The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 3 February 2015

Session 4

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HEALTH AND SPORT COMMITTEE

4th 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:

Dr Peter Bennie (British Medical Association Scotland)
Jennifer Buchan (Humanist Society Scotland)
Sheila Duffy (Friends at the End)
Catherine Farrelly (Scottish Youth Alliance)
Patrick Harvie (Glasgow) (Green)
Dr Gordon Macdonald (CARE for Scotland)
Professor Sheila McLean
Tanith Muller (Parkinson's UK in Scotland)
Dr Peter Saunders (Care Not Killing)
Dr Bob Scott (My Life, My Death, My Choice)
Dr Sally Witcher (Inclusion Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health and Sport Committee

Tuesday 3 February 2015

[The Convener opened the meeting at 09:45]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the fourth meeting in 2015 of the Health and Sport Committee. As I normally do at this point, I ask everyone to switch off mobile phones, as they can interfere with the sound system. However, panel members and people in the public gallery will note that clerks and committee members are using tablets instead of hard copies of the committee papers. I also welcome to the meeting Patrick Harvie, who joins us for agenda item 3.

Agenda item 1 is a decision on whether to take in private item 5, which is consideration of an approach paper to the Commonwealth games legacy. Given that we usually take such papers in private, can I have the committee's agreement to do so in this case?

Members *indicated agreement.*

European Union Reporter

09:46

The Convener: Agenda item 2 is appointment of a European Union reporter. I have had an indication that Richard Lyle is happy to take on the role. Does the committee agree to make Mr Lyle our EU reporter?

Members *indicated agreement.*

Assisted Suicide (Scotland) Bill: Stage 1

09:47

The Convener: Agenda item 3 is continuation of our stage 1 consideration of the Assisted Suicide (Scotland) Bill with two round-table evidence-taking sessions. I welcome everyone involved in the sessions to the meeting.

As is usual with such sessions, I will begin by inviting everyone to introduce themselves. First of all, I introduce Dr Mary Neal, who is the committee's adviser on the bill.

I am the MSP for Greenock and Inverclyde and convener of the committee.

Bob Doris (Glasgow) (SNP): I am a Glasgow MSP and the committee's deputy convener.

Jennifer Buchan (Humanist Society Scotland): I am from the Humanist Society Scotland, and I am actually one of Duncan McNeil's constituents.

Richard Lyle (Central Scotland) (SNP): I am a Central Scotland MSP.

Dr Gordon Macdonald (CARE for Scotland): I am from CARE for Scotland.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am a Mid Scotland and Fife MSP.

Dr Peter Saunders (Care Not Killing): I am from the Care Not Killing alliance of organisations.

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

Rhoda Grant (Highlands and Islands) (Lab): I am a Highlands and Islands MSP.

Mike MacKenzie (Highlands and Islands) (SNP): I, too, am a Highlands and Islands MSP.

Dr Bob Scott (My Life, My Death, My Choice): I am from the my life, my death, my choice campaign.

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

Sheila Duffy (Friends at the End): I am a retired journalist and a member of Friends at the End.

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

Patrick Harvie (Glasgow) (Green): I am the member in charge of the bill.

The Convener: We move directly to questions, the first of which is from Dr Richard Simpson.

Dr Simpson: This is probably one of the most contentious bills to come before the Parliament; indeed, I think that this is the third time that we have had a bill of this sort. In any case, the subject has been discussed on a number of occasions. The fundamental dichotomy that we are facing is between, on the one hand, the public's strongly expressed desire for autonomy and, on the other, the protection of vulnerable individuals. The public might be strongly in favour of what is set out in the bill, but Parliament obviously has a strong duty to ensure that those who are vulnerable are not subjected to undue pressure as a result of the bill.

My opening questions to the panel are as follows. On the one hand, how do you see us, with the bill, ensuring that there is the potential for autonomy? Is that what it is about? Is that all that it is about? On the other hand, do you feel that it adequately protects those who are vulnerable?

Dr Macdonald: Public opinion polls are often quite fluid on the issue, particularly when counter-arguments are presented. Last year, CARE conducted a United Kingdom-wide opinion poll specifically related to the Falconer bill—the Assisted Dying Bill—in which we presented five of the counter-arguments, and the level of support fell from, I think, 73 per cent to 43 per cent, equal to the level of opposition to the bill.

The point is that it is difficult to judge public opinion on the basis of a simple question. We have to give people the full arguments and then let them think about it and make up their minds on that basis.

Sheila Duffy: While I take the point that Gordon Macdonald makes, in all the surveys that have been conducted recently, the vast majority—generally around two thirds—of public opinion has been in favour of a change in the law as long as there are safeguards and the person has made the decision themselves.

Gordon and I have had this argument before. Of course ordinary people, once they think it through, realise that it is not a simple thing. The bill is contentious, which is why it is so important that we consider it seriously. I talk to a lot of ordinary people. I come from a very ordinary background. I talk to taxi drivers and people on the check-out and so on. It is not just those and such as those; it is not just Terry Pratchett, Jeremy Paxman and Richard and Judy. Ordinary people, when we actually talk to them, say, "Yes, I saw my mother suffer in that way"—or their brother, or their gran—"and I think there should be a change in the law."

There is support from disabled people and religious groups as well. When they are asked, as I said, around about two thirds want a change in the law. It is our MSPs' responsibility to bring that about.

Dr Saunders: I have been involved in this debate for more than 20 years, going right back to the House of Lords consultation in 1992, and the figures that have been quoted for those who are in favour of a change in the law on the issue have always been around 75 to 80 per cent. The point that Gordon Macdonald makes is that that is largely uninformed public opinion. The CARE poll was striking, because support for Falconer's bill, which is not dissimilar to Patrick Harvie's, dropped from 73 per cent to 43 per cent when the five major arguments against it were heard.

Those arguments were as follows. Every disability rights group in Britain is opposed, including Disability Rights UK, the United Kingdom Disabled People's Council, Scope and the not dead yet campaign. Virtually every medical group is opposed, including the British Medical Association and most of the royal colleges, although one or two are neutral. If we change the law, we put pressure on vulnerable people to end their lives for fear of being a burden—either a care burden, a financial burden or an emotional burden. The experience of other jurisdictions shows both an incremental increase in numbers and a widening of the scope of the categories of people to be included.

As well as being uninformed opinion, it is uncommitted opinion, in the sense that people will often give a reflex response to what are often high-profile, celebrity-driven, hard cases in the media. It is natural that they respond in the way that they do, but it is not a voting issue for most people.

It is also unconvincing, in the sense that, for example, most people support the return of the death penalty, but we do not reintroduce it because of the risk of innocent people being damaged; it is the collateral damage issue. That is why complex and difficult issues such as this one are not decided by opinion polls or referenda. They must be decided by elected representatives who have had the opportunity to weigh up all the evidence carefully.

Dr Scott: Dr Saunders raised a number of points there that I might come back to later, but to answer Dr Simpson's original question, there is indeed a balance to be struck between autonomy of the individual and protection of society at large—protection of the vulnerable. We are in the fortunate position of being able to look to evidence from elsewhere. For example, there is no evidence in Oregon that theoretically vulnerable groups in society—the very old, the less well-off and the disabled—are more likely to resort to assisted dying than would be suggested by their proportion in society.

We believe that there is huge public support for the bill. Voters support it: polls show that 69 per cent of them do, with 78 per cent declaiming that it is important or very important that the bill is passed. In our view, underlying the bill are three concepts, which I think Dr Simpson referred to: freedom of choice—autonomy—for the individual, but also compassion and tolerance.

We believe that there is substantial moral equivalence in this debate. It is quite proper to arrive at a different conclusion based on the same evidence, according to one's beliefs. We do not support the bill because the majority of the population is in agreement with its aims—although they are—but because we believe that it is the right thing to do.

Sheila Duffy: Spokesmen for lots of disabled groups are very vociferous and critical of any change in the law. However, we should look at the facts. When Lord Low of Dalston, who is himself disabled, spoke in support of Lord Falconer's bill, he referred to a YouGov opinion poll that was conducted among registered disabled people. Seventy-nine per cent of those registered disabled people supported a change in the law to allow competent adults who were terminally ill to control the time and manner of their death if they consider their suffering to be unbearable.

It is not just Lord Low. Baroness Brinton—who is in a wheelchair—supported Lord Falconer's bill in the House of Lords. She is a Christian and believes that the loving, benign God that she worships would not allow her intolerable suffering. It is very easy to say that all doctors and disabled groups are against the bill, but when disabled people are polled, you see that the facts are quite different.

Dennis Robertson: Can I come in, convener?

The Convener: I note your interest, but I am going to encourage some discussion first.

Dr Macdonald: The last time that the Parliament considered the issue, the End of Life Assistance (Scotland) Bill Committee took evidence from Linda Ganzini from Oregon. She conducted a study that showed that 26 per cent of people who requested assisted suicide in Oregon were depressed. There are concerns in Oregon about not just people who are depressed but the lack of safeguards and reporting mechanisms; there are quite a lot of concerns about the way that the system operates in Oregon.

Nevertheless, the bill before us today is not like the Oregon bill. In some ways, it sits between the Oregon experience and the Swiss experience. The situation in Oregon cannot be read across automatically into the Scottish context.

Dr Simpson: One of my concerns about the bill is its breadth and scope. Those who are eligible are those with a life-limiting condition. All our lives are limited in some way; "life-limiting" is a pretty broad definition. The definition of "terminally ill" in the Falconer bill, although equally difficult, includes the phrase "within six months". We are dealing with anyone who feels that their life is limited in some way or whose doctor says that their life is limited. The example I have given, which is an extreme example, is that people who have type 2 diabetes can expect to live 20 years less than someone with average life expectancy, so that is a life-limiting condition.

If we proceed with the bill, what measures should be taken to improve it so that it focuses on those for whom assisted suicide may be an appropriate measure?

Dr Scott: I agree, Dr Simpson; there is room for improvement in the bill's wording. The policy memorandum and explanatory notes make clear the bill's intention, but the wording leaves me and many others in some doubt as to specifically whom it is referring to. The intention is clearly not to say that everybody with diabetes is eligible to proceed immediately. There is room for improvement in the wording, and we would be happy to contribute to that.

10:00

Dr Saunders: We are deeply concerned about the wide scope of the bill. We are not just talking about people who have a terminal illness. The fact is that most progressive conditions have a life-shortening effect, so we are not just talking about cancer but about coronary heart disease; chronic obstructive airways disease; neurological conditions such as multiple sclerosis; diabetes; high blood pressure; obesity; dementia; many mental illnesses; and many acquired and congenital disabilities. All those fall within the bill's remit. We need to grasp the fact that, at the end of the day, it is not about whether the person qualifies under the bill but whether they feel that they qualify or whether a doctor is willing to sign a paper to say that they qualify.

Oregon has a six-month life expectancy requirement, but people have lived for several years after being given authority to kill themselves under the Oregon law. According to the statistics, in 2013, 16.9 per cent of those who killed themselves did not have a terminal illness. The footnotes in the annual report include references to deaths due to benign and uncertain neoplasms; other respiratory diseases; diseases of the nervous system such as Parkinson's; musculoskeletal and connective tissue diseases; viral hepatitis; diabetes; cerebrovascular disease; and alcoholic liver disease.

When the law is changed, people go up to the new law and then beyond it. Doctors will be prepared to sign the paper. Even in Oregon, we see the scope going far beyond what is in the law.

The incredibly broad scope of the Harvie bill, which includes even the ageing process or arguably even life itself as life-limiting conditions, encourages a free-for-all. When that is combined with the woeful lack of accountability and the savings provisions in section 24, which seem to give the benefit of the doubt to anyone involved, even for acts that are careless, omissions and so on, we have a recipe for concerning incremental extension and mission creep.

Dr Macdonald: In his first question, Richard Simpson touched on an issue of principle. The committee needs to consider whether, as a society, we want to send out the message that some people's lives are not worth living because of the quality of life that they perceive themselves to have. Alternatively, do we say that we have a responsibility to protect those who are in a vulnerable position and feel as if they are a burden on family, friends and the national health service, or under pressure to commit suicide for some other reason? The fundamental issue of principle is about protecting the autonomy of the few versus the needs and interests of the many.

Today and in previous weeks, the committee has heard concerns about the wording of the bill, and the Justice Committee has come up with many concerns about the drafting. My feeling is that the bill needs to be put in the bin. Even those who want legislation on the issue to come through should go away and draft another bill, because this bill is so full of holes that it needs to be dismissed at stage 1.

Sheila Duffy: Peter Saunders made a point about Oregon and implied that there is a slippery slope and that, once a certain category of people is allowed to have an assisted suicide, the category broadens. There is no evidence of that in Oregon. The law has been in place for 17 years and it has not been amended, broadened or changed in any way.

I go back to the argument that the status quo is much better than a leap into the unknown. I know that that view is sincerely held by Gordon Macdonald and Peter Saunders, but the status quo is not working. The law is not working now, and it does not need me or Baroness Warnock in the House of Lords to tell you that. The law does not protect anyone; it is a fudge. Keir Starmer had to make various pronouncements to try to clarify the Debbie Purdy case. No one accepts that the status quo protects people; it does not protect anyone. Those who wish to ignore the law, as some people have always done down the ages, can go to Switzerland or trawl the internet for the drugs to kill themselves. The law does not protect those people, either. Frankly—at the risk of sounding insulting; I do not mean to insult—the status quo is the coward's way out. The bill is serious. It must be considered because of what Bob Scott said, not because of what Sheila Duffy or Patrick Harvie says or what Margo MacDonald said. Supporting assisted suicide is the right thing to do.

In a civilised society, the way in which we treat our elderly and our ill is very important, as is the way in which we treat our disabled. I will defend Gordon Macdonald's right to have maximum palliative care—to have tubes, drips and oxygen masks, if that is what he wants for himself, his family and his members—to the end. I am arguing that we need choice. I do not want what Gordon Macdonald wants for myself. In a civilised society, we respect autonomy. I defend Gordon Macdonald's choice, and he is quite right: of course we must have more palliative care. However, to those who are at the end of their life and who are suffering intolerably, we must offer the possibility of assisted suicide.

The Convener: I will bring in Jennifer Buchan because she has not spoken yet, but I will let Dr Saunders in afterwards. You will get all the opportunity that you need to speak.

Jennifer Buchan: We heard earlier that the general public are not informed about the bill, or in terms of how they feel about assisted dying, because of celebrities and the media, and we have heard that what is proposed is a knee-jerk reaction. It is not a knee-jerk reaction. We want the bill to be passed. Four out of five people in the country have immediate personal experience of family members or friends who have suffered so greatly that they would not have them go through that again.

I am a nurse who has worked in hospitals and in the community. I have worked with people who have dreaded the time when living would become unbearable for them. I have sat on the beds and held the hands of people who have asked me to help them to go every day for weeks, and I have not been able to do that: I have had just to sit by their beds. Families have spoken to me afterwards and said that they cannot believe the torture that their relative has gone through. That is the experience that people in this country have, and that is why the bill must be passed.

Dr Saunders: I want to comment first on the current law. We often hear that the law is a fudge or that it is not working, but I think that the law that we have across the UK, which places a blanket prohibition on all assisted suicide and euthanasia, is clear and right and is working. Evidence that it is working is provided by the fact that a very small number of cases involve people going to places such as Dignitas—there are about 15 to 20 such cases per year from the whole UK. When we consider that there are 500,000 deaths in the UK each year, we realise that that is a minuscule percentage.

Evidence that the law is working is also provided by the fact that there are very few prosecutions. The law is working because the penalties that it holds in reserve provide a very powerful disincentive to exploitation and abuse and make people think twice. At the same time, it gives discretion to prosecutors and to judges to temper justice with mercy in hard cases—to let the punishment fit the crime, if you like. On one hand, it has a stern face to deter abuse; on the other hand, it has a kind heart to deal compassionately with difficult cases.

The best kind of laws and those that are easiest to defend are those that are very clear; it is far easier to defend the borders of a country if they fall along natural geographical features such as mountain ranges or rivers. In the same way, the laws that are most easily defended are those that have blanket prohibitions but give discretion to prosecutors and judges, which is the current situation in the UK. Once we change the law and create exceptions, people will push the boundaries. It is not about a slippery slope, which implies a passive process; it is about incremental extension or mission creep, and is about individuals pushing the boundaries of a new law that allows exceptions.

The two major arguments that are used to advance the bill are autonomy and beneficence. The problem is that those two arguments apply equally not only to physician-assisted suicide or to assisted suicide but to euthanasia. Whether it is lethal ingestion or lethal injection, they apply equally. They also apply to people who fall outside the already broad range of categories that are included in the bill, because there are people who do not have terminal or life-shortening conditions who would like to die, for whatever reason.

Once you create an exception and a right for some people, you immediately set yourself up for new hard cases to come along that challenge the boundaries under equality legislation. As we have seen in the Netherlands and Belgium, there is a gradual weakening and broadening of the categories of people. The best law to have is therefore one that is clear and places a blanket prohibition, but gives discretion to prosecutors and judges, as evidenced by the small number of people who go to Switzerland and the very small number of prosecutions that we have here.

Colin Keir: I have listened carefully to what has been said and I understand the categories of people who are being discussed. However, the one group of people who have not been mentioned is people who go ahead and commit suicide. You have talked about the small number of people who go to Dignitas; you are really talking about people who can afford to go to Dignitas. There has to be a group of people who decide, "I am not taking any more," and take their own life. Do we have figures for the number of people who do that? We need to know those figures alongside the Dignitas figures in order to work out exactly what is happening, because an awful lot of people take their own life.

The Convener: Does Dr Saunders have a response?

Dr Saunders: We know the figures, because they have been calculated. We know that 15 to 20 people per year from the whole UK go to Dignitas. We also know that if there was an Oregon-type law for the whole UK, there would be about 1,300 such deaths a year, and if there was a Dutch-type law, which allows both euthanasia and assisted suicide, there would be 13,000 such deaths a year in Britain. The current law is certainly restricting the number of cases. The number of suicides is much lower than that.

We need to grasp that this is not about the condition of the person; it is about the person with the condition. I give the example of the two rugby players, Matt Hampson and Daniel James. Daniel James was paralysed, found his life intolerable and went to Dignitas. Matt Hampson, who has an even worse disability and is on a ventilator, is an inspirational speaker who goes around schools and did everything that he could to change Daniel's position. We have to understand that this is about the person with the condition and their attitude.

10:15

It is not about unbearable suffering or pain. In Oregon, just 23 per cent of people who end their lives cite pain or even fear about future pain as the reason for doing so—it is well down the list of categories. The number 1 reason is autonomy, which is cited by 93 per cent of those people; the number 2 reason is loss of enjoyment of life, which is cited by 89 per cent of the people; and the number 3 reason is loss of dignity, which is cited by 73 per cent of the people. In Washington, which is a neighbouring state, 61 per cent of people who end their lives do so because of fear of being a burden, while the figure in Oregon is 49 per cent. Those are not physical symptoms; they are existential symptoms to do with loss of meaning and purpose. To take the step of allowing people to ingest lethal drugs for existential symptoms, most of which could be improved by good palliative care or much better support, would be the ultimate abandonment.

Dr Scott: I might be able to help Mr Keir with some information from closer to home. Figures that have been extrapolated from research that was carried out by Demos through the coroner system in England indicate that, each year in Scotland, about 50 people with terminal conditions choose to end their own lives. That is one person a week, and anecdotal information points to many of those deaths being violent in nature. I am happy to provide the committee with the source of that information should you wish.

Sheila Duffy: The point that Peter Saunders made about the two rugby players is very relevant because it underpins what we are arguing for, which is choice. Some people will choose to carry on with multiple disabilities and are able to suffer more pain than others; some people will reject that choice because they do not want it. Daniel James tried to kill himself several times before his parents agreed to go with him to Dignitas. I have grown-up children who are roughly his age, and I cannot imagine how heart breaking it was for Daniel's parents to support their son, go to Switzerland and come back to find two policemen on the doorstep wanting to question them about their motives. Is that the kind of civilised Scotland that we want? Is that the kind of civilised society that we want? We must protect our vulnerable, our elderly and our weak, but we must also give them choice over their suffering and their own future at the end of life.

Dr Macdonald: This boils down to the question of autonomy versus protection of the vulnerable. There was a report in the press this week about a couple of cousins from Troon who went to Switzerland not, as far as the press report was concerned, because they were terminally ill or had some chronic illness but because they feared being lonely if they were split up and sent to different nursing homes.

The fundamental question is whether we are content to move to being a society in which choice is the absolute public good. If that is the case, we should not put a restriction on it. In previous debates in which I have heard Sheila McLean speak, she has argued for autonomy and the extension of choice, including euthanasia, to other groups because her founding principle is autonomy. If that is to be the founding principle, you should not say that that choice should be restricted to the terminally ill or people who have chronic conditions. Why would it be wrong for people who are lonely to commit suicide or to be given assistance to commit suicide? We are talking about the state, through the medical profession or other professions, providing assistance to people to commit suicide.

That would run contrary to everything that the Scottish Government's and other public agencies' suicide prevention policies are about. They are about saying, "Don't give up. Life is worth living; it can be improved." You would be sending out mixed messages and also saying, "Actually, your life isn't worth living." You would be endorsing that view and encouraging people to commit suicide rather than saying to them, "Hold on a minute. That is not the case. You are valuable. You have intrinsic worth and there are people who love you." It is interesting that, according to the press report, a nephew said that he would have tried to discourage the cousins from committing suicide if he had known about it, but he did not know about it until after the event.

I think that that highlights where the legislation might go. Peter Saunders talked about it being extended and Margo MacDonald said that she expected that it would be extended to include other categories of people later on. We are crossing the Rubicon with the legislation if we introduce it, so I urge the committee to think very carefully and not to take that step.

Dr Scott: We have met representatives from the choose life campaign and we fully support the Scottish Government's suicide prevention strategy. Probably the natural response of everybody around this table and beyond to the very word "suicide" is to recoil because we are conditioned to regard it as a mistake and a tragedy—and rightly so. When suicide comes about as a consequence of mental illness or overwhelming emotional turmoil, how could that not be a tragedy? It is the few remaining cases that challenge our understanding—those in which suicide is carried out by sane individuals who have calmly decided to end their lives because of incurable illness and unbearable suffering.

There is a need for us to recognise that such action can be appropriate, even if—here comes the tricky bit—that conclusion runs contrary to our personal values. Showing tolerance—a concept that I think lies at the heart of the bill—towards the measured conduct of others, but of which we do not necessarily approve, is surely the hallmark of a truly civilised society.

Dr Saunders: We all cherish autonomy and we are all thankful that we live in a democratic society that respects autonomy, but we also recognise that there are limits to autonomy and that we are not entitled to exercise freedoms that undermine or endanger the reasonable freedoms of others. That is why we have laws and why the committee is here to craft those laws. Every single law on the statute books stops some person doing what they might desperately want to do.

However, the problem is that once we change the law to allow assisted suicide in any circumstances at all, we inevitably place pressure on vulnerable people to end their lives out of their fear of being an emotional, financial or care burden for others, and we place pressure on vulnerable relatives, as well. Those who would be particularly affected are the elderly, the sick, the depressed and people with disabilities—especially at a time of economic recession when many families are suffering and when welfare cuts are being made. The committee will hear from Inclusion Scotland later in the meeting about the effect on disabled people of having welfare withdrawn and the pressure that that creates. Such pressures can be very intense indeed.

When we look at the Oregon figures, remembering that Oregon is a very wealthy north-west American state, we find that 6 per cent of people cite the financial cost of treatment as a reason for having assisted suicide. In nearby Washington state, 13 per cent have that view. In Oregon a few years ago, two patients—Barbara Wagner and Randy Stroup—both applied to the Oregon health department for chemotherapy treatment for their cancers, but both of them received letters saying "We're sorry, but we can't fund your chemotherapy. However, we will fund your assisted suicide." They thought that that was quite interesting because neither of them had asked for that option.

The point is that once we legalise assisted suicide, we make assisted suicide a "treatment" option for a range of conditions, which means that a general practitioner or other doctor is obliged to present it as a treatment option. However, far more important is that, as a treatment option, it gets costed. When we put the cost of chemotherapy or radiotherapy at tens of thousands of pounds and the cost of palliative care or hospice care at £3,000 or £4,000 a week against the cost of a glassful of barbiturates—five quid—it is inevitable that there will be pressure to take the cheapest treatment option.

Do we want to put that choice of costed treatment options to families who are struggling and who are perhaps suffering welfare cuts, to the health administrators who allocate and pay for different forms of treatment, and to doctors? That is not somewhere that we want to go. The problem is that the cost will be a major driver to steer people towards suicide. If people had adequate support or care, they would not choose that option. In other words, it is not a real choice for them—people go that way only because they feel that they have no other choice open to them.

Sheila Duffy: On the point about treatment options, I just do not see that happening in Oregon. The palliative care and hospice movement in Oregon would put us in this country to shame, as it is among the best in the United States. I do not see a disconnect between palliative care and assisted suicide.

Death is the final taboo. If you ask somebody how often they have sex, they will tell you. You can ask somebody what they earn, and they will tell you. If you ask someone what arrangements they have made for their funeral, or whether they have discussed their death with their children, they will reply, “Oh, I’m no goin doon that road, hen.” It is the final taboo.

I honestly believe that, if the bill does nothing else, it will open up the discussion about death and end-of-life choices and about what the mum, dad, husband, wife, son or daughter wants or does not want. It will also prompt the question: why should the person opt for assisted suicide? In the Netherlands, for example, the palliative care system is much better than what we have here. I do not view the issue as either/or. The two things go hand in hand, and palliative care and hospice care will improve if the bill is passed.

The Convener: Reflecting on the evidence that we have received on treatment options and on what forms part of treatment, those who are involved in end-of-life palliative care, who do encourage talk about death and dying—that is their job—are almost completely opposed to the bill. The evidence from the hospice movement and others is very heavily against the bill. You say that the two sides are complementary—the suite of choices—so why have the palliative care and end-of-life people who are involved presented evidence that is heavily against the bill?

Sheila Duffy: There are certain very vociferous people who work in the hospice and palliative care movements who are against the bill. Jennifer Buchan is a nurse. You have been at the coalface, Jennifer. What is the reality?

The Convener: You have been invited in, Jennifer. I will go along with it.

Jennifer Buchan: I was fortunate enough to be asked to do the guest lecture at Ardgowan Hospice in Greenock in November. The topic was humanist pastors in the hospice situation. We also came round to discussing the Assisted Suicide (Scotland) Bill, because people knew that I was involved in it.

To say that the majority of people who worked in the hospice in Greenock were against the bill is wrong. We had a huge discussion about how brilliant palliative care is in this country. However, there is a tiny number of people that it is not for, and that tiny number of people are suffering. I used to be a nurse, but I am now a humanist celebrant. A lot of the time, I am conducting those people’s funerals. Over the past year, I have conducted the funerals of people who took their own lives together in what were very high-profile cases. The family have had to answer to the police and the procurator fiscal afterwards, which makes a bad situation much worse for people who were suffering in the first place. To say that everyone in the hospice service is against the bill is not quite true.

The Convener: I do not want to fall out with my constituent in public, but I would be very careful about suggesting that Ardgowan Hospice supports the bill.

Jennifer Buchan: I am not suggesting that at all.

The Convener: Okay. I have had representations and the hospice is clearly not in support of the bill. I was referring to the evidence that the committee has had. Lots of the evidence from that sector is heavily against the bill. I am not making a personal point; I am just reflecting the evidence that we have had.

10:30

Dr Macdonald: The UK is world leading on palliative care. I do not know the situation in Oregon—there may well be good palliative care there as well—but I certainly know that assisted suicides do not happen in hospices in Oregon. Without assisted suicide law, the UK has developed very good palliative care, although that does not mean that it cannot be improved. The committee heard last week that, particularly in general hospitals and in the community, there is a need for improved palliative care and improved training. However, just because a place has good palliative care, that is not an argument for legalising assisted suicide.

Most people in the hospice movement are opposed to the bill, as you have commented, convener. The reason for that is that they can see what can be done with good palliative care. Often, because people have not experienced good palliative care, they have a fear of the unknown, which pushes them to articulate the view that they wish assisted suicide to be legalised.

The Convener: Some members are getting a bit edgy and want to get in, and that may take us on to other issues so, if our witnesses do not mind, I will take some of those members.

I should give notice that the committee intends to look at palliative care. It is all very well saying that it is great and good, but it has not been reviewed since 2008, and there are issues that the committee wishes to examine.

Dennis Robertson asked to get in for a question a long time ago.

Dennis Robertson: The question that I was going to ask has probably been covered.

On the discussion that we have just had, Dr Scott said in an interview this morning that a “spurious argument” is made about palliative care in relation to the bill. I ask him to explain what he means by that.

The question that I would like everyone to consider is about the human rights aspect. We have a right to life, which is enshrined in law, but do we have a right to death? Do we have the right to decide how we die? If we do and if we progress with the bill, will it open up the door to people who perhaps believe that they want to die? Many people have said to me that they would rather be dead than have a condition, but they do not really mean that. If the bill opened the door, would people who make such comments initially because of a change of circumstances perhaps opt for assisted suicide?

I ask Mr Scott to answer on why he thinks the point about palliative care is spurious, then I will open it up to everyone to talk about the human rights aspect.

The Convener: We have received evidence that says that suicide is a human right. Are you referring to that?

Dennis Robertson: Yes.

The Convener: Dr Scott, do you wish to respond?

Dr Scott: Yes—I welcome that opportunity.

I speak as a retired general practitioner who, during his working life, had a special interest in end-of-life care in the community with my patients. The spurious nature of the argument that I was trying to clarify is that I see no conflict between what is proposed in the bill and appropriate palliative care, because I think that they are capable of coexisting comfortably.

I acknowledge that that is quite a big leap in understanding and recognition. I put up my hand and say that my position has changed. Previously, I did not believe what I now believe to be the case. I was against such a measure, but the weight of evidence persuaded me that it is appropriate for it to go ahead. That is not an implacable position. In future, I may change my view back again if the evidence persuades me, but at present it does not. It is an exceptional provision that is being proposed, not a routine part of medical care. It is an exceptional response to exceptional circumstances.

The Convener: Does anyone else wish to comment?

Dr Saunders: On the issue of palliative care, we know from all the surveys that have been carried out that between two thirds and three quarters of doctors oppose a change in the law; indeed, the BMA and most of the royal colleges, too, oppose it. However, I have always been struck by the fact that opposition is disproportionately high among palliative medicine specialists—for example, at the time of Lord Joffe’s bill in 2006, 95 per cent of palliative medicine specialists were opposed to it. We have to ask ourselves why it is that people who spend all of their time with the kind of folk whom one might regard as coming within the remit of the bill are most opposed.

I think that there are two main reasons for that. First, people who deal with the dying understand the vulnerability of dying and disabled people in a way that other doctors do not. They spend a lot of time with those people; they understand the family dynamics and the subtle pressures that families can put on them; they see their vulnerability and see them making choices often because they have no other choice; and they recognise the need for people to have legal protection.

However, the second reason is that palliative medicine specialists know exactly what to do with all kinds of different symptoms, whether they be physical ones such as pain and nausea, feelings of social exclusion or spiritual problems such as lack of meaning and purpose. Specialists are specifically trained to deal with such things.

Much of the push for this change in the law is coming from the worried well rather than from really sick people. In fact, the percentage of those dying who want euthanasia or assisted suicide is much lower than the percentage in the general population, simply because people change their minds when they see the care that they can have and when they experience good care.

As you will hear, I do not have a Scottish or an English accent; I come from New Zealand, and one of my colleagues in New Zealand looked after the president of the Voluntary Euthanasia Society of New Zealand in his final days. The man was suffering from a terrible cancer, the symptoms of which were very difficult to control, but right up until the very end he did not request euthanasia, even when prompted. He was anxious that, because of who he was, someone might do the deed for him.

Rob George, who is one of the leaders of the Association for Palliative Medicine of Great Britain and Ireland and who speaks on behalf of our movement, says that, in a lifetime of managing 20,000 cases of dying people, he could count on the fingers of his two hands the number who made persistent on-going requests for their lives to be ended or requests to die. In other words, once those people experienced good care, an overwhelmingly vast majority of them wanted assisted living, not assisted dying. They wanted care until they died, not an assisted death.

The question that we are left with, then, is whether we change the law for this very small group of desperate and determined people to allow them to kill themselves. The argument is about a balance of harms. I would argue that we should not, as doing so will simultaneously remove legal protection from a much larger number of vulnerable people.

Sheila Duffy: On the point that most doctors and medical healthcare professionals are against a change in the law, the fact is that it is very difficult for practising doctors to come out in favour of such a move, because they get labelled "Dr Death". The statistics prove that many doctors, including retired doctors such as Charles Warlow and Graeme Catto—I have a list a mile long that I can give you—are in favour of this.

Sadly, I am old enough to remember when doctors were bitterly opposed to the introduction of a national health service. They said, "We'll go to hell in a handcart. Free healthcare for everyone? Are you mad?" However, who today would not defend our wonderful national health service, even with all its faults? Frankly, this issue is too important to leave to doctors—and, in any case, I do not believe that most doctors are opposed to this. Of course, some are opposed, and I respect their views, but many have to sit on the fence. This issue is far too important to leave to doctors to decide. Indeed, when I have spoken to Bob Scott about this, he has said to me that it is more difficult to get a good death today than it was when he trained as a doctor, because doctors have to look over their shoulders in case people clype on them.

The Convener: Dr Scott, I think that that is your cue.

Dr Scott: Thank you, convener—and thank you, Sheila. I will broaden it out just a touch and refer the committee to a 2011 survey. I apologise for these statistics. The same information is used by both sides in the debate but, for what it is worth, here goes. In the survey, 1,000 GPs in the United Kingdom were asked what they would want to happen to them were they to find themselves in a position where they were suffering intolerably. The result fell neatly into three compartments. A third said that they certainly would wish to have the option of assisted dying, a third said, "No, thank you," and a third said that they did not know what they would do. To present the medical profession, including palliative care specialists, as being uniformly against the proposal is a misrepresentation of the reality.

If I fudged that on a personal basis, I apologise.

The Convener: Dr Macdonald wants to comment, and then we will go back to Dennis Robertson.

Dr Macdonald: The term "intolerable suffering" is not neutral, and it is also not well defined.

However, I want to comment on the human rights issue. Dennis Robertson is right. There is a right to life in the ECHR, and it is really the foundation of human rights. It did not come from nowhere, of course. The ECHR came out of a context in which that right to life had been grossly and systematically abused. There is no right to death, and the European Court of Human Rights has always refused cases that have been brought to it on that basis. There is no right to control death or the circumstances of death.

Death is an inevitability. In some ways, it is not something that most people would wish to have a right to. People would wish to avoid it. We have to be aware that, when people seek to control the timing and circumstances of death, the fallout of that may well be to deny other people their right to life. That is why we would say that the right to life of the many has to be given precedence over the demands of some people to control the timing and circumstances of their death.

Indeed, the evidence from Oregon shows that, in many cases, even when people are given the lethal dose of drugs, they do not take it. That is uncontested. Even in that situation, when people have the drugs in the cupboard, in many cases they do not want to go ahead with the act of suicide.

Dennis Robertson: We have explored the right to live, but should we not balance that and give people the right to determine how they wish to die? It might not be because they have intolerable pain or whatever; they might just feel that their choice is that they wish to end their life, for whatever reason. Should we look at that as a basic human right, as we have a basic human right to life?

Dr Macdonald: If you move towards that position in law, the problem is that you undermine other people's right to life. People might express that desire, but we have to look at everything else that is going on in their life. Are they clinically depressed? Do they feel that they are a burden on their family and friends? Is the inheritance being used up by care home fees? We have to look at the other circumstances and ask whether it is a considered, informed and reasonable position to take.

More to the point, we have to ask whether it is reasonable for the state to encourage people to go down that line. If the state does that, what will be the consequences for the culture in both medicine and society? The bill is not exactly the same as the Dutch legislation, but the evidence from the Netherlands is that there has been a shift in the medical culture. There is a situation in which 12.5 per cent of deaths are through terminal sedation, and they do not feature in the euthanasia statistics, which have gone up every year in the

Netherlands. We now see disabled infants being euthanased in the Netherlands. The culture has changed, and I suppose that that is our concern.

Oregon is a different scenario but, at the end of the day, if you change the medical and wider culture, pressure will be placed on people.

10:45

Dr Scott: I have a very brief point. I hesitate to stray into the field of the law, which is well beyond my expertise, but a majority of our Supreme Court has recently indicated that the current blanket ban is or may well be incompatible with article 8 of the European convention on human rights. I leave that with the committee and other experts to clarify.

Dr Macdonald: The Supreme Court said that Parliament should decide the matter. This Parliament has decided the matter in the past and it is considering it again now.

Dr Scott: That is where we are today.

The Convener: We are indeed.

Jennifer Buchan: I would like to say to Dennis Robertson that everyone has a basic human right to a good and peaceful death. As someone who works at the chalkface, I see that a lot of people do not get that. I do the funerals of people who have had very violent deaths. They have been alone and they have committed suicide; they have had a very traumatic death. No one should have to do that.

Sheila Duffy: Gordon Macdonald made a very good point about the cousins in Troon whose nephew would have tried to stop them if he had known what they were going to do. That puts the lie to the misunderstanding that, if you are wealthy and coming to the end of your life, your children, nieces and nephews will put pressure on you to go. I have not seen that at all. One of our members who went to Dignitas, Nan, who had a very large house in Chelsea and was very wealthy, said to us, “Please, don’t tell my daughter that I’m going to do this,”—she was racked with pain and had osteoarthritis—“because she will try to stop me.” Of course there are bad guys in the world—we know that—but most people want their parents and loved ones to go on. They want to encourage them.

I am thinking of my friend David, who died of motor neurone disease last year. He did everything in his power and his family helped him to try to combat motor neurone disease. He travelled down to London for trials and tests and things to try to prolong his life. I do not see this vision of the family saying, “Oh well, it’s your time to go.” My mother went through two wars and a depression and if I said to her, “You’ve got a good Post Office book, is it no time you went?”, she would have said, “I’ll make up my own mind when it’s time for me to go, thank you very much.” These are the 80 and 90-year-olds I mix with.

As Gordon Macdonald said, the nephew said that he would have tried to stop the twins. That is what I find among families. They do not want their loved ones to leave and they do not want them to have to resort to suicide. Frankly, going to Dignitas is not a joyful experience—it is a horrible experience. People want a dignified death, in their own house, with their loved ones around them, perhaps with a glass of Lagavulin in their hand, or Irn-Bru or something like that. That is what they really want. That is why it is so important to discuss this issue and support the bill and say, “This is what a civilised society would offer the very few people who would take advantage of it.”

Bob Doris: We are getting a lot of individual direct experiences this week, as we did last week, but that leads to generalisations being given. There are individuals and family dynamics that will be very different, depending on where you are. The figures given to the committee today show that in Oregon 49 per cent of those who underwent assisted suicide perceived themselves as a burden, whether or not they were, and I think that it was 69 per cent in Washington—I apologise if I have got those figures wrong; I scribbled them down earlier in the meeting.

We have also heard the word “exceptional” this morning—assisted suicide will be for “exceptional” circumstances—and we have heard the expression “tiny number of people”. We have to compare that with what the bill says. The bill will provide that those with certain illnesses or conditions will be eligible to seek an assisted suicide. Eligible individuals will be those with

> “an illness that is, for the person, either terminal or life-shortening, or ... a condition that is, for the person, progressive and either terminal or life-shortening.”

That does not sound like a tiny number of people to me and I would be interested to know whether anyone has estimated how many people in theory, not in actuality, would fall within that scope. It is important to know that, because we have to test it against the claim that this will be for a tiny number of people in exceptional circumstances.

To get to the point where, if the bill becomes law, it is for a tiny number of people in exceptional circumstances, we will have to look at whose job it is to offer the treatment choice. If someone goes to a GP and says that their pain is really bad and that they are not sure that they can go on, should the GP be duty-bound to say that one of the options is assisted suicide? If someone goes to a pharmacist for a chronic pain management and pharmaceutical review and they say that the treatment is not working for them, should the pharmacist have to say that? If someone has a nurse specialist to deal with their condition, should the nurse have to say it? For many conditions, there are managed clinical networks and treatment options along the way. Should the option be part of the managed clinical network? It is important to know all that, but I do not think that it is all in the bill.

When any law is passed, we normally have some form of public information campaign to make people aware of their rights. I do not want to use the word "advertising" because that is not what I mean, but people have to be made aware of the rights that they can exercise, and assisted suicide would be a right if the bill is passed. Who would make people aware of that right? Who in the medical profession should have to make people aware of it?

Irrespective of the views that people are expressing at the committee today—and I respect the fact that people have various different views—if we do not clarify the roles and responsibilities and whose job it is to inform people, is there a danger that we could compromise or conflict certain individuals who are involved in people's care? I have deliberately not mentioned palliative care because those issues were well aired last week.

The Convener: There is lots in there.

Sheila Duffy: Virtually every week, someone from the media calls me to ask, "Do you have someone going to Dignitas? Can we follow them?" Sadly, we are talking about the "Freddie Starr ate my hamster" syndrome. I come from that background and I do not defend it. However, we find that the press will generally report—perhaps overreport—what is happening and what is available.

The bill is complicated. I have spent the past year of my life reading it and re-reading it and thinking "Oh my God, how are they going to catch us out today? What am I not going to be able to answer?" and the bill could well be amended. Basically, I have no worry that people who live in Govan, Castlemilk, Hilltown, Dundee and so on will not be able to understand and will not be informed about their choices. The bill is very clear: a person has to make their own declaration. It is not as if someone will go to their doctor or pharmacist, who will say, "I think this is for you." People will have had to make a declaration; they will have decided for themselves.

Ordinary people take their death seriously, and as we get older, we take it more and more seriously, I assure you. People do not wake up one morning, decide that their condition is really painful and say that they are going to end it all. Most of the people I have known or have met who have gone to Dignitas or have taken their own life have agonised about it, sometimes for weeks and months.

I am not worried about the information: it will go out through the press and debates and other public events. People will understand what is available, why it is available and the safeguards that exist for those who have misgivings about the bill.

Dr Saunders: We need to be very clear that we are not talking about a right to die. We are talking about a right to kill oneself and to have help to end one's life. That is different. In order to give somebody a right to end their life, we need to give somebody else the power and authority to make that happen. The thing that concerns me most about the bill—and I say this as a doctor and someone who knows doctors—is that it gives far too much power and not nearly enough accountability to doctors who are not really in a position to make the judgment that the bill requires.

We are talking about calling on busy general practitioners, who are under a lot of pressure and who do not necessarily have the skills of palliative medicine specialists or psychiatrists, to make judgments about patients whom they might only just have met and whose family situation they do not know; to assess their mental capacity when they might not be able to do so; to assess undue influence; and to judge whether a condition falls within the broad range of conditions, or whatever. There are a huge number of pressures and there are some doctors—and I am talking about a minority here—who really scare me and who, if they were to have such power and authority, would abuse them.

I see nothing in this bill to stop, say, a Shipman who gets a taste for killing and authorising such things abusing the situation. The bill does not contain safeguards; instead, it contains eligibility criteria for illness, capacity and so on. Those criteria can be stretched, and at the end of the day, the question will not be whether a patient meets the criteria but whether a doctor is prepared to tick a box to say that they do so.

I know that we are not talking about abortion today, but the Abortion Act 1967 operates a similar system in which doctors say in good faith whether a patient falls within a certain category. The provisions in that legislation were meant to apply to a very small number of people, but we have now had 8 million abortions in Britain, or 200,000 every year. One in every five pregnancies ends in abortion, and 98 per cent of them are carried out on mental health grounds, with a doctor ticking a box to say that continuing the pregnancy poses a greater risk to the patient's mental health than having an abortion. However, when the Academy of Medical Royal Colleges looked at the issue, it found no evidence that the mental health ground ever applied.

I am sure that we will all have different views on that issue, but my point is that if you give doctors the power and authority to make the judgment to end life according to certain criteria, and if the legislation does not have the teeth to hold them accountable, they will push the boundaries. What worries me most about the bill is that the only provision that seems to be about keeping doctors accountable is one that lets them off. I am talking about section 24—or the savings provision—which removes culpability for incorrect judgments and inconsistent actions as long as they are made “in good faith”. It contains no penalties for abuses or careless errors and makes no suggestion about how such things might be investigated.

I am really worried about the small group of doctors who, if the legislation were passed, would be enthusiasts for this. They would be given too much power and they would simply abuse it. You have got to remember that many doctors feel—

The Convener: You have made your point, Dr Saunders. It has caused a bit of a reaction, and I want to encourage others to comment on it. I invite Dr Scott and Sheila Duffy to comment, and I should tell everyone that we have only 15 minutes left and that I need to get some others in.

Dr Scott: I want very briefly to say that I do not recognise Dr Saunders’s description of medical practice. The bill implicitly contains a rebalancing of the relationship between doctors and patients, but our view is that it empowers the individual and that it is for the individual to decide whether the provisions are appropriate to them.

Sheila Duffy: I really think that the reference to Dr Shipman was unnecessary hyperbole and simply fudges the issue. What this contentious bill needs is cool, clear and pragmatic discussion of the evidence and the statistics. Dr Shipman was an unbalanced, drug-using individual, and no one under any circumstances would defend any of his actions. The reference simply clouds the issue when what we need are cool, clear heads to look at the arguments for and the arguments against.

The Convener: Bob, do you want to follow up on your question?

Bob Doris: Given the time that we have left, convener, I will leave my comment sitting. I want to give Mr Harvie, the member in charge of the bill, the opportunity to comment, at your discretion.

As a politician, I apologise for accusing all my witnesses of not answering the question that I asked, but that is what I felt. I asked what the safeguards or protocols would be when a GP, a pharmacist or a nurse specialist got involved in the conversation about assisted suicide. Would they lead it or would they be passive in the process? Should there be guidelines for that? Should there be public information campaigns? I have a variety of concerns and, irrespective of my personal views, I believe that it is for people to bring certainty in relation to those issues. That is what I was hoping for, but neither side of the debate has given me that certainty.

I thought that the comment about Mr Shipman perhaps did an injustice to some of the comments that could have been made about some of the concerns that I have. With total respect, I say to Ms Duffy that I do not think that you engaged in the question. What you said was “It’ll all be all right on the night.” Far be it from me as a politician to suggest that witnesses have not actually answered the questions that I asked, but I just want to leave that sitting there.

11:00

Sheila Duffy: It will be all right on the night because there are safeguards built into the bill and the person has to raise the matter themselves. At the moment, if I go to my doctor and say “I’m in intolerable pain. I want an assisted suicide,” he or she will turn round and say “I can’t discuss that. Please don’t even raise it.” If the bill is passed, individuals will at least feel free to discuss with their doctor or healthcare professional what their feelings are.

Bob Doris: I will read the *Official Report* of the meeting. I am not personalising the issue, Ms Duffy; I am just giving my impression of the evidence, based on the question that I asked. I will consider it all carefully. Thank you, convener.

Dr Macdonald: Certainly the evidence that we have heard from health professionals before is that they do raise the issue of suicide with patients if they are trying to find out whether the person is suicidal. If we were to legalise assisted suicide, that would have an impact on the freedom of health professionals to have those discussions with patients. They have such discussions because of suicide prevention strategies and the need or desire to discourage people from committing suicide.

In the scenario where the bill has been passed, if a doctor raises the issue of suicide with a patient, will the patient go away from that conversation thinking, “The doctor thinks I should commit suicide,” or will the patient go away saying, “I shouldn’t be having these suicidal thoughts”? We need to get to the bottom of that dilemma.

On Bob Doris’s point about who initiates the conversations and what processes there would be, the bill includes a lot of processes in relation to ticking boxes and signing forms, but there is no detail about where the conversation comes from.

Yes, a preliminary declaration has to be signed, but at what point does it get signed? Who raises the discussion in the first place? It is not clear that the suggestion could not be put to somebody.

Dr Shipman's case is the extreme, is it not? However, it is a historical fact. In that case, a second doctor was involved—or a number of second doctors, potentially—who signed the cremation forms and did not give due diligence to what they were doing. The concern is that what the bill proposes becomes just a tick-box exercise.

I have family who work in general practice and I know that general practitioners are under huge pressure at the moment and have 10 minutes to see a patient. It is not even clear in the bill that it would be the person's own GP who would deal with them; it might be a GP whom they have never met before. Therefore, I think that there are significant issues with what the bill proposes.

Richard Lyle: I have listened to some very powerful arguments and statements this morning, but I want to turn to a statement that Jennifer Buchan made earlier. I compliment all the nurses who work in hospices and hospitals, who deal with the unfortunate deaths of people and give a lot of comfort. On palliative care, the committee has received evidence that some people cannot be helped by such care and that assisted suicide could be a complement to such care rather than an alternative. Do those who are opposed to the bill agree that palliative care has its limits—even though this country has possibly one of the best palliative care systems—and that assisted suicide could be a complement to palliative care rather than an alternative?

To go back to the point that Dr Macdonald made, is there any evidence that people with terminal and life-shortening conditions are currently using suicide as an end-of-life option?

Dr Macdonald: Do you want me to answer that question?

Richard Lyle: That would be good, Gordon.

The Convener: You two just go ahead.

Richard Lyle: We will have a private discussion.

The Convener: I do not want to spoil that cosy relationship, so we will hear from Dr Macdonald and then from Dr Scott.

Dr Scott: I would just—

The Convener: No—we will hear from Dr Macdonald first, and then from Dr Scott.

Dr Macdonald: I am not a palliative care specialist, but the palliative care specialists who gave evidence to the committee are of the view that there is no place in palliative care for assisting people to commit suicide. I think that you have to listen to the people who work in that area.

No doubt, we could still have good palliative care if we legalised assisted suicide. The question is, with pressures on budgets in the health service, a lack of training and so on, would people be given access to the palliative care? I welcome the fact that the committee is going to look at palliative care. A few years ago, Roseanna Cunningham proposed a bill to establish a statutory right to palliative care in Scotland, and I encourage the committee to consider whether we should legislate for that. However, that is a debate for another day.

I am sorry, but I cannot remember your second question.

Richard Lyle: Is there evidence that people with terminal and life-shortening conditions are using suicide as an end-of-life option?

Dr Macdonald: I have no doubt that Sheila Duffy would be able to cite a list of people for whom she would say that that is the case. However, the fundamental question for us is this: if some people were allowed to choose that option, what would be the negative consequences for other people? Would there be a disadvantage for people in that they would be made to feel under pressure—either internal or external pressure? Last week, we heard from Baroness Finlay about the case of the elderly lady who was being visited by her relatives but whose relatives stopped visiting her because—according to the elderly lady—her life insurance policy had run out. There are concerns about such things, and there is a balance to be struck.

Suicide, or attempted suicide, is not a criminal offence in Scotland, but assisting somebody to commit suicide is and we would say that that should remain the case.

Dr Scott: I repeat what I said earlier. The evidence shows that, every week in Scotland, one person who is terminally ill commits suicide. That is an extrapolation from the figures in England.

In relation to palliative care, it is important to recognise that no place in the world that has enacted legislation to allow its citizens to manage their own death in one form or another—the province of Quebec was the most recent to do so—has, in the light of experience, seen fit to repeal those laws. If the impact of the laws is as dreadful as those who are opposed to the legislation would have us believe, why has that not happened? Quebec has introduced legislation that combines palliative care and assisted dying. It is possible to do so.

Dr Saunders: Quebec has done that, but the legislation has not yet been enacted and it is being challenged. Over the border in the US, two states—Oregon and Washington—have changed their law to allow assisted suicide, but there have been more than 120 attempts to change the law in other states and all those attempts have been defeated. In addition, Oregon and Washington changed their laws only on the basis of a referendum. Whenever the issue has been debated in a US state Parliament, it has been defeated, even in those states with a political balance that one might think would make them more open to such a change.

You must remember that palliative care involves not just the relief of physical symptoms, but physical, social and spiritual care—it is total-person care—and we know that, when people have their physical, social and spiritual needs properly met, requests are rare even in countries that allow euthanasia or assisted suicide. That must put the onus on us to ensure not just that the very best care is available but that it is made accessible and affordable to people.

Despite all the best palliative care, there are a very small number of people who will still want to end their life but, as I said earlier, the overarching reasons for them wanting to do so are existential, rather than physical. They are about loss of autonomy, loss of enjoyment of life and loss of dignity. There are many other people in this country who are not terminally ill or suffering any life-shortening condition who want to end their life—most suicides do not involve people who are terminally ill. Those people want to end their life for exactly the same reasons—loss of enjoyment of life, loss of dignity and so on.

We have to be very careful about the messages that we are sending. We know about the dangers of suicide contagion, the Werther effect and so on. It is very difficult to run an effective suicide prevention strategy on the one hand and, on the other hand, to promote the idea that assisted suicide is a treatment option or an acceptable choice that we want to affirm for people who want it, regardless of whether or not they are sick, for reasons of loss of enjoyment of life. That is a very dangerous road to go down.

We have to accept that, under the law that we have, with a blanket prohibition—stern face, kind heart, and discretion to prosecutors and judges—there will be some desperate and determined people who are not able to end their life. I am afraid that that is the price that we must pay in a democratic society in order to protect the much larger number of vulnerable disabled and elderly people.

The Convener: I am anxious to bring in Rhoda Grant. I also need to give Patrick Harvie some time at the end.

Rhoda Grant: I refer members to my entry in the register of interests. I have an intern from CARE and one from Inclusion Scotland, which is represented on the next panel—I wanted to put that on the record.

I wish to ask the witnesses about a conscience clause. We have heard some evidence previously about the fact that the bill does not have a conscience clause. We have been told that that is not a devolved matter and that we cannot therefore have such a clause in the bill. How would the witnesses deal with that point, and how would they ensure that people were able to opt out if they did not wish to take part in the process under the bill in future?

Dr Scott: Our understanding is that the bill does not include a conscience clause, as it is beyond the powers of the Scottish Parliament to put one in. However, it is clear in the policy memorandum that no doctor should be compelled to participate in the process. It is nigh on certain that, were the bill to be passed, the General Medical Council would modify its regulation and standards for doctors, taking into account the possibility of doctors not taking part in any part of the process.

The Convener: Do you wish to add to that, Ms Duffy?

Sheila Duffy: I think that Dr Scott has answered the question.

Dr Macdonald: If there is not a conscience clause in the bill, there is no legal protection. It is not beyond the competence of the Scottish Parliament to engage in dialogue with Westminster, even post referendum, to ensure that there could be a conscience clause. It is not acceptable just to say, “There’s no conscience clause, and we can’t legislate for that.” There has to be a conscience clause in legislation, and it has to be a robust conscience clause.

The issue of other jurisdictions was raised. The Northern Territory legalised assisted suicide, but that was then overturned by the Australian federal Government and Parliament. It is not that there have been no places in the world where assisted suicide was legalised but is now no longer legal. I mention that as a point of record.

Dr Saunders: The Human Fertilisation and Embryology Act 2008—the HFE act—the Abortion Act 1967 and Lord Falconer’s bill all have conscience clauses in them; the Assisted Suicide (Scotland) Bill does not. It is essential that there is one. Even when there are conscience clauses, there are arguments in court about their scope. I cite the Glasgow midwives case.

When there is no conscience clause, the treatment that is prescribed becomes part of the full range of treatments that are required under the specialty concerned, and pressure will inevitably be placed on doctors, nurses and pharmacists. That is an essential point to note.

11:15

Patrick Harvie: I thank all the witnesses for their evidence, whether they support or oppose the bill. We have heard some very interesting and reflective views.

I want to pick up on a couple of points. Dr Saunders, you made some comparisons with abortion and the requirement for signatures from two doctors. You said that, over the decades, there has been a change in the way in which that is applied compared with the expectation at the time the legislation was passed. I put it to you that that change is more reflective of the wider change in the provision of healthcare in society, which has, over the decades, moved away from a top-down, authoritarian, doctor-knows-best approach towards a position that reflects the expectation that people have the right to make informed choices on their own terms and to be empowered to do so.

It is clear that some people do not think that that should be the case in relation to abortion. I am perfectly happy to say that I do think that it should be the case in relation to abortion. However, surely the concern that you reflected is relevant to the bill only if you can present evidence that women are being subjected to abortions against their will.

Dr Saunders: My reason for mentioning the Abortion Act 1967 was not to get into a discussion about the ethics of abortion, because I am sure that there would be a range of views on that. I just used it as an analogy, noting that, when the law was passed in 1967, it had strict safeguards, and the reason for that was to provide protection for the life of the unborn child. My point is that the law has not changed but the interpretation of it has. In effect, doctors, acting in good faith, authorise about 98 per cent of abortions outside the original intended scope of the 1967 act.

My point is that, once you allow a right to assisted suicide in certain circumstances, the same drift will happen. We see that in the jurisdictions that have changed the law. In the US states of Oregon and Washington, in Belgium and in the Netherlands, we see three key things. The first is an annual increment in the number of cases. For voluntary euthanasia cases in the Netherlands, it has been 10 to 20 per cent a year since 2006. The second thing is a widening of the scope. It starts with the terminally ill, and then it is the chronically ill. It starts with adults, and now in Belgium it is children. It starts with the mentally competent and it then shifts to the mentally incompetent—those with dementia.

The third thing, and probably the most worrying of all, is that as time goes on we see a change in the public conscience and the medical conscience. That does not worry some people, but it worries me a lot that the public conscience changes so that people come to accept situations that, 10 or 20 years ago, they would have found intolerable.

Most people are shocked about what is happening in the Netherlands and Belgium at present, but many people there, and particularly doctors, are not shocked and do not see anything wrong with what is happening. That change in the public conscience is something that happens once the law is changed. People start to push the boundaries, and the law is not properly upheld.

Patrick Harvie: I am sure that there is no intention to conflate, accidentally, a change in public opinion, a change of medical practice and a change in the law. Some of the changes that you cited fall into those three different categories. I would—

Dr Saunders: They all interact with and change each other.

Patrick Harvie: I suggest that the balance of public opinion is already fairly clearly in favour of some form of change in the law toward assisted suicide. However, the context in which you made those remarks about changing medical practice and attitudes among doctors was related to some quite extraordinary comparisons with, for example, Dr Shipman. I think that you said that, once doctors have the power—in my view, this bill is about putting power in the hands of individuals about their own lives, not putting power in the hands of doctors—they will push the boundaries.

Surely your comparison with abortion is accurate only if that decision-making power is being taken away from patients and decisions are being imposed on them by doctors. I suggest to you that that is not the case.

Dr Saunders: With abortion, we might argue that the legal protection and the decision-making power have been taken away—

Patrick Harvie: From whom?

Dr Saunders: From the person that is aborted.

Patrick Harvie: Well—

The Convener: I am prepared to indulge your asking a direct question of Dr Saunders, Mr Harvie, and I will take other bids, but I cannot allow you to interrupt each other.

Patrick Harvie: Understood, convener.

The Convener: Dr Saunders, please come to your point quickly.

Dr Saunders: My point about Shipman is not that all doctors are like him—clearly, they are not—but that even with a very strong law in place someone clever such as Shipman was able with the collaboration of other doctors signing off drugs and cremation certificates to get to the point where he could kill more than 200 people. There are a few who will push the boundaries, which is why we need strong laws that are very clear and specific and which contain proper safeguards and strong penalties in reserve to deter and deal effectively with exploitation and abuse. We do not see that in this bill; it contains eligibility criteria but no strong legal safeguards to protect vulnerable people.

Patrick Harvie: I suspect that all committee members will recognise that, whether or not the bill is passed and whatever the law itself says, if wicked people choose to break it, that is a serious matter. As the example that has been cited demonstrates, that can happen in the absence of any law on assisted suicide.

I also want to pick up on a point made by Jennifer Buchan in response to the convener on the balance of views within a profession. Do you agree that, although the range of organisations that represent, for example, medical professionals, lawyers and palliative care practitioners will, in many cases, take a position against a change in the law, that does not reflect the balance of views of the people who work in those fields? Is that the point underlying your discussion with the convener?

Jennifer Buchan: That is exactly right. I even had a member of the clergy come up to me the other day and say, “I hope everything goes well at the committee meeting”; when I said, “That’s great—thank you,” he said, “I support the bill, but I can’t say so.”

Patrick Harvie: Is that all to do with the fact that the stance that an organisation takes collectively is part of the cultural norm and the status quo and—I mean this not as a criticism but as a reflection of the way in which organisations collectively make decisions—that some organisations might be inherently conservative as far as the status quo is concerned?

Jennifer Buchan: Definitely.

Patrick Harvie: I wonder whether other witnesses have views on that matter.

The Convener: I believe that Dr Macdonald indicated that he wished to comment.

Dr Macdonald: It should come as no great surprise that some members of the BMA, the Royal College of General Practitioners or the Church of Scotland might be in favour of this bill. After all, we live in a free and democratic society in which people come to different views. However, the point is that those institutions have considered the issue over a long period of time and have come to a considered view that is supported by the majority of their members or the people who are there. I do not think that we can say that, just because one minister—I was going to say “Church of Scotland minister”, but I do not know whether the minister in question was from the Church of Scotland—one doctor or a few people say this or that, that undermines an organisation’s considered position.

Dr Scott: I want very briefly to provide some clarification on the point that Dr Macdonald made. When, in 2013, the Royal College of General Practitioners consulted its 49,000 members throughout the UK on assisted dying, 1,309—or 2.6 per cent—remained opposed to any change in the law. If that is presented as a majority, one has to ask how representative that is.

Dr Saunders: That is because 77 per cent of those who responded opposed such a change.

Dr Scott: In absolute figures, it was 1,309 out of 49,000 members.

Dr Saunders: Yes, but of those who responded to what was a voluntary survey, 77 per cent opposed a change in the law.

Dr Scott: Seventy-seven per cent of those who responded.

Dr Saunders: Yes.

Dr Macdonald: That is democracy.

Dr Scott: But it was only 2.6 per cent of members.

The Convener: The committee has heard evidence and received representations from individuals, including ex-GPs and others, and from organisations, and that is what we will be evaluating at the end of the day. Unfortunately, we cannot take phone calls from people.

Do you wish to ask any other questions, Patrick? I am happy for you to do so.

Patrick Harvie: I am aware that you are very tight for time, convener, but I just want to say that the final point about the difference between consultation exercises, democracy and the overall balance of public opinion probably speaks for itself. Given the evidence that we have heard, I think that we understand that difference.

The Convener: Okay. I thank all the witnesses for their attendance, their valuable time and their evidence.

At this point, I suspend the meeting so that we can set up for the next panel.

11:25

Meeting suspended.

11:35

On resuming—

The Convener: We continue our stage 1 scrutiny of the Assisted Suicide (Scotland) Bill. I welcome all the participants for our second round table of the morning. My name is Duncan McNeil; I am the MSP for Greenock and Inverclyde and convener of the Health and Sport Committee. Dr Mary Neal is the committee's adviser on the bill. I ask everyone to introduce themselves.

Bob Doris: I am an MSP for Glasgow and deputy convener of the Health and Sport Committee.

Professor Sheila McLean: I am emeritus professor of law and ethics in medicine at the University of Glasgow.

Richard Lyle: I am an MSP for Central Scotland.

Catherine Farrelly (Scottish Youth Alliance): I am a member of the Scottish Youth Alliance and a carer for my mum, who suffers from primary progressive multiple sclerosis.

Dr Simpson: I am an MSP for Mid Scotland and Fife.

Dr Peter Bennie (British Medical Association Scotland): I am the chairman of the British Medical Association Scotland and my working job is consultant psychiatrist.

Colin Keir: I am the MSP for Edinburgh Western.

Dr Sally Witcher (Inclusion Scotland): I am the chief executive officer of Inclusion Scotland.

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

Rhoda Grant: I am a Highlands and Islands MSP.

Dennis Robertson: Good morning. I am the MSP for Aberdeenshire West.

Tanith Muller (Parkinson's UK in Scotland): I am the parliamentary and campaigns manager for Parkinson's UK in Scotland.

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

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

The Convener: Thank you. Our first question is from Bob Doris.

Bob Doris: I will continue the line of questioning that I have explored over the past few evidence sessions, which is on whether the bill, if passed, would medicalise assisted suicide. In other words, would assisted suicide become one treatment option within a suite of treatment options for people with a variety of life-limiting conditions? What safeguards could be put in place regarding—I have used this example before—whether GPs, pharmacists, specialist nurses or whoever should initiate a conversation on assisted suicide with someone who makes it known to them that they do not think that they can go on and that they cannot cope with their pain? Should assisted suicide be presented as a treatment option and, if so, would that medicalise it? Are there irresolvable conflicts in that or could safeguards be put in place to ameliorate my concerns?

Dr Bennie: I start by stressing that the British Medical Association represents all branches of the medical profession: GPs, hospital doctors, doctors in training, medical students and retired doctors. We have a clear policy against assisted dying and we are very strongly of the opinion that if the bill proceeds it must have some form of conscience clause.

Bob Doris asked a broad question: if the bill became law, would that in effect mean that a discussion about assisted suicide could be seen as a necessary part of a discussion of therapeutic options? It seems to me that that would be a significant possibility. However, if the bill has a strong conscience clause, which we believe to be essential, that would lead to real difficulties in how such discussions would play out in practice. There would be a group of doctors who would be protected by law from becoming involved in the process of the statements and declarations that would need to be made, and another group that would not be in that category. That would make it difficult to have the kind of broad discussion about therapeutic options that doctors always want to have.

Professor McLean: The answer to the question is that it is inevitable that assisted suicide would have to be part of the on-going discussion with patients about their options, in the same way as somebody who came to a clinician concerned about being pregnant and not wanting to be pregnant would have to have the obvious discussion about abortion.

Peter Bennie makes an important point about some doctors choosing not to be involved. However, to use the abortion analogy again—I hate to do that, but it is relevant—the BMA and the GMC have made it clear to clinicians that if they are not prepared to participate in a pregnancy termination, they have an obligation to refer the patient to another clinician who might be prepared to do so. I imagine that similar guidance would be issued in the circumstances that we are discussing.

The bill medicalises assisted dying by authorising only healthcare professionals to carry it out. I do not think that we can avoid the fact that assisted dying is medicalised by the bill. However, it is medicalised only to the extent that it requires clinicians, when they are prepared to participate, to respond to the competent, genuinely felt, often-repeated request of an individual patient who has made the decision.

Bob Doris: I am trying to get my head round the practicalities. We have heard a variety of evidence from the stakeholder groups that have come to the committee in the past few weeks. They have expressed concerns about how the bill could undermine the relationship between a health professional or allied health professional and an individual who might have a transient desire not to go on at one point in time, but whose feelings might change or fluctuate over the course of their experience, perhaps because they receive better palliative care or because their mental and emotional health improves or varies.

If an individual is to be completely aware that they have a right to make a preliminary declaration, they have to get that information from somewhere. Someone has to provide them with that information. When this becomes a public health issue, as I suppose it will, there will be public information campaigns and people will have to know where to go. Will that lead to the promotion of assisted dying? I am not trying to escalate issues that are not there, but I want to be clear in my head about how all individuals will be made aware of the option and about how we can do that in a way that does not undermine a relationship between a relevant professional and an individual.

The Convener: I offer my apologies to Dr Witcher and invite her to speak at this point. She tried to catch my eye to answer the previous question. If you would like to address the other questions before I allow others in, that would be helpful.

Dr Witcher: I will do my best. One of the difficulties that I have is that, in a way, the bill is coming at the issue further down the line when we have objections to some of its fundamental starting points.

Bob Doris asked about safeguards. One of the problems is that it is hard to see the safeguards in the bill as it is currently drafted in many respects, and we might also want safeguards in many respects. We might want to be clear about the particular groups that are being targeted, when we have already heard about the evidence from other countries on the expansion in numbers and coverage that ensues. We might want safeguards so that we can challenge when something has not happened as the bill intended and the overall cop-out clause basically says that, if it was done in good faith, even if it was inconsistent and did not go along with what was originally said, that is fine.

11:45

How on earth will we prove that? Who knows what goes on in a conversation between a GP and an individual? Where is the evidence? How will anybody see what goes on in that situation? Ultimately, even if it were about bringing a case, would it ever be in the public interest? How would we know that relatives had not been pressurising that individual? There are so many issues. It is partly to do with the fact that people might come to a view about the quality of their life, which is to do with factors such as the experience of abject poverty caused by benefit cuts and huge cuts to social care provision. We heard earlier about Oregon, where the reasons why people went down this road were to do not with pain but with loss of dignity and not being able to enjoy life any more; for a large proportion of them, it was to do with fear of being a burden.

The point that we would want to make is that none of those factors is necessarily inevitable. We talked about medicalisation. Where there really is medicalisation is in the straightforward assumption that a person who has a medical condition—a life-shortening condition of some sort or another—must therefore have a certain quality of life and that the medical profession is best placed to judge that. The reality is that someone could have a very severe impairment and experience a very good quality of life, or they could have a slight impairment and experience a very bad quality of life. What determines quality of life is not necessarily someone’s condition; it is to do with the services that they receive and whether the services and support that they get accord them dignity or choice and control. It is to do with whether they have the money and whether they are demonised or oppressed by the attitudes that they encounter and the culture that exists.

We have examples—this is not uncommon—of people having to survive in nappies overnight. A case was taken on that particular subject. Some people talked earlier about a civilised society. The civilised society that we have today is one that thinks it is okay to leave people in that situation and thinks it is okay to have people relying on food banks in order to survive. Let us think about this. If that is the reality of life as confronted by somebody who has a disability or impairment—whether it is bullying in a care home or fear of other things—the reality is that life will not look terribly attractive, will it? Maybe if someone does not have dignity, choice and control in the way that they live, dignity, choice and control about the way that they die becomes rather more important to them. The point is that, as the independent living movement has said repeatedly, it is about getting dignity, choice and control in the way that people live their lives and supporting people to have the best quality of life.

Talking about safeguards, if you take your foot off that particular brake and say, “Okay, it is fine for people to go and make the decision,” think about Governments that are not particularly interested in supporting people to have a good quality of life because that costs a lot. Maybe their priority is tax cuts for rather better-off people. It is one way of dealing with the pensioner time bomb is it not? You do not do something to ensure that people have good quality of life; you say, “Well, they’ll make the decision. Leave it to them and they’ll make the entirely sane, rational decision that this is not a life that they want.” This is why a number of disabled people support the bill. We have daily experience of what it is like not to have autonomy, choice, control or dignity in the way that we experience our lives, but that is not inevitable. That is my point.

Professor McLean: I want to return to Mr Doris’s question. The discussion between doctor and patient is something that canvasses all options. It is not for the doctor to say, “I think you should choose an assisted suicide because, frankly, you’re a pain or a drain on my resources.” It is for a doctor to say, “Here are your options. This is what I would recommend.” That is what doctors do all the time when they discuss things with patients. I do not see it as a threat to the doctor-patient relationship in that sense.

Bear it in mind that after any discussion had been held, the person would still have to jump through the hoops that the legislation would present of making declaration after declaration. I believe that that would be far too cumbersome, given that other people can choose death simply by refusing life-sustaining treatment. However, that is maybe a different discussion.

If it is permissible, I will touch briefly on what Dr Witcher said. It is a serious condemnation of any society when people with disabilities are treated inappropriately. I think that Dr Witcher’s point was entirely well made. However, the interesting point about Oregon is that, to use an example that has been used quite regularly in the evidence, the vast majority of the people who opted for assisted death in Oregon were cancer sufferers; most of them were over 65 and terminally ill with cancer. Oddly enough, despite what people had anticipated, most of them were highly educated and three quarters of them were in hospice care or in a hospice programme at the time that they made their request.

I think that we need to take the concerns of the disability lobby very seriously indeed, and that this is something that we as a society need to look at. However, I am less sure that the bill would directly impact more on the particular group of people with disabilities than on other groups.

Catherine Farrelly: I want to return to something that Sally Witcher said. As a carer, I have experienced a lot of things with my mum—about wheelchairs and so on—and I know that how people are treated has a massive effect on their lives. For example, my mum’s wheelchair broke and she got a new one, but something was not right with the adjustment of the chair. She phoned and asked whether it could be fixed, but she was told, “You need to wait a month. We need to get an OT to come out.” She needed to use the wheelchair in order to move around, but she had to wait for a month with a chair that did not fit right and which was uncomfortable for her to sit in.

Such things have a massive effect on how people like my mother feel, and so does their treatment in society. For example, something as simple as going into a restaurant and asking for a table for a wheelchair causes a panic. All you want is a table, so you say, “Show me the table and I’ll move the chair out the way.” Do you know what I mean? Things like that are very difficult. We go into a coffee shop and my mum orders a coffee while I stand next to her, but then the people speak to me rather than to her. People sometimes seem to think that because a person is in a wheelchair or is suffering from an illness they are therefore not worth talking to or not worth as much as someone else. That has a massive effect on those people.

Promotion was mentioned. If the bill was to become law—not that I want that—people would obviously have to know about it, but if assisted suicide is promoted there is a real danger that it will be seen as the only option. If people needed to know about it, we would need to ensure that they were aware of every other option and that it would not be seen as just one option over another. I think that that is a really big danger.

Dr Bennie: Thinking further about whether it could change the relationship between doctors and patients and the way in which doctors are perceived by patients if the bill or something similar were to come on to the statute book, I think that there is a very real risk that it would. If we take a current discussion between a doctor and a patient that looks partly at whether the person is expressing a wish to be dead or a wish towards suicide, that clinical discussion is framed primarily around trying to establish the reasons behind that wish and, in particular, whether some of the reasons behind it are linked to some form of mental illness.

If legislation of the nature of what the bill proposes were in place, I think that that would very much change the relationship between the doctor and patient to one in which it is equally possible that the patient would take the discussion to be as much about whether the doctor might be forming some sort of judgment that their life may be reaching a stage at which they do not want to live it. There is a danger of that drifting into the kind of territory that both Sally Witcher and Catherine Farrelly talked about; at heart, it is about recognising the dignity of each individual and not trying to prejudge what the person thinks about their own lived existence.

Rhoda Grant: How will a doctor react if a person whom they know not to be very resilient requests assisted suicide? The GP might think that, given time and support, the person might not want to carry things through. I suppose that this comes back to the interaction with suicide prevention rather than assisted suicide. If the doctor thinks that the person in question will change their mind and not want to take forward their assisted suicide request, can the doctor turn down the request or do they have to refer the person to another GP, who might not have the same background or share their way of thinking? What is the interaction with suicide prevention?

Dr Bennie: Do you want me to have a go at that, convener?

The Convener: Yes, please.

Dr Bennie: I start by expressing some reluctance to get too much into the detail of the bill. The BMA's very clear policy, which has been generated by democratic processes, is that we are in principle opposed to assisted dying. I am not sure that, from what the bill says, anyone around the table could say what would be envisaged when a person said in a discussion with a doctor—one of their GPs, say—that they were interested in assisted suicide. I assume that, if the doctor thought that the patient did not meet the criteria, they would tell them so, but I do not see how that would stop the patient simply seeking out another doctor.

Professor McLean: Coming back to a point that I made to Peter Bennie, I would have thought that the option of an assisted death was a last resort, metaphorically and literally, in the sense that it is one of a range of options that one would expect doctors to canvass with their patients. I would not expect them to canvass it at the very beginning, in the same way as they would not canvass the use of, say, chemotherapy until further down the line. They would say, "First, let's try these options to see whether they are suitable and whether they work." Telling a patient that the option is available is merely one aspect of a complicated to-ing and fro-ing process between doctor and patient, which includes recommendations from clinicians about the best approach.

To me, that in no way interferes with the suicide prevention strategy—I would expect all good doctors to start by helping someone to live, not by offering them the option to die—and I do not see why allowing the assisted suicide option in the small number of cases in which the people who go down that path still choose to die will have any impact on the suicide prevention that most clinicians are committed to. I suspect that, most of the time, the option will come from the patient. After all, any Government that passed such a bill would be responsible for ensuring that the availability of the option was known about.

The Convener: I will tease that issue out. In today's discussion and in discussions that we have had in recent weeks, the issue of autonomy has come up. The human right to suicide is a bit different from managing a patient in the way that you just described; ultimately, the case that people will make is that, almost irrespective of everything else, this is their right. There is a wide range of circumstances in which they will exercise that right, and ultimately it is their decision, not the doctor's. How do you frame legislation that takes account of all that and the pressures that might or might not be on people?

Professor McLean: That is what legislation around the world has attempted to do and what in some cases—indeed, in many cases—it seems to have done with reasonable success. There is nothing coercive or anti-autonomous about someone advising people, on the basis of their expertise, about what those people can or cannot do in such circumstances to alleviate their problems. That does not defeat autonomy; it simply helps people to make an informed decision instead of a random decision based on impulse.

The professional's engagement is important at that level, because it allows people to get expertise and knowledge about their condition and what can be done about it that they would not necessarily have had if they had not seen a clinician at the time. The person still acts autonomously if they make the ultimate decision, but they do it on the basis of as much information as the professional can supply them with about the range of options that are open to them, such as palliative care, surgery or whatever it happens to be.

I am sorry that I am talking too much, but I want to make a point about rights. As somebody said earlier, it makes no sense to talk about a right to die. We have an obligation to die, but we do not have a right to die. People are arguing for a right to choose and to act autonomously.

The cases in the European Court of Human Rights have been referred to. It is worth remembering that, although the Court turned down Mrs Pretty's and Mrs Purdy's requests, it nonetheless held that Mrs Pretty's article 8 right to personal integrity had been invaded by the United Kingdom Government's policy. The court recognised that the issue is about personal integrity, autonomy and choice and is not about the right to die.

12:00

Dr Witcher: On doctors' judgments on the quality of life that the people whom they see have or do not have, my experience and that of other disabled people—this is anecdotal—is that, whereas doctors and other members of the medical profession might be well placed to decide on people's medical condition, prognosis and diagnosis and on whether their condition is or is not life shortening, that is not the same as being able to say what the person's quality of life must be, as I have said.

There is anecdotal evidence about "Do not resuscitate" notices being put at the end of people's beds without consultation and without their knowing, because assumptions are made that a person could not possibly wish to be resuscitated given the degree of impairment that they must experience. Given that those things happen and that there are those attitudes in the medical profession, it is very worrying—more than that, it is alarming—to think that people with such judgments could have such an incredibly sensitive conversation with a person whom they wish to advise.

Disabled people are directly affected by the bill. Somebody remarked earlier that they were not sure about that, but disabled people certainly are a key group that the bill is targeted at. We do not have to look far in the explanatory notes to find references to the likes of us and the likes of me. We need to be able to trust the medical profession and know that it wants what is best for our lives and is not making false judgments but listening to what we say. We need to be absolutely confident that any such suggestion is not driven by other considerations, such as the cost of treatment or palliative care or just of maintaining over many years somebody who has a life-shortening condition.

I know that the bill is concerned to promote autonomy and choice, but we have to consider what causes people to make decisions. Coercion is unlikely to take the form of somebody hitting somebody else over the head with a blunt object—that is not what happens. It is much more indirect than that; it is about the messages from the culture that surrounds us. We are part of that and we absorb the messages about our life being worth less, about being scroungers and all the rest of it. We absorb messages about being a burden on the taxpayer. We could say that that is not coercion, but there is that pressure and culture, alongside the fear of becoming disabled.

Much of the support for bills such as this one is driven by a profound fear of becoming disabled, ageing and becoming ill. Rather than say that we should make it easier for people with that profound fear to end their lives or let them feel confident that they could do so should that terrible thing happen—even though being disabled is not necessarily terrible, as people can have a very good quality of life, believe me—we need to challenge those negative attitudes and have public policy that ensures that, when people are old, ill or disabled, they get the best quality of life possible, and that the right sort of support is available to enable full and independent living as equal citizens for as long as possible.

Tanith Muller: I preface my remarks by making it clear that Parkinson's UK neither supports nor opposes a change in the law. My comments must be taken with that in mind.

I was interested in the discussion about the doctor-patient relationship and the difficulty of having such conversations. In the experience of lots of people with conditions such as Parkinson's, the reluctance to raise such issues already seems to exist—I am thinking of conversations about decisions to refuse treatment and conversations about a potential loss of capacity as the condition progresses.

I have sometimes heard clinicians say that they do not want to raise the issue because they do not want to appear to have written somebody off, but we see how that prevents people from making decisions at a time when they can make decisions. The concerns about seeming to write people off and about saying to somebody, "It's not looking good," are inhibiting conversations that might help people as they face their life with a degenerative condition. The committee needs to think about whether there is a difference between the conversation about assisted dying and other conversations about the reality of life with a condition that is causing deterioration over time that people already face.

Catherine Farrelly: I will respond to something that Sally Witcher said about coercion. I agree that the way in which people are treated has a massive effect on how they feel. As I said, a lot of things that are going on in society make people feel that they have no worth, but everyone has the same worth and should be treated the same.

Support is not always there for people who have conditions. I am not saying that there is not amazing support available, but it is not always easy to access. Support for the people who look after those with conditions is not always easy to access. I have discovered that when I have been struggling. It is not always easy to get the right support, but it needs to be there no matter what. We need to make sure that people are reassured that they will be looked after and cared for. They need to know that they will get the best-quality care and that, if they need something, they can phone someone who will try to get it for them.

When someone is stuck and cannot do anything about the situation—when they need someone to help them but no one is there—that has a massive effect on their life and on the lives of those around them. It also has an impact on how they are treated by society. People with such conditions are not always treated as they should be, which is ridiculous. They should be treated with respect and should be counted along with everyone else. The fact that someone has a condition does not make them worth any less than anyone else; they need to be treated with respect and care. Simple actions such as moving things out of the way so that a wheelchair does not wreck a shop make an incredible difference to how people feel.

Richard Lyle: I will go back to what Professor Sheila McLean said. I would like the panellists' individual views. We all agree that we wish to hold on to our loved ones as long as we possibly can. We have all been in situations in which people have died and we have wished that we could have told them this, that or whatever. However, should we not also respect a person's right to choose to die if they want to die? We heard about a situation in which a nurse was sitting with someone and holding their hand. Nurses have to face that situation day in, day out. I have asked this question consistently over the past couple of weeks. When someone wants to die, should we not allow them the right to die?

Catherine Farrelly: I understand your point. However, there is a need for safeguards, as there is a danger of people being coerced or pressured into assisted suicide. Laws are there to protect people. That is how I see it. Laws are supposed to protect people and, if just one person dies as a result of the bill who did not want to, the law will not have protected them.

Another thing about the bill is that, once someone is dead, we cannot bring them back. Once they have had assisted suicide, they are gone and we cannot change it. That is a massive point.

The Convener: Dr Bennie, do you want to comment?

Dr Bennie: I was mainly indicating that Catherine Farrelly had been waving at you. I was keeping a low profile because Richard Lyle asked for our personal opinions. I am absolutely not going to give you my personal opinion. I am here to represent the British Medical Association.

Having said that, I will say something on the subject. Richard Lyle's question was, "Should people not have the right to die?" I do not think that the bill is about that. It seems to be much more about people wishing to have as much control as possible over the way in which they die. To an extent, it is about the timing as well, but it is mainly about trying to avoid what for some people is the horrific known of what is coming, but for many people is the horrific unknown of what is coming. That relates absolutely to the core purpose of good-quality palliative care.

Dr Witcher: I echo a lot of what the two previous speakers said. I am here to represent Inclusion Scotland and not to give a personal view, but I would say that this is about the wider good. There are all kinds of reasons why family members might wish their aged relative to be with them for longer or for less long. How are those of us who are outside the family dynamic ever really going to know what is going on? We are not—we are never going to know. That is why it is dangerous to proceed, because we will never know the reasons. We will never know quite what happened. That is the issue.

It is perfectly clear that the bill is open to abuse. In as much as it tries to make it as easy as possible for people who want to go down the road of assisted suicide to do so, it simultaneously and inevitably makes it as easy as possible for people to abuse the process, through the lack of safeguards. That is the problem.

In my view—this is my view, but I hope that members of Inclusion Scotland would accept it—this is about the wider good. People who would never choose to go down this road if they had autonomy, choice and control over their lives might be pushed into it by the factors that I have detailed. I will not go through them again, but they include relatives who would perhaps like to get their hands on the money. I am sorry to say that there are people like that out there. We cannot support something that can allow that to happen.

As a previous speaker said, we must not allow one person to be the subject of what would be, in effect, assisted murder. That cannot be allowed to happen in a civilised society.

12:15

Professor McLean: So-called liberal western democracies such as the one that we claim to be are based on the Millian principle that the state should not interfere to prevent people from exercising their free will unless it can show that there is harm, rather than the other way round. We can speculate that there are people out there who would like to see their loved ones die—perhaps, in the circumstances, we should call them their "relatives" rather than their "loved ones"—but we do not know that for a fact. We also do not know whether the bill could prevent that from happening. As a result, I do not know whether such speculation is entirely helpful.

Another problem is that there is a temptation in the debate—not necessarily the debate that we are having here, but the debate that is taking place everywhere—to second-guess individuals' decisions. The law presumes every individual to be legally competent to make their own decisions, and only if it can be proved to the contrary will a decision be challenged in any other situation. If someone makes a decision that is based on their judgment—not someone else's—about their quality of life, there is a sense in which, even if we do not like it, we as a society should respect it unless we can show that doing so would cause significant harm to third parties. The fact is that we do not have evidence of that from any of the legislatures that have legalised assisted dying or voluntary euthanasia. We should not speculate too hard and second-guess people's decisions.

The Convener: Do we need to wait, then, for evidence from other legislatures about how things have worked to allow us to proceed?

Professor McLean: The Netherlands is just one country, and it does not provide the best parallel for this bill as it has also legalised voluntary euthanasia. Oregon probably offers the best and most obvious parallel; it has been very efficient at collecting data, which means that there is a systematic body of information about who has chosen this—

The Convener: As I understand it, the point is that we have no evidence to say no. If we have no such evidence, where is the evidence to say yes?

Professor McLean: That is my point. If we base our society on a Millian approach, which we theoretically do, the state has to prove that it has a right to intervene in people's freedoms rather than individuals having to prove that they have the right to make their own decisions.

Dr Witcher: I am not claiming to be an expert on this, but my understanding is that in Oregon the law specifically relates to terminal illness. Is that not correct?

Professor McLean: No—well, someone has to show that they are terminally ill, which is one of the potential provisions in this bill. In Belgium, someone can also be intolerably ill. Interestingly, when the Belgians legislated for assisted dying, they simultaneously made access to palliative care an absolute right for every citizen.

Dr Witcher: My point is that this bill goes very far beyond terminal illness and that, as a result, Oregon is not necessarily a helpful comparison.

Dennis Robertson: We have heard that there are pressures on people from society, with, for example, people who are suffering being made to feel like a burden. Going back to Professor McLean's point about the need to be informed, how do we determine whether the information that a person receives and how they are informed are not actually a form of coercion? Does the bill contain enough protection to ensure that a person can make an informed decision outwith coercion?

There is the kind of subliminal coercion that, as has been mentioned, arises from various societal pressures, but people with disabilities, say, can sometimes have a fear about how progressive their disability or illness might be. It is perhaps an extreme example, but we have heard about a case in Belgium in which twins who were deaf decided to end their lives because of the fear of going blind. Might people make their decisions not through coercion but through information?

Professor McLean: It is a very good question, because the problem with this bill and, indeed, the other bills on this matter is that, if the logic of the principles that underpinned them was to be carried through, you would have to allow anyone who was competent to choose death. That would be the absolutely and immaculately philosophically correct approach.

Some problems arise when we try to limit the group to whom we think the opportunity should be offered. We never know whether any patient who makes a decision—whatever the decision is—is truly informed. Many decisions may be life threatening, just as much as a decision about assisted suicide may be. The difference is that, under the bill, people have a long time to think about the decisions, whereas, for example, a patient who opts for chemotherapy but who has not been adequately informed about the side effects does not have that time.

In some ways, making the procedure cumbersome—as I would describe it—means that there is a longer period of time for people to reflect, to find out information and to ask for more information than there is in the standard situation. We do not know whether doctors inform their patients properly or not; we do know that there are doctors who are reluctant to tell patients that they have put a DNR order on them, which seems unacceptable in the extreme. The trend in medicine seems to be increasingly towards informing patients, and we should encourage that.

Dennis Robertson: Bearing in mind the medical direction that is given and the factors involving health, social care, family, carers, friends and whatever, where do we draw the line between coercion and being informed? Is coercion sometimes directed through being informed? Does the bill protect the individual from being coerced through being informed?

Catherine Farrelly: The way in which someone says something will have a massive effect on how it is perceived. Furthermore, there is no way to guarantee that someone has not been coerced—I do not think that there is a way to guarantee that 100 per cent. For that reason alone, you should not be considering passing the bill. You cannot allow coercion to happen.

Dr Bennie: It is certainly hard for me to conceive of a way in which a doctor could be certain that there was no coercion. That is part of what, under the bill, doctors would be asked to arrive at a decision on, and I do not know how they could be certain about that.

The decision-making process is bound to be different in a scenario in which the ultimate result is the planned death of a person. That will always be different from having discussions with a patient about the risks or benefits of any particular treatment or about whether or not there should be a do not resuscitate order. I very much back what Sheila McLean was saying about it not being appropriate to place DNR orders without proper careful discussion with the patient—or, if the patient does not have capacity any more, with the people in the appropriate capacity. However, that is a very different issue from doctors effectively being asked to make a decision on whether a person has or has not been coerced and, on the basis of that decision, saying that in their view as a doctor it is appropriate to proceed further down the route towards a planned assisted suicide.

The Convener: To pick up on Professor McLean’s point, does the issue of coercion or pressure, including the wider pressures on the person, affect the decision-making process to take aggressive, intrusive treatment or to withdraw treatment from the person, which will result in their death? Is there a difference between the type of decisions that you would make when embarking on intrusive, aggressive treatment, the withdrawal of treatment or assisted suicide?

Is the coercion or pressure as it has been described any different for assisted suicide than for any other types of decision that you would take? You might be taking a decision to have aggressive treatment—but not for yourself—and you might be a bit apprehensive about it. There might sometimes be questions of instinct or survival, of keeping the family together or of a last chance. Is that principle of coercion or pressure on people to take any of these decisions any different from the pressure that would be on someone to seek assisted suicide?

Professor McLean: I cannot see that it is. It strikes me that the critical difference between the two is that, when assisted suicide is legalised, healthcare professionals feel themselves to be directly implicated in it. They do not feel that in the same way if someone refuses life-sustaining treatment. That is what is often at the root of the debate. It is not an ethical issue and it is not about coercion.

One thing that is not in the bill occurred to me when we were talking. As the committee probably knows, in England and Wales, if a doctor decides that they want to remove assisted nutrition and hydration from a patient who is in a permanent vegetative state, the House of Lords has indicated that a court would be required to judge whether that is the right decision. The court of protection in England and Wales performs that function, as it did for cases such as that of Tony Nicklinson.

In the somewhat belated additional report that I sent to the committee—I apologise for its lateness—I asked: if there are genuine concerns, bearing in mind the fact that capacity to make a decision is a legal and not a medical concept, why do we not have a judicial or quasi-judicial body that is equivalent to the court of protection to decide on them? The courts have plenty experience of deciding about whether somebody has been coerced into making a decision. That might provide the ultimate safeguard that people seem to be looking for.

The Convener: Does anyone else want to come in? Richard Simpson? [*Interruption*.] I am sorry—Dr Witcher.

Dr Witcher: I do not take it personally, convener, but I might if you continue.

I just wanted to come back to the question about whether merely being informed could be construed as being coerced and whether the bill contains sufficient protections to prevent that. The short answer to that is no, it does not.

Something as simple as tone of voice could be construed in a certain way. We do not know how something is going to be received. Being informed about something means that we have to decide how we are supposed to interpret it, and people will interpret it differently. It is perfectly clear that the safeguards are not there in the bill to prevent that from happening.

On the convener’s point about whether coercion is any different in different situations, whether it applies in one situation but not in another, or whether it applies more in one situation than in another, the answer is that it is terribly hard to know. What all of us think about everything is likely to be a mishmash of unwittingly absorbed messages from a variety of sources, personal experiences and all kinds of things, only some of which we might be conscious of. It is therefore hard to know when an attitude or someone’s feeling about their worth is legitimately what they feel and think or whether it has been foisted upon them indirectly.

There is a difference between this kind of legislation and other ways in which people might choose to end their lives. First, it is about giving out a very clear message that assisted suicide is politically and legally legitimised as well as being socially legitimised. There is evidence from Belgium and the Netherlands, although not necessarily from Oregon, about the increase in uptake of the measures once they come into being. The most recent expansion was in Belgium where a convicted rapist and murderer wished to be and was duly put out of their misery. I think that that happened at the beginning of this year.

We are not just talking about children. We are starting to see the measures move into all different kinds of categories. Witnesses in the earlier evidence session talked about the change in the culture of the medical profession and society when something becomes just what we do. If someone feels as if their life is worthless, it will be their right to put an end to it. Conversely, we have an emphasis on suicide prevention. How are we going to disentangle that? I certainly cannot do it here and now. There are some important points to bear in mind.

12:30

Another angle is the link between suicide and deprivation. One of the more spurious arguments on the bill is that it would open up the opportunity for people who cannot afford to go to Switzerland to end their lives. Links between deprivation and suicide are clearly defined anyway.

There are some very big questions about the implications of the bill and where it could lead. A previous speaker said that it is not about a slippery slope. It is quite purposeful. I believe that there is a campaign in Holland that seeks to make assisted suicide available to anybody over the age of 70, including anyone who is just a bit fed up with their life.

As was said, people make decisions for all kinds of reasons. It is not a matter of saying that people should not have autonomy but of understanding what makes people choose something, what is inevitable and how public policy and different cultural messages can make a huge difference to the choices that people make and the way in which they use their autonomy. I keep coming back to that and I have yet to hear anybody come up with an answer or argument that goes against it.

Dr Simpson: Professor McLean raised the issue that I want our witnesses to address. It came up in our evidence session with Baroness Finlay, who is an opponent of the bill, while Professor McLean—I hope that I do not misconstrue her position—is generally in favour of it or in favour of having something.

We have heard the concerns about doctors and we have heard from Catherine Farrelly and Sally Witcher about the concerns about coercion and the attitude of society. It seems to me that what the bill proposes does not answer those questions adequately but a court or tribunal system might. I am talking about a system that takes the decision out of the hands of the individual doctor and away from their relationship and puts it into the hands of a court.

If the individual themselves and the person who was going to facilitate the assisted suicide were to jointly apply to a court for the right to do it, there would at least be the potential for a proper examination of all the factors, such as whether the individual was receiving the care that they should receive. If the court judged that they were not receiving that care and that they wanted to commit suicide simply because their dignity was not being adequately respected or they were not getting the aids and equipment that would allow them to have a reasonable life, it could say that it did not think that palliative care had been adequately explored. The same would go for other issues.

I am sorry that I am being a bit long winded. Should the decision not reside with a court or tribunal rather than with the mechanisms that are proposed in the bill? The capacity issue is also important, and we have not talked about it.

Catherine Farrelly: My issue with what you said is that no safeguard is 100 per cent certain. We are talking about someone’s life, and we cannot 100 per cent guarantee that they have not been coerced or that something has not happened to force them to make the decision. Things can go wrong, so we cannot allow this to happen.

Bob Doris: I do not want to take up too much of the committee’s time. I was interested in Dennis Robertson’s line of questioning in relation to coercion, which made me think again about the nuts and bolts of the bill.

If someone went to a GP with a declaration, what would be taken at face value? That is the wrong expression. What would a suspicion of coercion involve? What kind of toolkit could GPs and others have to do the best that they could to ensure that there was no coercion, if that was deemed to be necessary?

Moving away from that issue—let us assume that we could solve it—in the same situation, an individual could in theory go to another GP who could sign off on whatever, at which point any alleged concerns about coercion would be lost. Family GPs might know other members of the family quite well and might have them on their patient list and be aware of dynamics that another GP who does not know the family would not be. If the proposal were to be passed, and a GP had concerns about coercion, how could they notify someone about that? In theory, an individual could go to another GP and go through the process of assisted suicide without the GP who initially raised concerns knowing about it.

I am trying to think of ways in which we can build in as many safeguards as possible as the bill goes through Parliament. Should there be regulations or something on the face of the bill to say what the process should look like?

The Convener: Or tribunals, for example.

Dr Witcher and Dr Bennie want to speak, as does Nanette Milne, and I want to bring in Patrick Harvie before we finish. Are people comfortable with me sending out for lunch? [*Laughter*.]

I ask everyone for brief contributions.

Dr Witcher: I want to talk about the idea of using the courts. I can understand why that suggestion might be put forward, but we have to be clear that courts are not necessarily any better placed than anyone else to make judgments about people’s quality of life.

You need look no further than the case of Elaine McDonald, a former ballerina who suffered a life-altering stroke in 1999. Her local authority thought that it was perfectly fine to leave her in incontinence pads for 10 hours at a stretch. Her case was taken to the European Court of Human Rights, which ruled that the treatment was not a breach of her human rights and that the council had discretion to do that because of the benefit to the wider community that the savings would achieve. That is one example of courts singularly failing to understand what quality of life means and why dignity is so important.

Dr Bennie: I have only one brief thing to say about courts. One would assume that the level of proof required in any such process would be the civil standard of balance of probability rather than the criminal standard. That would certainly be rather short of the standard that Catherine Farrelly is looking for.

Bob Doris raised an issue about the safeguards that can be put in place to prevent someone from shopping around—if you will pardon my use of the phrase—for a GP in a situation in which one doctor does not fill in the paperwork because they have concerns about the case. It is difficult for me to see what safeguards there could be, particularly in a process that is predicated on the autonomy of the patient.

The Convener: In the court case that you mentioned, was the court not sending the matter back to parliamentarians? Is the court keen to deal with a case like this? Is it not saying that parliamentarians need to sort out the detail of the issue and that the decisions cannot be left up to the courts?

Professor McLean: Are you talking about the permanent vegetative state cases?

The Convener: Yes.

Professor McLean: No. The court was specially created to deal with those difficult issues. When the Tony Bland judgment was reached—bearing it in mind that this is a case in which the individual has not made a decision and people are making a decision on their behalf—the court said that in all situations in which treatment withdrawal was predicted, that should be scrutinised by a court. We did not do that in the equivalent Scottish case.

The Convener: How would that apply to assisted suicide?

Professor McLean: The quasi-judicial or judicial body is a mechanism not to judge quality of life, as the person has done that themselves, but to decide whether a person is making an informed, free and uncoerced decision. That is something that courts do all the time, and they have made many decisions in respect of medical care with respect to coercion. Often, those cases concern Jehovah’s Witnesses.

I offer that merely as a thought. If people are sufficiently concerned to ensure that individuals can—as I believe—make up their own minds, one route for providing reassurance would be to allow someone over and above the GP to scrutinise the quality of the decision. That would work, if we think that it is necessary to second-guess people’s original choices.

Dennis Robertson: Would the courts not then try to gain a professional opinion? They may go back and get a psychiatric assessment, and perhaps other reports too, to enable them to come to a decision. The process will be prolonged and protracted. Perhaps a mechanism to require every person to undergo a psychiatric assessment could be built into the bill in the first instance.

Professor McLean: That is not by any means my preferred option. I merely make the point that it would be one potential mechanism for ensuring that some of the concerns that have been raised could be met head-on. It would at least ensure that the test of capacity—which, as I keep saying, is a legal rather than a medical test—would be adequately addressed, so that we could be sure that somebody is competent and is making a decision freely, in as much as anyone makes a free decision. That would be one way of testing the validity of the ultimate choice that is made, but it is not the only way. I do not think that it is necessary, but it is a possibility.

Tanith Muller: I want to come back on the point about capacity, which we highlighted as a major issue in our submission. If the law were to be changed, whatever system there was in place would need to include a more robust mechanism to assess capacity, particularly for people with progressive neurological conditions such as Parkinson's, in which there is fluctuation, and measuring capacity raises issues that are not necessarily typical. The bill as it is drafted would not meet the criteria for dealing with those issues.

The Convener: Nanette Milne can go next, and then I will bring in Patrick Harvie, with the committee's permission.

Nanette Milne: I will touch briefly on a point that has not been dealt with at all today, which is the role of the licensed facilitator, and in particular the interaction between the facilitator and the health professionals. Presumably the facilitator would not be well known to the individual and would have no interest—as it were—in the person's future.

There is a very fine line between assisting suicide and committing euthanasia, which a facilitator could be faced with doing for someone who is extremely disabled and perhaps unable to take whatever potion they planned to take to commit suicide. Are there any comments from witnesses round the table?

The Convener: Are there any takers for that one?

Professor McLean: You will have seen from my submission that I cannot work out what the facilitator is for, beyond what the name implies. It seems to me that, if someone is to help a person in a situation of that gravity, it would be far better to have in that role somebody whom the person knew well, and who cared about the person, rather than a stranger. I understand why the stranger requirement was built in, but it seems to make no particular sense. My answer to your question, in a sense, is that I do not think that we should have the facilitator in the first place.

The Convener: I will bring in Patrick Harvie.

Patrick Harvie: Thank you, convener. I want to pick up on a factual point with Dr Bennie.

You explained the BMA's position and, at one point, you said that it was a policy generated by the democratic process within the BMA. My understanding is that the BMA has not yet asked its full membership for a position on the issue, and has in fact on a few occasions voted not to do so. Am I wrong about that? Has the full membership been asked for a range of opinions? If so, what is the balance of opinion in the BMA's membership, either on the bill or on the general principle?

12:45

Dr Bennie: With regard to the general principle, this specific bill has not been put to any BMA democratic process. The BMA determines its policy at its annual representative meeting, which is roughly analogous to the national political parties' annual conferences. On several occasions at those meetings over the past 10 years, we have debated various issues around assisted death and euthanasia, and we have all the policy on those matters, which, if necessary, I can share with you at a later stage.

It is probably helpful to declare as an interest, rather than as a conflict of interest, that one of my previous roles in the association was to be the chairman of the annual representative meeting. I have actually chaired six of the annual ethics debates on various ethical matters, several of which have dealt with assisted death and assisted suicide. On one occasion in that process—I think that it was in 2006—the policy that was arrived at after considered debate was to take a neutral position; in other words, a decision would not be taken either way. However, that policy was reversed the next year, again by the democratic process, and for the rest of the time, we have had the very clear policy that I outlined previously.

As was suggested in the previous panel's evidence, that, of course, does not mean that every single one of the 150,000-plus members of the BMA is opposed to assisted death. However, we are quite confident that the majority are. As for whether we have put the question to our entire membership in an opinion poll or questionnaire, the answer is no. It has also been pointed out that, when one of our sister organisations did so, it got a very small percentage response from its overall membership. Our view is that, on such an important and nuanced issue, you have a better chance of getting a considered and proper decision if you have a democratic debate with a vote at the end of it than you have if you simply send out a questionnaire. After all, the likelihood with any questionnaire is that you will struggle to get a 10 per cent response. It seems to me that we effectively formulate our policy in much the same way that most national political parties do and in a way that is steeped in democracy.

Patrick Harvie: Your comparison with political parties is interesting in this case, because this is an issue on which political parties tend to be neutral and which they allow to be a matter of conscience for individual elected members.

If you have not taken the proactive approach of surveying your full membership on the basis that you expect a low turnout, is there any other way in which delegates, who I presume are elected locally to attend the annual representative meeting, solicit views and try to find out the balance of opinion? There must be some way of determining the balance of opinion.

Dr Bennie: There are two points to make on that matter, the first of which is about how the representative meeting works. The second is about another process that we have just put in place and which I will come to in a minute. Those who attend the meeting are specifically intended to represent the constituencies that they come from and therefore ask for opinion from the broader swathe of doctors out there.

Furthermore, over the next few months, we will run a series of meetings across the UK, including two in Scotland, in which we will consult specific groups of doctors and the general public. The doctors will be selected at random, but the various branches of practice and specialties will be taken into account to try to get a representative sample. In effect, we will be trying to get a bit more depth of knowledge about not only the overall view, but the reasoning and thinking behind it.

The process, which will take place over the year, is designed neither to reinforce nor to change policy. It is, if you like, a form of qualitative research; it is a different way of looking at our members' opinions while allowing us, in parallel, to look in a bit more detail at the opinions of the general public. After all, we heard in the previous evidence session the headline figure of 80 per cent of the general public who are in favour of some form of assisted suicide or assisted dying. Of course, those percentages can often change when you dig down into the detail, but by the end of the year we should have a more solid base than we do at present. I am certainly quite confident that we have a solid democratic base for the view that we take.

Patrick Harvie: So, in short, you are confident that there is a majority, but you are not able to say what the proportion is.

Dr Bennie: I am confident that there is a majority. I also know that it is absolutely obvious that there are a number of doctors in the minority of our membership who are against it.

Patrick Harvie: Thank you. I want to pick up on another argument, which began to be articulated first by Dr Witcher, but was also mentioned by several other members. As Rhoda Grant did, I should also declare an interest in that my office participates in the internship programme from Inclusion Scotland—we have somebody from the programme based in the office at the moment.

Some of the arguments are around quality of life—which of course is subjective and under the bill would be judged by the individual themselves, not by somebody else—and on-going external pressures, such as inclusive support and poverty and the welfare system. I think that Dr Witcher used the phrase "dignity, choice and control in the way that you live". Do the witnesses generally perceive there to be a categorical distinction between people for whom there is a set of on-going pressures in their lives and those who, even with the best public attitudes and the best quality of services, have reached beyond the point at which they are able to exercise dignity, control and choice in the way that they live, because they are dying? Acknowledging that the bill includes quite a broad spectrum of scenarios, do the witnesses see a categorical distinction between the issues that are raised in relation to people who are living, and people who are dying and wish to take control of the means or the timing of that death?

Dr Witcher: Is there a categorical difference? No, not really. I would reject the idea that dignity becomes an impossibility at any point with palliative care, the right support and so on. Dignity is absolutely critical here. Yes, it is a continuum and yes, there are degrees that will be possible in terms of what people can effectively do. The more important point—and the distinction—is that if you do not have dignity, choice and control when it comes to how you live your life, the attraction of having dignity, choice and control in terms of how you go about your death is increased. As I said, the evidence from Oregon makes it clear that dignity, control and choice are the primary reasons why people go for it, rather than things such as pain and suffering.

Are we as a society prepared to just say, "Okay. There is a stage—and that stage could shift with public policy—beyond which you are not going to get choice and control, and dignity will not be possible"? I am reluctant—in fact, I am not prepared—to accept that. I think that a society that accepts that risks going down a very dangerous path. That is all I can say on that.

Tanith Muller: That is a very difficult question for an organisation to answer. Among the 10,000 people in Scotland who are living with Parkinson's disease, you would find a real range of views, from Dr Witcher's to one that Margo MacDonald would have held. It is really difficult to find an absolute, when the people I work with have such a very wide range of views on this issue. It is very hard to come down on one side or the other without seeming to disrespect the views of people on both sides of the debate.

Patrick Harvie: Those were the two main issues that I wanted to pick up on from the evidence that we have heard. I find it hard to understand how someone could not accept that some people are reaching the point of death. Albeit that a range of scenarios are catered for in the bill, it seems to me that there are significant distinctions in the issues or objections that might be raised in those different scenarios.

With your permission, convener, I would like to write to the committee to pick up on several of the points that have been made over the course of the evidence sessions. I think that that might be the most effective way of responding to the very many points that have been raised. Otherwise, we might be here for a very long time.

The Convener: Yes. You will have that opportunity at some stage anyway in the coming weeks.

Thank you all very much for your attendance, the evidence that you have given and the written evidence that we have received from you.

12:55

Meeting continued in private until 13:20.

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