisions for themselves.

However, there are some very rare cases in which autonomy cannot go first. For example, a person could never sell themselves into slavery, even in Scotland. I believe that assisted suicide is one of the cases in which autonomy must go second to the whole concept of inherent human dignity. A person cannot sell themselves into slavery because of inherent human dignity.

In my submission to the committee, I talked a lot about inherent human dignity—that is, the inherent value, worth and meaning of life. When a society starts to say that certain persons may no longer have that value, worth and meaning in life, that we accept, as part of society, that assisted suicide should take place and that the Scottish Parliament should accept that there are certain persons in

Scotland who no longer have that meaning, value and worth, that undermines the whole concept of inherent human dignity, which is the very basis of our civilised society and of the Scottish Parliament.

There are some very rare cases in which autonomy undermines the whole concept of inherent human dignity, which is when things become dangerous for a civilised society.

Dr Smith: I want to take us back to the original question, which used the word "truly". Can somebody be truly and completely autonomous? We have to take a step back and look at the matter.

Autonomy is not about the atomistic idea that people get to choose for themselves and nobody else has any say. No autonomous decision works in that way. An autonomous decision cannot be made in that way; there are always influences on our lives, whether from people talking to us, friends and family, or financial implications. There are always issues that affect whatever decision we make. We do not make decisions unfettered from everything around us.

If we are going to talk about this being an autonomous decision, we need to be clear that an individual does not act alone, separate from the rest of society—individuals do not act in that way. Therefore, when we talk about autonomy, we generally mean authorship—the notion that our life is our own and that a person gets to decide how their life operates and to make the decisions that are important to them given how they see the world and their place in it. I do not think that that is different from or in conflict with the notion of dignity that Dr MacKellar presented, and I certainly do not think that it is in conflict with it in this particular case.

On the notion of inherent human dignity—if there is such a thing; I am generally a sceptic about the notion of dignity to begin with—the idea is that we all matter because we are all individuals and that people get some authorship, but we do not expect everybody to act in lockstep in the same way. If we did that, that would not respect dignity and autonomy.

Therefore, the two notions of dignity and autonomy are not necessarily in conflict, and I am not convinced that they are in conflict in this particular case for that reason. The idea that we have some inherent human dignity seems to me to be based on the notion that we are the authors of our own lives. If you have ever read a book, seen a movie or watched a play, you will know that the ending matters. There are sometimes really good books or movies in which the whole thing falls apart in the final 10 minutes. We say, "Oh, man. That was a bad movie," but it was not a bad movie because of anything other than the final 10 minutes. Therefore, endings matter—they matter to the story and for authorship in the way that the rest of the story does. A bad ending is just as bad as a bad beginning.

If we are talking about autonomy and dignity, we have to see autonomy less in atomistic terms and more in terms of authorship.

The Convener: Thank you for that. I think that some of the panel members are anxious to get back in.

Robert Preston: If autonomy is the bill's driving force, one is entitled to ask why it is restricted to assisted suicide. What about the autonomy of people who are unable to take their own lives, even when they are supplied with lethal drugs? Why are we having this restrictive form of autonomy?

We have to consider the legislation's impact on social attitudes, which have a very strong connection with ethics. As a society, we treat people who attempt suicide with understanding and compassion, but we do not regard suicide as something to be encouraged or assisted. That is why we have suicide watches for those who are considered to be at risk of harm, and why we attempt to resuscitate attempted suicides and have all the suicide prevention strategies that successive Governments north and south of the border have introduced.

We also have to look at another aspect. The trouble with the focus on autonomy is that it tends to present the law as something that tries to stop you doing what you have a right to do. The purpose of a law that restrains us from assisting other people's suicide is to protect vulnerable people. A law that says that people with certain medical conditions may be given assistance with suicide might have been framed with the best and most altruistic intentions in mind—indeed, I am sure that such intentions lie behind this bill—but, in effect, it is saying that the protection that is given by the law should be different for those who have certain medical conditions. It could be argued that such a law could very well send the message that the law offers less protection to those who are chronically or terminally ill than to those who are not chronically or terminally ill.

Dr MacKellar: Coming back to Dr Smith's point about the link between autonomy and inherent human dignity, I believe that inherent human dignity cannot be restricted just to autonomy. I was originally a scientist and know that, from a scientific perspective, everyone here is nothing but a pile of biological cells. That is all that we are, and it is all that we can prove that we are.

However, each of us believes that we are more than that and that we have value and worth. That is not down to autonomy; it is because each of us believes that we have value and worth that we respect the autonomy of others. In the history of humankind, there have been certain persons who had full autonomy but to whom the state refused to give value and worth. Autonomy cannot be the basis of inherent human dignity; it is only because of inherent human dignity that we respect the autonomy of others.

That view is reflected in the European convention on human rights, article 2 of which talks about the worth and value of life as the reason why it should be protected and respected. It is only later on, in article 8, that the concept of private life and autonomy comes in.

I understand that, for a lot of people, the concept of inherent human dignity is extremely difficult to determine. There is no definition of the phrase in the Council of Europe, which is responsible for the European Court of Human Rights; in fact, there is no definition of human being in the Scottish Parliament or at Westminster. However, we all agree—and we must all agree, even though we cannot prove it—that we all have this inherent human dignity, which is the basis of our all having equal rights, equal value and equal worth.

Autonomy goes up and down with the person. Some people in Scottish society have a lot less autonomy than others, and there are some who have a lot less quality of life than others, but they have equal value, equal worth and equal meaning in life. That is based on inherent human dignity.

Dr Smith: I am not sure that I ever said that dignity and autonomy were the same thing; I said that in this particular case dignity and autonomy were linked.

Again, I am a sceptic about the notion of dignity to begin with, but I am happy to accept that, whatever it is that we mean by dignity, it is separate from whatever it is we mean by autonomy.

Dr MacKellar: I agree.

Dr Smith: That is fine, but it does not mean that in this particular instance the two notions are not linked. Linking and connecting them and, in some sense, making them mutually supportive, which I think they are in this case, is in no way an indication that they are the same thing.

The notion that we are all individuals and that we all have individual moral worth is fine, and I am happy to accept it, but it exists because we allow people to make decisions, at least in part. I am not convinced that being able to take away decisions from people and say to them, “Well, in this particular instance, we do not like your decision so we’re not going to allow you to make it,” is, in fact, representative of the notion that we are all individuals and we all have inherent moral worth. People make decisions that we do not like all the time and, as a consequence, we have to accept that the whole reason why we have a society is to allow people to make decisions that we do not agree with.

The Convener: I see that another couple of panel members want to speak. I must thank everyone for their full participation in this discussion—the MSPs can get the morning off. [*Laughter*.]

Professor Laurie: Following up on the discussion about the relationship—or not—between autonomy and dignity, I remind the committee that the previous version of the bill referred to dignity. I was one of the people who argued very strongly against that, because I thought that it gave rise to exactly this kind of confusion. I just do not think that it is helpful as a legislative device; in fact, I think that it is problematic. One of the advances that have been made in this version of the bill is its focus on the notion of autonomy. It is exploring the issue—and it is inviting Scottish society to explore the issue—as an aspect of the respect agenda; it is all about the choices made by individuals who are able to make those choices.

Of course, if the bill is about autonomy, another question that arises is who qualifies. At the moment, the bill focuses on life-shortening and terminal conditions. What about people who are in excruciating pain but whose life is not being shortened as a result? That is a very good question, but it does not have to be addressed in the first iteration of any legislation that is passed. One thing that I would argue very strongly for—and our institute has said as much in its submission—is the need for regular review. Arguably, there should be a periodic, three-yearly review, which would ask exactly that question of whether the notion of autonomy that is being embodied in law is appropriately inclusive. Political expediency suggests that you have to be cautious at this first stage, and I think that that is what the bill represents.

Professor Jones: I agree, albeit with some qualifications, with what Dr Smith and Professor Laurie have said in their submissions and in their evidence this morning.

One thing that is argued very well in the J Kenyon Mason institute for medicine, life sciences and law submission relates to the consistency of making the provisions in the legislation open only to those who are over 16 and not to those who are under 16. That could be open to legal challenge. You should not believe that, if the Parliament decides to pass the bill, what the bill sets out is what will actually happen, given the legal challenges that will come. That is because of the consistency of the law and the logic of the bill. If the bill applies to people in a particular category and it is based on a right, it is logical to ask why mature minors are excluded from exercising that right. I think that the approach is unsustainable, and it is worth looking not just at the bill but at the bill's logical implications and what might come further down the line.

With regard to mature minors, I draw people's attention to Belgium, which in 2002 legalised a form of assisted dying—it was euthanasia, so it was not exactly the form of assisted dying set out in this bill—for those over 16. In 2013, it extended the law to minors with no lower age limits, precisely because of the arguments that I have highlighted.

I also note that, in her policy memorandum to the previous bill, Margo MacDonald said that she hoped that there would be a chance to revisit this issue after people's experience of the legislation, and Professor Laurie, too, has indicated the need for review. If you are at all concerned about some of the bill's underlying principles, it is worth thinking not just about what is on the face of the bill but about what is logically connected to that and what will come further down the line. It is what follows that is actually what the Parliament is voting for.

I completely agree that it is important to make decisions in life, that the end of life is very important to people, and that people should be involved in the decisions that they make. That is true throughout life and it is true at the end of life. I also agree with Dr Smith's submission that it is sometimes useful to consider assisted suicide in relation to other end-of-life decisions. However, with regard to those decisions, although we have a right to refuse interventions, we do not have a right to demand interventions irrespective of what the medical establishment or society thinks or what a particular doctor thinks would be beneficial in a specific instance. We therefore do not have full autonomy in relation to those decisions; we have restricted autonomy with regard to both what we do and what people do with, for and around us. Again, it is not just about my decisions—I have a right to make my own decisions—but about other people's decisions in respect of me, and the logic of that.

10:15

The Convener: Do you want back in, Dr MacKellar?

Dr MacKellar: Yes, just to say a few words.

Down in London, the Human Fertilisation and Embryology Authority, which regulates everything relating to human embryology, regularly has horizon-scanning sessions that it defines as systematic examinations of information to identify potential threats and risks, and emerging issues and opportunities. Maybe we could have a horizon-scanning session in this area to look at what will happen in future if the bill is enacted.

The bill is based on three principles: autonomy, quality of life and dignity. At the moment, the bill is restricted to persons whose lives are ending. However, on the basis of autonomy, a person who is tired of life should, rationally, also be able to end their life. That is already happening in the Netherlands: people who are tired of life are, on the basis of autonomy, accessing euthanasia—not many are doing so, but a few are. On the basis of quality of life, the bill is of course restricted to people who believe that their life has no quality and that they are dying, but a lot of people who are unconscious might also be said to have an extremely poor quality of life. From a rational perspective, the bill's provisions should be extended to cover such people. If we legalise assisted suicide, what are the consequences from a rational perspective of extending the scope of its application to other situations? That is a question that we should consider.

Dr Smith: What happens in Belgium and the Netherlands is slightly a red herring, because they have out-and-out euthanasia laws. However, their laws are also based on a different foundational claim from the one that is being talked about with the bill. The Belgian law is based on the Netherlands law, which changed in about 1984 on the basis of the notion of unbearable suffering. I think that the first case in the Netherlands that dealt with the issue involved someone who was a doctor helping her mother to die. She was charged with murder, but the defence to the charge was a defence of necessity. She had two ethical duties, the first of which was to deal with the unbearable suffering of her patient and the second of which was not to kill her patient, but the two duties were in conflict, so she chose the duty of helping to prevent unbearable suffering over the duty not to kill—that was the necessity defence.

The entire Dutch system of assisted suicide is based on the notion of unbearable suffering. As a consequence, when Belgium decided to do similar things to the Netherlands, its notion of euthanasia was based on the idea of unbearable suffering. Therefore, when it comes to claims about what will happen if the bill comes into effect, the logical implications are different. The logical implication of unbearable suffering is that it will happen whether someone is autonomous or not, which is perfectly understandable.

If the notion is based on autonomy, which is what the bill and the Oregon and Washington legislation are based on, that has different implications. You may ask, "If someone is suffering unbearably but is unconscious or doesn't have the capacity to tell us, shouldn't they be entitled to the same thing?", but the answer would be no, because that would not be an autonomous decision. If the decision is based on a notion of autonomy and you do not have the ability to make such a decision, it simply does not apply in that case. For example, we do not allow people who lack capacity to get married because, even though they really like each other, they lack capacity. That requires an autonomous decision in the same way that the bill does for assisted suicide.

As a consequence, we must be careful about extracting what the Belgians or the Dutch have done and applying it to what might happen here. If you are going to do that, you must pay attention to the whole system. Their system is radically different from the one that is being proposed in the bill.

Robert Preston: I have a brief comment. Dr Smith is right about the laws in the Netherlands and Belgium. In the case of Belgium, the requirement is that the patients have reached a futile condition; in the case of the Netherlands, the requirement is that the patients are suffering unbearably. However, the bill is also based on the concept of unbearable suffering. If you look at the words—if we are not careful, we are just playing with the words—of the declaration, which is in schedule 2, you see that the applicant says:

"I have reflected on the consequences for me of the considerations set out in paragraph 6"—

one of which is that

"I have an illness or condition of the kind set out in paragraph 7"—

"and, in the light of having done so, I have concluded that my quality of life is unacceptable."

In other words, a judgment is being made not simply about autonomy but partly about the patient's ability or perceived ability to accept a certain quality of life.

Professor Jones: I was going to make the same point—I have the same quote in front of me. However, to extend it further, not only has the patient to make that declaration but the doctor has to say that the patient is being reasonable in doing so. Therefore, the patient not only has to say that they are being autonomous but has to say in relation to what they are being autonomous, which is ending their life, and to say why they want to do so. Why is that? Because of how their life is. We might say that it is because their

"quality of life is unacceptable"

rather than because they are enduring unbearable suffering, but that is playing with words.

The issue is about the person's quality of life and the doctor is being encouraged to make a judgment on the reasonableness of that person's judgment. The ability of the doctor to make that judgment means that the doctor could make the same judgment with respect to someone who had made no request for assisted suicide.

If the doctor can say of a person, "Yes, I think that your claim that your quality of life is unacceptable is reasonable," then the doctor can also make a decision about whether it is reasonable to say that someone who is not able to enunciate that has an unacceptable quality of life. The bill is encouraging the doctor to make judgments about the reasonableness of quality-of-life judgments. Otherwise anyone, without any qualification, could say, "I would like to have assistance with suicide," and the doctor would just have to say, "Well, yes, you can have that." Why are there qualifications? Because some claims are thought to be more reasonable than others. Some claims about what is unbearable or likely to be unbearable or what is in the general field of being an unacceptable quality of life are reasonable and need to be respected, whereas other claims are not and may be expressions of depression or something else.

The Convener: I want to move the discussion on to ownership and whose life it is. People have very strong emotions when they think about the end of life and the associated difficulties. They may think, "I own this body—it's my life and my decision to make." It is about autonomy and not just about allowing people permission. People think at that point in their lives that it is important that it be recognised that it is their life and they own it.

Are there any comments? I say to Graeme Dey that I will always go to the panel first, but I also have a couple of bids from members to come in to move the debate on.

"It's my life, my body, I own it and it's my decision." Robert Preston will comment.

Robert Preston: I think that I am repeating a point that has been made already. If somebody believes that their life is their own to dispose of as they wish, there is nothing stopping them doing that at the moment. The bill is not about legalising suicide; it is about licensing somebody else to involve themselves in bringing about a person's death. That is a totally different matter.

Dr MacKellar: I agree with Mr Preston. The bill is not about people committing suicide, which is unfortunate and happens, but about the Scottish Parliament and Scottish society accepting assisted suicide—accepting that some lives no longer have any meaning, worth and value. That is the problem.

People believe that their lives are their own. I agree. The kind of dignity that is mentioned in the bill is also their own. It is the dignity of self-respect—the kind of dignity that says that the way that people see themselves is important and that becoming dependent on others is a kind of loss of dignity. That is what we call non-inherent dignity. There are many different kinds of non-inherent dignity. A High Court judge is given non-inherent dignity, but if he has a fight outside a pub, he loses it. Non-inherent dignity can come and go. However, the concept of inherent dignity—that everybody has inherent value, worth and meaning—belongs to society and not to the individual. Once the Scottish Parliament starts to say that that such inherent human dignity can be lost, where do we go? Inherent human dignity makes a society civilised and, I argue, is the basis of the Scottish Parliament.

Professor Laurie: In many respects, the current legal position embodies what you said, convener, about it being my body and my decision, because people have an absolute right in law to refuse medical care. Whether with good reasons, bad reasons, no reasons or irrational reasons, as long as the person is competent, they can refuse.

However, the idea that that morally implicates only the individual who refuses is a nonsense; I agree with colleagues around the table that other people are morally implicated in such refusals. Therefore, all the decisions that we take in our lives necessarily involve others. The bill asks whether the moral decision should be extended to those who might be able to assist us in taking such decisions.

The final act has to be the person's, under the bill, but the question is whether there is a meaningful distinction between some of the acts and omissions that are under discussion. There is a lot of discussion about the fact that, many times, the distinction is irrelevant. If we recognise the fact that people can refuse care and die because it is their choice to do so, the question is whether it is morally consistent not also to reflect in law situations in which people can be assisted to die.

Dr Smith: I frequently hear the notion that, if somebody decides that they want to die for whatever reason, particularly in contexts such as we are discussing, they have somehow decided that their life has ceased to have value and dignity. That notion always slightly confuses me. It strikes me that that is not what many of the people who engage in assisted suicide are saying. They are saying, rather, that because their lives have value and dignity, they want them to end because if they continue, they will be worse.

We do not object to the fact that stories, movies and plays do not go on for ever; they have to end at some point. The notion that, for whatever reason, somebody's life is unbearable at that point in time or that they do not wish it to continue does not mean that they think that it has ceased to have value: it means that the value that they are placing on it is that it is over now. They are saying that they have reached the end of the journey and that it is time to stop. That decision does not strike me as suggesting that I would have lost the value in living, or lost my inherent dignity.

I am particularly concerned at the notion that inherent dignity is owned by society and not by the individual. I am not sure that I see a legal or ethical basis for that claim, and I do not particularly agree with it. Society is a collection of individuals, and if society decides that certain things have inherent dignity, that strikes me as being a very dangerous path to take.

10:30

Robert Preston: Something that Stephen Smith said made me think that we may have been taking the wrong tack. He said that there seems to be an assumption that anyone who, under the terms of a bill such as this, would want to end his or her life somehow believes that his or her life does not have dignity or worth. I cannot speak for others round the table, but that is certainly not my point of view. I have no doubt at all that anyone—or most people—who would apply for assisted suicide under the bill may well want to go on living, but may decide that the time has come to die. I am not questioning the motive, but that is not the point. The point is that, if we are going to give individuals the right to have assistance from someone else to bring about their death, we have to be sure that that will not impact unfavourably on other people. Other people could be coerced or brought under pressure, or made to feel that it is something that they should do.

There has been discussion about decisions to refuse treatment, including life-sustaining treatment. When a patient refuses such treatment, that is not the same as saying, "I wish to die." Most patients who refuse life-sustaining treatment are just refusing treatment: they do not want the treatment to go on, and they accept death as a probable consequence of refusing treatment.

There is a distinction to be made between accepting death and bringing on death. The bill proposes—this is the Rubicon that it crosses—that some people should be licensed to take action that is deliberately designed to bring about the deaths of other people. It has never been a defence in law—against murder, for example—that the victim consented. The bill is crossing a Rubicon that can be defended with ethical arguments—both sides can—but it flies in the face of social attitudes to suicide.

The Convener: Dennis Robertson is indicating that he has a question, but Graeme Dey and Patrick Harvie are also waiting to come in. I propose, after Dr MacKellar's response, to take a question from Graeme Dey.

Dr MacKellar: I want to come back to something that Professor Laurie said. A good example of relational values would be two people in a hospital who are very sick from the same disorder. One person may say, "I want to die; my life has no meaning left", and would access assisted suicide as per the bill. What kind of message does that give to the person in the next bed who might be suffering from exactly the same—or an even worse—condition?

I am struggling to understand what Professor Laurie said at the end of his answer. For me, inherent human dignity has a very strong relationship with the meaning of life. If someone knows that they have worth, value and meaning in life, why on earth would they want to end their life? There is something contradictory in that.

That point is reflected in the choose life campaign, which I believe the Scottish Parliament initiated. It is aimed at trying to reduce the very high suicide rate among men in Scotland. What is Scottish society doing? Is it saying, "You think your life no longer has any worth, and you want to commit suicide, but we as a Scottish Parliament and as Scottish society disagree with you. We believe that, even though you might be suicidal, your life still has meaning and worth"? The Scottish Government has sent suicide prevention co-ordinators around Scotland to try to reduce the incredibly high rate of suicide. That is why, just yesterday, Mr Clegg was talking about reducing the very high rate of suicide in England. As a society, we must believe that every single life, no matter how close to death it is, has equal inherent value, worth and meaning. The Scottish Parliament must believe that.

Graeme Dey: To pick up on Mr Preston's point first, surely the bill seeks to bring about the avoidance of unbearable suffering.

I understand perfectly Dr MacKellar's point about looking to the horizon, but if we strip this back, perhaps there is a danger that we are missing the point. If we reject the bill, we would potentially be saying to people with terminal conditions that they must suffer unendurably because we say that they should. We would, in effect, be imposing that judgment without ever understanding where people with terminal conditions are coming from. I do not think that we can duck that issue, even if it suits us to do that. My question, therefore, is whether we have the right as a society to say that to people.

Robert Preston: I would like to pick up on a technicality about a point that Graeme Dey has made. You talked about people who are suffering from terminal conditions. The bill is not just about terminal conditions; it is about chronic and terminal conditions. To be subject to the bill's provisions, a person simply has to have a progressive and life-shortening illness. There are hundreds of thousands of such people—there cannot be a street in Scotland where there is not somebody in that category. If I may say so, sir, you are turning the argument on its head. You are saying that if we do not have a law such as this, we are compelling people to suffer. I accept that in certain cases it may not be possible even for modern medicine to find pain relief or other symptom relief. That may be so in some cases, although it is increasingly not the case as medical science advances. However, you cannot therefore say, "Well, in that case you're forcing people to stay alive and suffer, so we must change the law." The case has to be made for changing the law.

Dr MacKellar: The concept of suffering is a very difficult one for me. The more we think about suffering, the more mysterious it becomes. Suffering is part of what human beings are. Some of the greatest human beings in history have suffered an awful lot. I do not understand suffering, so I cannot give you an answer. I believe that the committee will later hear evidence from palliative care consultants. What I do know is that suffering, in hospices at least, hardly exists. I am talking about physical suffering. There are situations, for example in the Highlands, where a person might be very isolated. It may be that, where physical suffering does arise, the general practitioner may not have received appropriate training. I would not deny that.

There is a different kind of suffering: the second kind is psychological suffering. According to evidence from the Royal College of Psychiatrists, when depression is diagnosed and that depression is encouraging a person to try to end their life, it can be treated—not in every case, but in nearly every case. What we are actually talking about in the bill is existential suffering—the suffering that comes from being afraid of death and of being lonely. That kind of suffering is not medical. It is the kind of suffering that we all have, faced with the fact that we will all die, and with many other things.

I come back to the concept of inherent human dignity. It cannot be trumped by suffering. A lot of people suffer. We all suffer. A lot of people suffer a great deal but they still have their value, their meaning and their worth. If we put it the other way round, if suffering trumps inherent human dignity, then everybody is different and everybody has a different value, a different worth and a different meaning. We cannot live in that kind of society. We are all equal. We must remain equal.

Professor Jones: I agree with something else that Dr Smith said in his submission, which is that it is useful to look at what has happened in other jurisdictions, with the qualification that he gave that we need to look in detail because each jurisdiction is different. I suppose that there are five jurisdictions that we should consider: the Netherlands, Belgium, Luxembourg, Switzerland, and three states in the United States, although there is evidence for only two of those. Although there are differences between those jurisdictions and Scotland and differences in the legislation, they at least provide evidence. I agree that we should look at the evidence differently, but at least we would have a more concrete idea of what we are talking about.

Whatever law you are talking about and whatever discussion you are having, it is a false dichotomy to say, “Either we do this or we do nothing.” It is a false dichotomy to say that people have unbearable suffering, so either we change the law or we leave them in their suffering. There are more than just those two alternatives.

Whatever the state of medical science, there are certainly unmet needs out there with respect to healthcare in general, with respect to people with chronic conditions and with respect to support at the end of life. Certainly, more needs to be done. I strongly oppose the bill, but even if the law changed, that would still be the case. It would not be the case that everybody who had the prospect of a bad death would decide that suicide would be a less bad death. We will all die; everybody around this table will die. The question is how we will best be supported when we die and to what extent changing the law will address that problem. It will not address the problem for most people. I do not think that anybody here thinks that most people would access the law. Most people will need other kinds of support when they die.

I return to Belgium, which was one of the countries on my list, and one of the good things that it did. In 2002 it passed two laws at the same time. One was about assisted suicide. The other, which was the result of a political agreement, was to pass a law about palliative care—Belgium gave a statutory right to palliative care, the result of which was that there have been significant year-on-year increases in funding for palliative care. Belgium really crept up the table and did a lot of good work. What happened in Belgium was mixed. I am strongly opposed to some of the things that happened in Belgium, but some good things happened, too.

Do not think that this change in the law is the only possibility on the table with respect to answering the needs of people who are suffering or are thinking about their death. There must be other things to think about and other things to do. I say that those things are the priority. We should not be complacent. Sometimes I think that the people who are opposed to this kind of legislation sound rather complacent, as though hospices have it sorted out and you can have a good death. That is not the case, because most people cannot access such care. It is not just about what can be done in the best cases; it is about how to deliver this across society. That is a question that we will have to answer whatever is done in this Parliament. That is the more important question for more people when you are talking about people’s suffering.

Professor Laurie: I think that we agree that it is not for any individual, any Parliament or any society to prescribe how people should die: people die in many different ways. This is about giving a small number of people the choice to die in a way that they would determine. One of the examples that we have not mentioned this morning is Oregon. Its legal framework is more akin to what is being proposed in Scotland than to what happens in Belgium, the Netherlands or elsewhere. Recent figures from Oregon show that in 2013 fewer than 22 deaths in every 10,000 resulted from the legislation. That is 0.0022, so you are talking about a tiny number of people. Nonetheless it facilitated the choices of people about how to end their lives. They are not scared of death itself; they are scared of a wild death.

The evidence suggests that, as in previous years, the three most frequently given reasons why a person chose that particular option were the following: loss of autonomy, which was given by 93 per cent of people; a decrease in the ability to have an enjoyable life, which was given by 88.7 per cent; and a loss of dignity—as they saw it, not as it was defined objectively by someone else—which was given by 73 per cent. The bill is about giving those people the choice that they would want; it is not about prescribing it for everyone.

10:45

Robert Preston: I was not going to talk about Oregon but, as Professor Laurie has raised it, I have to, as I am afraid that he is rather adrift. The bill is not similar to Oregon’s so-called Death with Dignity Act, which is limited to people who are terminally ill and have a maximum of six months to live, and is much more akin to Lord Falconer’s bill south of the border. This bill is for people who are chronically and terminally ill. We are not talking about the sort of catchment area that is the case in Oregon; we are talking about a catchment area that is perhaps 10 times as large. There are huge numbers of people who have the sort of illnesses that are prescribed in the bill. We do not know how

Oregon's law is working, because there is no audit system. A doctor is required to report that he has done it, but that is the end of it. Nobody actually examines the cases and says whether they have been carried out in accordance with the law.

The point that I was going to make concerns the question of existential suffering, which Dr MacKellar raised. I agree that a lot of the suffering that is involved in this issue is existential: it is about wanting control of one's death and wanting to die in the manner in which one wants to die. There is absolutely nothing wrong with that at all. However, there are cases in which there is also physiological suffering, and I agree with Mr Dey with regard to those cases. There are cases in which even the best palliative care cannot bring relief from suffering.

I would be prepared to go along with the sort of law that is proposed if two conditions were fulfilled. The first would be evidence that the law, as it stands, is oppressive. I have seen no such evidence, but it is one of the questions that those who are proposing laws of this nature seldom address. The second condition concerns safeguards. If the bill were in the state that it is at the moment, I would say no. However, if it could be made clear in the bill that there were serious safeguards that did not involve a doctor simply saying "to the best of my knowledge" or "in my opinion," but involved going through a specific process to establish that the person met all the criteria, I might be prepared to go along with it. However, as it stands, the bill is simply not fit for purpose.

Professor Jones: We need to consider all the evidence. There are a limited number of countries to consider. There are many differences between this country and the state of Oregon—I am glad about that. We should also look at Washington, which has massively overtaken Oregon already with regard to the numbers. Further—and here I agree with Mr Preston—the law that we are discussing today is much wider than others.

In that regard consideration needs to be given to Switzerland, whose law is wider still. In Switzerland each year, under the law, there are around 500 deaths of Swiss citizens, and 200 further deaths of suicide tourists, compared to around 70 deaths under the law in Oregon, so the number of such deaths in Switzerland is larger by a factor of 10. Of course, Switzerland is twice the size of Oregon, but the figures are significant. Oregon, Belgium and Switzerland have comparable population sizes to Scotland's, although what happens here will not necessarily be the same as what has happened in Oregon, because of the nature of the bill.

The lid needs to be lifted off what is happening in Switzerland—there is not enough data on what is happening there; the numbers are much higher and safeguards are much weaker—and I have grave misgivings about the supposed safeguards in the bill. You should look at all the countries in which there is assisted dying and make up your own minds.

Dr MacKellar: I agree with what Professor Jones has just said. Washington has similar legislation to that which is in Oregon. There, between 2012 and 2013, there was a 43 per cent increase, which is huge—those are the latest numbers that we have. In Switzerland, the numbers are going up. Again, we do not have the exact numbers but, between 1998 and 2009, the number of assisted suicides in Switzerland went up by 590 per cent—that is just for Swiss citizens; the numbers for people coming from abroad are quite different.

The numbers are also going up quite quickly in Belgium and the Netherlands. They have not yet reached a plateau. We do not know where they will plateau, but the figures are going up quite fast. We do not know where they will plateau because when you legalise something it becomes normal over time. For example, one submission mentioned seatbelts. When legislation made wearing seatbelts compulsory, it was at first abnormal to do so; then it became normal and now we do not even think about it. With time, things become normal and, because they become normal, more and more people will access what is being proposed.

Another thing that makes something become normal is sheer numbers. The more people access something, the more normal it becomes, so there is a feedback system. We do not yet know what will eventually happen in Oregon or Washington, which is why it is important that we do some horizon scanning. We should look at Oregon, Washington and maybe Switzerland as experiments for which we do not yet have the results.

The Convener: I will try to get a couple of members in. There may be some similar questions and answers. I invite Dennis Robertson to ask a question and, with the committee's permission, I will skip forward a bit and take Patrick Harvie, although some committee members have still to ask questions. Is that okay? I see that members are nodding.

Dennis Robertson: The word "coercion" has been mentioned a few times. Obviously some people are more susceptible than others to persuasion—we are all susceptible sometimes, if there is a good argument. What are the safeguards against coercion?

Dr MacKellar has often mentioned the suffering of the patient. Does the patient sometimes look beyond themselves and want to take their life because they see the impact that their condition is having on others who are caring for them? Their decision is therefore not based only on their quality of life, because they are looking beyond that at the impact that their suffering—to use Dr MacKellar's term—is having on others. How do we safeguard against the sort of coercion that people can maybe apply to patients?

The Convener: Thanks for that, Dennis. There are a whole series of questions around that about vulnerability and why people could be coerced or pressured to take decisions.

Professor Jones: I do not think that it is just about coercion, because influence is much broader. I again make the point that, if we are anxious about influence, it is because it comes back to the whole notion of assisting, encouraging and relating to others. In my experience, it is regrettably common that people think that other people will be better off without them and they severely underestimate the grief that people will feel after they have gone.

Certainly, with regard to ordinary suicides, people who commit suicide often think that other people will be better off—they sometimes think of others and do not just think in a selfish way. However, suicide is archetypically devastating for those who are left behind. It can have a hugely negative effect on them—although not in every case and not equally—particularly because those left behind feel that they were not able to help the person.

A person may feel that others will be better off if they are dead, but a person can make wrong assumptions about what other people think. The person who is vulnerable could make assumptions about what other people who care for them think—they assume that other people think that they are a burden and that kind of thing, when that is not necessarily the case. We should not think only of unscrupulous relatives who do not want the person around and that kind of thing. There is often a misperception, because of dependence and vulnerability, about a lack of solidarity and a lack of relationship, so that the person thinks, "When I'm gone, it will be better." However, depending on how they go, it might not be better at all; it might be much worse. Sometimes, people have to try and let other people care for them, which is not easy.

People are vulnerable to such ideas—they are vulnerable to all kinds of suggestions. For example, I do not think that there is anything in the bill that would stop a doctor from suggesting assisted suicide as a reasonable option among a patient's treatment options. There is nothing stopping a doctor saying, "I think in your situation I might consider assisted suicide." If it is a normal end-of-life decision, it would not be coercive to suggest that among the range of decisions.

We have, and should have, huge misgivings about other people even suggesting that, because that suggestion is insidious—it undermines. All the time, questions arise such as, "What are people thinking about me? Would they be better off without me?" It is a misperception, but it is one that people can easily fall into.

Robert Preston: There is a spectrum here, from arm-twisting coercion, through to hints dropped and suggestions made, to something called care fatigue, which relatives do suffer from. An increasing number of people are incapacitated and have to be looked after by their families. Often, families need two people working to pay a heavy mortgage, but one member of that family cannot work, because the person concerned has to be looked after. You can see the situation. Someone might think that they are going to die in a year's time or in two years' time, so why not get it over with and leave their inheritance, because their family are struggling financially and cannot look after them? I agree with Professor Jones on that—it is a very wide spectrum.

How do we guard against that? A doctor assessing a case might be able to detect that situation if he knows the family, but do we live in that kind of society? My doctor has never been to my house in 12 years. If I applied for assisted suicide, he would not have an earthly as to whether I was being coerced and whether I was capable. He would not have a chance. We do not live in the age of the family doctor, who knows the family and who would know whether or not coercion is taking place.

We have laws not because most of us behave decently, but because some of us do not. We should remember that.

Dr MacKellar: Professor Laurie mentioned the first three reasons why people accessed assisted suicide in Oregon and Washington. The fourth reason applies to 61 per cent of people, according to the most recent results from Washington. The reason is that they feel that they are

"a burden on family, friends and care-givers".

A further reason was the

"financial implications of the treatment",

which applied in 13 per cent of cases.

We have learned that, in a modern society, being a burden on others is dishonourable. I believe that, in our society in Scotland, we have to relearn that to be a burden on others is normal and acceptable. It is what society is all about.

We had an African physician on our council—a Muslim. He said that, when he went to his first debate on euthanasia and assisted suicide in Scotland, he was horrified. People who were disabled, old and so on were honoured in his village. As a society, we have to relearn that. We all started off our lives being completely dependent on others and some of us will end our lives being completely dependent on others. There is no dishonour in that.

I have to learn that, too. I have to remind myself to be proud of being a burden on others, because they want to help me—they are my friends. A real society is a society in which people are friends.

Professor Laurie: Clearly, we cannot second-guess people's reasons or circumstances and whether they would or would not be unduly influenced. All that we could hope for in a legislative framework such as the bill would be to put in place particularly tight measures in the first round of a review.

One thing that I would like to see in the bill is an authority that had a clear role in reviewing requests and reports and that could intervene timeously. Secondly, there is no suggestion in the bill that the two doctors involved must be independent of each other, so we need to ensure that there is some degree of independence. We need to ensure that, during the first review period, Scotland could build up a robust evidence base on what was actually going on and review that in due course. We could then ask whether the evidence showed that there was any suggestion of undue influence, and act accordingly. I would be very concerned if we were to speculate on the likelihood of undue influence being brought to bear when we did not know whether that was happening.

11:00

The Convener: With regard to the law on homicide and subsequent investigation, it is not inconceivable—although I may be going back here to the novels and films that Dr Smith mentioned—that a surprising inheritance might be found following an assisted suicide. How would the assisting person be protected in such a case? Would they face a prosecution for homicide because someone discovered an unusual inheritance that came as a surprise to other people? How would such a situation be dealt with after the fact? What possible criminal proceedings could those people—rightly or wrongly, and whether they were well motivated or not—find themselves in after an investigation following an assisted suicide?

Professor Laurie: I would not want to speculate on the criminal situation, but I would say that the passing of the bill is about not just one piece of legislation, but an entire framework. It is about identifying clearly which authority would be in charge; what powers it would have; and with whom it would have to work, which would include the Crown Office and the professional bodies, including the doctors and pharmacists.

The bill includes the notion of facilitators partly because we know that there is strong reluctance among many sectors of the medical professions to be involved in assisted suicide. Of course, the bill necessarily involves them, but there is no recognition that some sort of provision for conscientious objection is needed. I understand that there are reasons for that, relating to powers that are reserved to Westminster, but a framework would need to take account of all those points, including the ability to investigate the sorts of issues that the convener raised.

Professor Jones: On the point about having bodies that regulate or review, there is a real problem with regard to facilitators that lies almost on the surface of the bill, which is the question of who guards the guards.

One pattern that occurs across different jurisdictions is that people who have previously pushed for legislation subsequently wish to get involved in pushing the boundaries of legislation, sometimes by being on the regulatory bodies or by getting involved in organisations that operate mobile euthanasia facilities.

Very few cases have come up for review in Belgium and the Netherlands. In Belgium, that is because the most extraordinary cases—of which there have been some—involve somebody who is also on the review panel.

There is a problem with review bodies, as can be seen across England's regulatory structures. Some of the regulators in England are quite strict in what they require, and others are very close to the people whom they regulate and so they rarely refuse requests—in fact, they actually try to facilitate them in different ways.

We should not just think about structures on paper. There is a question of who guards the guards, and the answer should not be simply, "We don't know." We can get some idea from looking at those other countries, so we should have a look at them and see what can sometimes happen with some of the regulatory bodies.

Dr Smith: I agree with that, and I agree that we should look at other countries. However, when we do so, we should not look only at the limited number of countries in the world that allow some sort of assisted dying. We should not look simply at Belgium, the Netherlands and Luxembourg, or at states such as Oregon and Washington; I think that Montana, New Hampshire and Massachusetts are the other three states.

We need to look at the way in which things work in the regulatory state that we already have. In many discussions about assisted dying, it is taken as a given that we prohibit it, as if that is not a regulatory state that people have created and as if there are no impacts, evidence and downsides to the regulatory state that we already have. If we are going to look at evidence—and I am a firm believer in looking at the evidence that exists—we must also ensure that we look at evidence about how things are working at the moment. That can be hard to investigate, which means that there is very limited evidence out there.

However, the limited evidence that we have does not show that the current prohibition is all that great a system. A study from 2002—which I should point out is decidedly anecdotal, uses only a small sample and is, incidentally, from Australia, an entirely different jurisdiction—highlights some particularly troubling instances with regard to coercion and suggests that if people do not have the full and obvious discussions, they either dismiss doctors or end up going down routes that no one ever wants to see anyone go down.

Coercion happens under whatever regulatory system is in place. If you are expecting the regulatory system that the Scottish Parliament comes up with to be perfect, I hate to tell you that that is not going to happen. There are always going to be instances of abuse; after all, there are instances of abuse of every piece of legislation anywhere in the world. The question is how we limit such instances and make the legislation as good as it possibly can be. I therefore echo everything that Professor Laurie said about ensuring that there is an investigatory body with the kinds of powers that, unfortunately, are not available in Oregon.

We also have to pay attention to issues such as communication. With regard to the issue of coercion as it relates to this bill, I am particularly concerned about the 14-day time limit for using the prescription. That strikes me as fairly coercive. Evidence from Oregon and the Australian study that I have just mentioned suggests that in many of these cases people want the medication not necessarily to use it but to be able to wake up in the morning and say, “No, I’m good. I don’t need this today.” That is, in fact, a life-affirming measure for them. I do not think that that would happen in all cases, the majority of cases or even a significant minority of cases, but the evidence that we have suggests that it happens. If we are going to talk about things such as coercion—and I think that it is important to discuss coercion and vulnerability—we have to pay attention to the coercion in the current system.

The Convener: Did you wish to comment, Mr Preston?

Robert Preston: I will be very brief, convener, because I know that you want to bring in other members.

I completely agree with Dr Smith that the 14-day period in which lethal drugs must be used is a form of coercion; it is silly and should be taken out. However, the medical practitioner statement, a draft of which is in the bill, says:

> “To the best of my knowledge, he/she* is making the request voluntarily and ... has not been persuaded or similarly influenced by any other person”.

Is that phrase “To the best of my knowledge” really good enough, given the prospect of coercion? I come back to my earlier point that the bill contains no processes for ensuring that it is safe; there are only aims.

The Convener: I call Patrick Harvie.

Patrick Harvie: Wow. [*Laughter*.] Thank you, convener. It is extraordinary how in such evidence-taking sessions simple questions can give rise to very complex and lengthy answers. Of course, that was probably inevitable.

I want to pick up briefly on a number of areas in which I think there might be misunderstanding, or on which there have been comments that might be misinterpreted. I am sure that there has been no deliberate attempt to misrepresent what is in the bill.

Various statements have been made about people being licensed to take action that brings about someone else’s death. That is clearly prohibited under the bill. We are talking about assistance to allow someone to take their own action at the end of their life.

There is also the notion that value, dignity, worth and quality of life are the same thing. They are all important concepts but they are different. It is important to restate that dignity—whether inherent or non-inherent dignity—is not defined in the bill. We talk about a judgment that a person makes about the quality of their own life.

I think that it was also implied at one point that the bill could apply to people who have not made a judgment about the quality of their own life, including people who were incapable of doing so because of unconsciousness. That is clearly not set out in the bill.

I will ask two questions, one of which is specifically for Dr Smith and one of which is more general. The general question is about the comparisons that we might make to other ethical considerations. Because autonomy is not an absolute concept in any of our lives—because, as Dr MacKellar said, we are all reliant on one another and all depend on one another as part of a society every day of our lives—the ethical considerations will become complex, particularly in the provision of care to people who are at the end of their lives or people with complex needs. However, that is not the same as a comparison with suicide in other circumstances.

Debbie Purdy died recently. There can be no doubt that she wanted assisted suicide—she campaigned for it over a long time. It was not available to her and the only option that she had was to refuse nutrition. In effect, she starved herself to death. She said clearly, “I do not want to die but I am dying.” There is a difference between taking control of a process that is happening and suicide in other circumstances. Surely the comparison that we might make with other ethical considerations concerns the actions that people might take in assisting someone to decide to refuse treatment, for example.

For instance, placing a note that says “Do not resuscitate” is an action that someone would take to assist someone else—a patient—to give effect to their own decision. Last week, we heard about the comparison with a patient coming off dialysis in the knowledge that they might die within days. There are other circumstances, although they are perhaps rare, such as someone choosing to participate in an experimental drug trial in the full knowledge and with their doctor knowing fully that it will not give them any particular benefit and might even hasten their death but could generate research data. That surely gives rise to a far more complex set of ethical considerations that has a closer bearing on the one that we are talking about than the comparison with suicide in other contexts does.

My specific question for Dr Smith is about the comment that he made on the 14-day period and whether it could be perceived as, or have the same effect as, a form of coercion. He described the affirming effect of someone having access to the drug—the person having the drug on hand and knowing that, each day, they might wake up and think, “I can get through today. I do not need it today.” Is he convinced that that is due to the physical presence of drugs in the room, house or building or is it due to the knowledge of control—that is, the knowledge that the decision rests with the person and that there are people who are willing and able to assist them to give effect to their decision?

Margo MacDonald chose the 14-day period to balance the ability to know that the judgment of capacity was recent and, therefore, still had some relevance with the other considerations that Dr Smith mentioned. Can we assume that the affirming effect comes from the person knowing that the decision is in their hands rather than from the drugs being on the bedside cabinet?

Dr Smith: To be honest, I have no answer to that question because I do not know. The evidence indicates that the effect happens. As I said, there is evidence from Oregon and from the study in Australia that it has happened. However, I do not think that either study specifically considered whether the effect was due to the physical location of the drugs or merely to the idea of having access.

In either case, the 14-day period remains slightly problematic, because the decision still has to be made within that 14-day period. Even if it is merely the notion of having access to the medication, I know that I can call somebody and get the pills if I need them, as opposed to having the pills right there. However, that still means that I have to make the decision within a limited period of time and that I cannot say that I am okay for the first 14 days but that on day 15 it has gone too far over the line, wherever that line is.

I do not know the direct answer to your question. My concerns about the 14-day period would probably exist irrespective of whether it involves the physical location of the medication or merely the idea of having access to it.

11:15

Professor Jones: With regard to the right to refuse treatment, I do not agree that those who refuse treatment are never suicidal. There could be a suicidal refusal of treatment, but we respect refusals of treatment for other reasons, because there is a right of non-interference, which is to do with our limits on how we bump into each other. I am worrying about coercion. If we did not have a right to refuse, we could be coerced to be treated by doctors. We can be coerced to be treated by doctors, but only in specific circumstances that are limited by law. In general, we do not like to have coercion by doctors, and that is why we have refusal of treatment.

Reference was made to assisted dying being different from other suicides in other circumstances. That might be because our archetype for suicide is youth suicide. It is not a sexy subject, but in as much as suicide gains publicity and people have campaigns about suicide, it is youth suicide that pulls on the heart strings. However, if you look at rates of suicide, you will find that it is actually older men—over 65 and over 85—who have much higher rates of suicide, but that is not what gets reported. It is the two teenagers who die in the car whom people care about.

I had a disabled friend who committed suicide and who may have fallen under the terms of the bill because he had a long-term, chronic condition. He committed suicide in what we might call an oldfashioned or traditional way. People who are vulnerable or who are older do commit suicide. The bill applies to people with life-limiting, progressive and chronic conditions who may have years to live. It is not just about people who are imminently dying, so I do not think that the difficulties of dealing with depression in certain circumstances can be easily separated from the many cases of suicide that we currently have.

Related to that, and returning to the data stuff, there is a similar bill in England at the moment, and one of the arguments that have been put forward for that bill is that it is an answer to suicide among terminally ill people. However, people who are terminally ill are already committing suicide in various ways. If they had assisted dying, it would be an alternative to the horrible deaths that they have at the moment when they hoard up pills and then take them. It is difficult to get at the evidence, but it seems that legalising assisted dying reduces the number of suicides among that category of people. There will still be high levels of suicide. Indeed, Oregon has a much higher than average rate of suicide, as does Switzerland. The highest rate of suicide in western Europe is in Belgium. There are no exact parallels, because there are many factors that go into those statistics, but there are connections. We cannot altogether distinguish thinking about suicide and suicide prevention among vulnerable people, those with disabilities and the elderly, from the kind of legislation that we are considering. They are not so separable.

The Convener: I will take Dr McKellar and Mr Preston, and then we will move to our last set of questions.

Dr MacKellar: I want to return to two points that Mr Harvie made. First, he is right to point out that the concept of dignity does not appear in the bill. I used to work in the Council of Europe, drafting human rights law on biomedicine issues. In Strasbourg, I learned that all good legislation is based on human rights, all good human rights are based on human ethics and all good human ethics are based on an inherent concept of human dignity. As a result, even though it might not mention it, all legislation is based on human dignity.

Secondly, I also agree with Mr Harvie on a point that Professor Jones has just mentioned. A person on dialysis who has only a few months left is entitled to switch off their machines, especially if they see them as a burden. That is something that we all accept.

However, one issue that has not yet been mentioned in the discussion is the role of suicide facilitators. As I understand it, the policy memorandum says that members of the Humanist Society Scotland would take on some of those roles. I recently watched a film about the French section of Exit, membership of which is open only to those who live in Switzerland. About a dozen volunteers were participating as facilitators in Exit, and the film was heart-rending in the way that it showed the anguish and psychological tiredness that they eventually experienced. Facilitating a suicide is not easy. The Humanist Society Scotland does a great job with secular weddings and funerals, but that is completely different from being a suicide facilitator. I do not believe that anyone in this room would like to take on that role. From a psychological perspective, you have to see people dying again and again, and the Swiss suicide facilitators in the film—there were only 12 of them, and they dealt only with the French part—were overwhelmed by the amount of work that they had to do and were extremely tired.

At the end of the film, Dr Jérôme Sobel, the president of the French version of Exit, says that what they do is not really a task but a vocation and that they have to do what they do. I am concerned that people who are in favour of assisted suicide might find themselves becoming suicide facilitators. That would be very dangerous for them, because they would not know what they were getting into. To be a suicide facilitator, you have to be extremely psychologically robust, and that must be taken into account.

Rhoda Grant: I want to make a brief comment on those remarks, which bring me back to Dennis Robertson’s question about coercion. Does the fact that someone needs to book a facilitator and that they are using a facilitator’s time represent an additional coercion? It might be worth reflecting on that issue.

With regard to conscience clauses, which we have briefly touched on, is there any way of including an opt-out in the bill? After all, this is not just about personal autonomy, but about the autonomy of the doctors and so on who are looking at the assisted suicide request and who will have the final word on the matter. If we cannot include a conscience clause, we might be asking people to go against their own beliefs or, indeed, their training to facilitate these requests and, unless we give them the option either to opt in or to opt out, different people might operate to different standards. Is there any way that we can put such a clause in the bill?

Robert Preston: I was going to make only one point, convener, but now I will have to make two. I promise that I will be brief.

The first issue, which Mr Harvie raised, relates to existing decisions to refuse or withdraw treatment. When a doctor takes a person off dialysis or withdraws a life-saving treatment, either with or without the patient’s consent, they do so not to bring about the patient’s death. It is done in the expectation that the patient will probably die, but it is actually done because the treatment is unduly burdensome or futile. Intent is very important in ethics, which are what we have been discussing this morning.

The issue of the conscience clause is very important. There has to be a conscience clause at some point—you cannot force doctors to provide assisted suicide—but it has one very unfortunate side effect. Assuming that the situation north of the border is what it is south of the border, at the moment only one in five doctors say that they would participate in processes such as this. The net result of that is that anyone who wants assisted suicide will find himself or herself in the hands of a small number of referral doctors who know even less about them than the doctors with whom they are registered. We have to have a conscience clause but it has an unfortunate downside.

Professor Jones: There has just been a decision at the Supreme Court in England overturning a decision in Scotland with respect to conscience clauses for abortion. That decision came as a surprise to some because of what they had thought was the protection of a conscience clause. If you have a conscience clause, something to bear in mind is how what is ostensibly in the conscience clause may be subsequently interpreted by lawyers, which will be influenced by human rights law and so on. It seems extraordinary that there is not a conscience clause in the bill, but I would not overestimate the kind of protections that a conscience clause would give without thinking about broader human rights.

An issue at the moment in Belgium is that there is no duty to refer to another doctor for euthanasia. They were thinking of bringing in such a duty, but they did not. In abortion in this country, there is a duty to refer. Whatever a conscience clause said about a duty to refer, the interpretation of the law in England will be influenced by the general view of conscientious objection, which is that you have a duty to refer. I refer to the obiter dicta of the Supreme Court judgment. It is just to say that whatever is in the clause, you need to have thought to how that will be interpreted.

The problem that I have with conscience clauses is that they assume that everybody has a duty to do something unless they opt out. That is the wrong way round. In the bill as it stands, it is not clear to me that there is any duty to provide assisted suicide. There is a sort of assumption that once the bill is passed, ministers and bodies will take it on and it will become a right, and therefore there will be a duty to provide that right. However, there is nothing in the law that says that.

If there is no duty to provide assisted suicide, you do not need a conscience clause. You just say, “This is not something that I have a duty to provide.” What is unexamined here is that the more it looks like medical care, the more it becomes something that people think they have a right to as part of end-of-life care. That also means that regulators have a duty to regulate, ministers have a duty to provide resources and there has to be National Institute for Health and Care Excellence guidance on the poisons that are used in assisted suicide. If assisted suicide is part of ordinary medical care, those things have to be in place and then people have to start opting out.

A number of submissions on the bill pointed out that there are assumptions about what would happen with other people. I agree with Professor Laurie. You need to think about a whole framework. The likely framework is that assisted suicide would be considered medical care and therefore something that people have a right to, and therefore something that other people have a duty to provide unless they opt out by a conscience clause. Further, the ability to opt out by a conscience clause will be limited by what lawyers in general have said about conscience clauses.

The Convener: I am conscious that Bob Doris started the questions long ago and wanted back in. After that, I have another two questions and we need to make progress for the next 15 minutes.

11:30

Bob Doris: My point links to the idea of a conscience clause, because it is about the medical professional’s role in the process if the bill is passed. I have looked at what would be considered a life-limiting condition, which is not defined in the bill. For example, type 2 diabetes will in theory reduce life expectancy by up to 10 years. Who would have a duty to inform people who are not coping with their type 2 diabetes that they have the treatment option of assisted suicide? Where would that sit in the relationship between a medical professional and their patient? At what point would that information be given?

Scotland and the rest of the UK have a series of managed clinical networks by which patient pathways are clearly steered. Could the bill lead to the medicalisation of assisted suicide? People go through managed clinical networks for a variety of conditions, whether via their GP or a GP referral, and a duty is placed on the medical professional to manage people—of course with their agreement along the way—through a range of options, one of which could be assisted suicide if the bill was passed. Where would that sit with the medical professional’s fundamental role of protecting, enhancing and nurturing life, health and wellbeing? That is one of my concerns. I seek to tease out whether anyone shares those anxieties and whether the bill—leaving aside my view on it—can be improved to give reassurance on those concerns.

The Convener: Are there any brief responses to that?

Professor Jones: We can look at what the General Medical Council says about good medical practice on treatment options. If we considered assisted suicide to be a treatment option, a doctor would have a duty to inform a patient about it as one of a range of options. If assisted suicide was to be kept out of that range, that would not be just a matter of a conscience clause, because we would also have to think about how assisted suicide related to GMC guidance and medical care generally. As soon as it went into the medical care category, a lot of other stuff would come into play, including a duty for a medical professional to show a patient that they had a right to it.

Professor Laurie: The guiding principle of the bill is the individual's autonomy. I hope that an individual would be supported to take responsibility for decisions that they might take at the end of their life. I understand that a conscience clause is a reserved matter for Westminster as part of professional regulation, which is why it is not in the bill.

In exploring a broader framework, we would, arguably, engage with the professional regulatory bodies, such as the GMC and the British Medical Association—the doctors' union—about what they would consider to be ethically appropriate support for the autonomy of their professionals in steering the assisted suicide pathway. However, ultimately, the individual is responsible for decisions about the end of their life.

The Convener: What would change if assisted suicide was considered therapeutic?

Professor Jones: The situation is not like that of abortion, and the only reason why I brought up abortion is the conscience clause for that, which is the most famous conscience clause. If we considered assisted suicide to be part of medicine and end-of-life care, it would be regulated in the same way as other areas when a doctor has a duty to inform people of their range of options. It would become a duty of doctors to say to a patient, "One of your options is assisted dying," if that was a legal option. If it was a medical option, a medical professional would have a duty to inform people that they had a right to it, even if he conscientiously objected to doing it.

A medical professional might also have a duty to suggest the option in certain circumstances if they thought that it would be beneficial. I suggest that people should read the GMC guidance on good medical practice and particularly the guidance on treatment and care at the end of life. If we imagine that assisted dying is a treatment option, we can put it through the regulation and see what the pattern would be. There is a real possibility of that happening, because even though the facilitators for assisted dying might not be doctors, three doctors would be involved in the process, along with medical notes and decisions about conditions. A lot of medicine would be involved, so the default position would be that assisted dying was regulated in the same way as other medical areas are.

Robert Preston: It is interesting that, as far as the decision-making process is concerned, the bill provides for physician-assisted suicide, but when it comes to the act, it ceases to be physician-assisted suicide. In fact, it is very unclear what kind of assistance could be provided under the bill. Would it be allowable to push somebody under a train, for example? The bill refers to the use of drugs "or other means".

South of the border—I am afraid that I keep using that phrase—where Lord Falconer's bill is being considered at Westminster, it has been suggested that the High Court should take such decisions. As things stand with Lord Falconer's bill, the High Court would take such decisions after they had been taken by doctors, which is a bit strange, as that would be just a rubber-stamping process. One possibility might be to consider whether, as well as being taken out of the assistance process, doctors could be taken out of the assessment process, thereby leaving them as providers of professional advice to others who would make the decisions.

Nanette Milne: Professor Jones touched on the fact that we are not talking only about doctors. Depending on the setting, we are talking about nurses and pharmacists as well. The pharmacist who came to last week's meeting felt strongly that the bill should contain a conscience clause as far as pharmacy is concerned. I know that there are forms of suicide other than suicide by drug use, but I presume that pharmacists would be involved in providing the means for suicide in the vast majority of cases.

The Convener: Patrick Harvie has a supplementary point.

Patrick Harvie: I reacted slightly to the comment about pushing people under trains. I am sure that the committee is capable of telling when someone is taking the subject seriously and when they are not.

Comments were made last week about the inclusion of a conscience clause. Pretty much everyone who has discussed the issue acknowledges that a conscience clause is required but that the regulation of medical professionals is reserved. Witnesses at last week's meeting seemed to be open to the argument that the conscience option could be delivered through regulations and that it does not have to be included in primary legislation. I invite reactions to that suggestion. The robustness of the argument is clear.

It is worth reflecting on the fact that the recent judgment on the conscience clause in relation to abortion clarified the position as people have understood it for a long time and did not overturn it, as it was suggested might happen.

The Convener: Do the witnesses wish to respond? That point might have been more appropriate for last week's witnesses.

Nanette Milne: Last week, it was pointed out that there is a fine line to be drawn between assistance and euthanasia. The bill does not provide a clear definition of a licensed facilitator's role. Does anyone wish to comment on that?

Dr MacKellar: The title of section 18 is "Nature of assistance: no euthanasia etc". I picked up on the fact that the bill does not define euthanasia, although it is mentioned in the title of a section. That should be clarified.

Sometimes the line between assistance and euthanasia is fine. That is why it is important that, if the bill were to come into effect, the facilitator should be present. At a previous evidence session, there was discussion about whether a facilitator would always have to be present. Section 19 says:

> "A licensed facilitator is to use best endeavours ... to be with the person",

but what does "best endeavours" mean? Normally, legislation would include a provision such as, "A licensed facilitator shall be present," so the bill raises a lot of questions.

If assisted suicide is brought in, we should go down the same road as Switzerland, where the facilitator brings the drug and provides it to the person, who then takes it. The facilitator should make sure that there is no drug left and that no one else puts the cup to the patient's mouth. If the drug is put into the patient's mouth, that becomes euthanasia.

It is interesting that, where euthanasia and assisted suicide are both legal, as in the Netherlands, euthanasia is 20 times more present than assisted suicide. With assisted suicide, things can go wrong. The person can take a long time to die or can even wake up, and there can be a lot of complications. That is why euthanasia is used in the Netherlands 20 times as often, because then one can really make sure that the person is dead.

It would be unacceptable for the facilitator to go away when the process was taking place and just let the relatives be with the person. Who knows what the relatives would do? They might not even be aware of the legislation. The position on that would have to be tightened.

Professor Laurie: As the discussion has demonstrated, incredibly fine ethical judgments would have to be taken at all points in any framework that was laid out. We cannot expect any single piece of legislation to address all the points.

I suggest that, if an authority was put in place that had not only a supervisory role but an advisory one, people who were talking about somebody's final arrangements could go to it with what they were proposing and seek guidance on what was appropriate. However, the bill makes it clear that the final act has to be by the individual, so the issue would be about the fine nuances of what counts as the final act.

The Convener: I will put something to you for clarification. In talking about events leading up to the final act and the procedures that would be put in place, you suggested creating an offence for breaches. Were you suggesting that we could create an offence for people who were not following the procedures properly?

Professor Laurie: The point that I made was about cases where manifest undue influence has been established. I would like to see an offence for circumstances when somebody has clearly unduly influenced the person.

The Convener: Would that be a specific criminal offence?

Professor Laurie: Arguably, it could be.

The Convener: What would it look like? Have you thought that through?

Professor Laurie: I am not a criminal lawyer, so I cannot necessarily say what type of offence it would be, but that could be for discussion and exploration. The bill takes account of errors—acts or omissions—that are made in good faith. It recognises that such things will not necessarily lead to criminal or civil liability. The corollary is that we should make it manifestly clear that, if somebody deliberately coerces the person into such circumstances, that will be the subject of criminal prosecution.

Professor Jones: I am not in favour of the bill, but that does not mean that I think that all criticisms of it are justified. It is fairly clear that it is intended to be an assisted suicide bill and not a euthanasia bill, although there will be fine distinctions and some of that will have to be in regulation.

My concern is not that the bill would legalise euthanasia—I do not think that it would—but that, further down the line, a number of people would want to revisit that if the bill was passed. Through various changes, people would say, “Logically, if we have this, why not also euthanasia?”

However, this is not a euthanasia bill but an assisted suicide bill. In that respect it is different from the legislation in the low countries, Switzerland and the states of the United States that have assisted dying legislation, in that the final act is the person’s own act. I commend Scotland for calling for an assisted suicide bill but not an assisted dying bill, which I think is seriously misleading language. I think that, if we polled people, a majority would think that assisted dying covered euthanasia as well as assisted suicide. However, the bill is not a euthanasia bill but an assisted suicide bill.

Robert Preston: I echo what Professor Jones said. There is candour in the bill and, having come from looking at the Westminster bill, I think that that is refreshing.

There is something of a disconnect on licensed facilitators, which I have never really understood. When we get to section 17, it is clear that we have come to the end of the decision-making process. What is not clear is how the drugs or other substances get to the licensed facilitator and then to the person concerned.

Section 18 seems to say that there must be no euthanasia. I am a little puzzled by section 18(1), which states:

> “Nothing in this Act authorises anyone to do anything that itself causes another person’s death.”

I would have thought that supplying somebody with lethal drugs to take could be construed in that way, but I will leave that to one side.

Section 19 states that the licensed facilitator’s role is

> “to provide, before, during and after the act of suicide ... such practical assistance”

and to provide

> “comfort and reassurance.”

It states that the facilitator should

> “be with the person when any drug or other substance or means dispensed or otherwise supplied for the suicide of the person is taken or used”.

I am not quite clear what the machinery is that moves us from the decision to supplying the substance. It does not seem to be prescribed anywhere in the bill.

The Convener: I bring the discussion to an end. We have had a good long session, and we appreciate your attendance and participation. The views that we have heard have been interesting and in some ways challenging to the committee, and we appreciate the valuable time that you have given us. I thank you all very much for being here.

11:46

Meeting continued in private until 12:55.

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