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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 17 February 2015

Session 4

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HEALTH AND SPORT COMMITTEE

5th 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:

Patrick Harvie (Glasgow) (Green)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health and Sport Committee

Tuesday 17 February 2015

[The Convener opened the meeting at 09:46]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's fifth meeting in 2015. I ask everyone to switch off mobile phones as they can interfere with the sound system. Members of the public and everyone else should note that some of us are using tablet devices instead of hard copies of our papers.

Agenda item 1 is a decision on taking business in private. I ask the committee to agree to take in private at future meetings consideration of our approach to national health service boards budget scrutiny. It is our normal practice to do that. Does the committee agree to that?

Members *indicated agreement.*

The Convener: We have apologies from Richard Simpson, who for understandable reasons cannot be with us.

Assisted Suicide (Scotland) Bill: Stage 1

09:47

The Convener: Item 2 is the Assisted Suicide (Scotland) Bill. This is the committee's final evidence session on the bill and we are joined by Patrick Harvie MSP, the member in charge of the bill; Andrew Mylne, head of the non-Government bills unit; Louise Miller, senior solicitor, office of the solicitor to the Scottish Parliament; and Amanda Ward, adviser to Patrick Harvie. Patrick has prepared an opening statement. After that, we will go to questions.

Patrick Harvie (Glasgow) (Green): I will be brief. I thank the committee for its serious consideration of the bill. This is a more complex bill than many members' bills. My previous member's bill was about two and a half sides of A4 and on a relatively simple issue. This bill involves more complex argument and deserves detailed consideration. I am grateful that it has received that.

The commitment that I made to Margo MacDonald was to present her bill to Parliament as best I could. On that basis, I do not intend to propose radical changes to the bill as she drafted and introduced it, but I have said from the outset that I am willing to consider changes from other members, assuming that they are properly drafted and will not undermine the bill's basic principle.

Evidence to date has shown a good case for making some minor changes, such as improvements in the recording and reporting procedures. There has been considerable discussion of the final 14-day time limit, which some witnesses have argued is needlessly restrictive. I am convinced that a reasonable solution can be found to that issue. We will undoubtedly explore that in detail during the questioning.

I do not intend to propose more radical changes, but the committee has noted and discussed the difference between eligibility under the bill and eligibility under the Assisted Dying Bill at Westminster. The committee may feel that the issues are significantly different in respect of terminally ill people and those with progressive conditions. If the committee eventually decided to recommend changes in relation to those aspects, I would listen with an open mind to what was proposed. If a different position on eligibility was decided on, that should not undermine my bill's basic principle or prevent Parliament from making progress on assisted suicide.

That is all that I will say by way of an opening statement. I look forward to answering the committee's questions.

The Convener: Thanks for that. You mentioned the principle of the bill, which I would like to tease out. Will you explain to us what you believe the principles that underpin the bill are? How does the bill achieve or promote those principles?

Patrick Harvie: The bill represents the continuation of a decades-long change in healthcare and medical practice that has involved a considerable move away from a slightly top-down approach—as some witnesses acknowledged, that meant that in previous generations patients were often excluded from the decision-making process and had information about their condition withheld from them—to one that is much more focused on patient empowerment, patient decision making and the principle that each of us has the right to determine major choices about our own lives.

As various panels of witnesses have made clear to the committee, autonomy is not and never has been regarded as an absolute principle, but it has an important place in modern healthcare and in the decisions that we make about our lives. The basic principle is to shift power and decision making into individuals' hands.

I take on directly the argument that some witnesses have made that the bill implies or suggests that some people's lives are less valuable than those of others. Nothing could be further from the truth. The bill takes almost as a first principle at a philosophical level the idea that, because all our lives matter and are valued, we have the right to make major decisions for ourselves in a supported and informed way. The principle of the bill is to place that power in the hands of the people about whom those decisions are being made, so that we each have a right to make those decisions for ourselves in a fully informed and supported way.

Richard Lyle (Central Scotland) (SNP): Good morning. I listened intently to your opening statement, and you have answered some of the questions that I was going to ask you. We all had a high regard for Margo MacDonald. I thank you for taking forward her bill and for the work that you have done on it but, regardless of whether people support the bill, they are concerned about flaws in it.

You said that the bill is complex. You sat in on most, if not all, of the evidence sessions. How do you address some of the concerns that people have about the bill's flaws? How can we resolve those flaws? You said that you would welcome amendments. How many amendments would need to be made to make the bill fit for purpose?

Patrick Harvie: I argue that the bill is fit for purpose. I do not think that the Scottish Parliament has passed many major pieces of legislation that have not been amended. The parliamentary scrutiny process is important and its value is shown in how bills are shaped during that process.

On the areas that I flagged up in my opening statement, it would be relatively straightforward, for example, to ensure that initial reports were made to the Crown Office and Procurator Fiscal Service rather than to the police. It has been broadly acknowledged that that fairly minor change is the right one to make. The police, the Crown Office and other witnesses all broadly agreed that that would be an appropriate change. It would be relatively straightforward to ensure that there is a process for reporting to a central body and for that body to maintain an overview of the assisted suicide cases that have proceeded. As I said, my view is that I will not propose more radical changes.

Concerns have arisen about the context in which we make decisions. That relates to the notion that autonomy is not an absolute principle and that all of us make decisions about our lives in context. That is one area where the situation might be seen to be very different for someone who is dying and has little time left to live and who wants to take control of the timing and manner of that death. The issues in those circumstances are very different from those when someone has a progressive condition. The committee might want to take a different view about eligibility for those reasons.

Rather than try to answer the question by talking about all the concerns, I ask the member whether he wants me to reflect on specific aspects.

Richard Lyle: In all my discussions with Margo MacDonald, I always thought that she was talking about people who were near the end of life and who wanted to go with dignity. However, many of the evidence sessions have thrown up the idea that the bill would allow anyone, such as a 20-year-old, to walk in and say to a doctor, "I'm fed up with my life and I just want to end it; I want to go." Was that Margo's intention? Do you agree with me and most of the people who are contacting us that her intention was that assisted suicide should be for people who are near the end of life and who believe that they have a right to end that life, rather than for a 20-year-old who says that they want to commit suicide or asks to be assisted to die?

Patrick Harvie: You are right, in general. The phrase "a bit fed up with life" was used by at least one witness as a reason that someone might suggest for seeking an assisted suicide. Frankly, I do not think that there is any real evidence from the other jurisdictions that have a form of assisted suicide that people would make such a decision or even seek an assisted suicide on those grounds. Although there are differences between the Oregon system and that proposed in the bill, that system provides perhaps the closest parallel. The evidence from Oregon shows that the vast majority of people who go through with an assisted suicide shorten their life by only a very short period.

I do not think that the notion that people would seek an assisted suicide because they feel a bit fed up is realistic, and nor would such a person be eligible. It is clear under the bill's criteria that it would be completely unacceptable—indeed, it would not be legal—for such a person to be offered assistance to commit suicide.

You are right in your general description of Margo MacDonald's intent, particularly when we look at someone's judgment that the quality of their life is unacceptable and the recognition from a medical professional that that judgment is consistent with the facts that are known about their condition. Those are the circumstances in which people are living and in which some of them are committing suicide. Statistics show that there are about 50 suicides of terminally ill people a year. That should concern us all—in fact, it should distress us all. Given the circumstances in which those people make those decisions, none of us should be willing to say that the law should leave people with no other option but that.

10:00

Rhoda Grant (Highlands and Islands) (Lab): The bill seeks to make assisting someone to commit suicide legal—it would decriminalise assisting someone to commit suicide—although it expressly outlaws euthanasia, as the law does at the moment. However, the bill does not define either concept. We have had evidence that suggests that there is a very thin line between the two. Some people have said that helping someone to take their medication or whatever would be assistance, but others have said that just being there and supporting would be assistance. How do you define the concepts?

Patrick Harvie: I will first explore the notion of decriminalising. As has been made clear in the evidence that the committee has received from Professor Chalmers, which is included in the papers for today's meeting, there is a lack of clarity about what is and is not criminal and, beyond that, what is and is not open to prosecution under the current law in Scotland. Under that law, people who might be contemplating asking for help to end their life because of intolerable suffering or people who a loved one might ask for help to end their life because of intolerable suffering have no clarity at all about their legal position and what actions they may or may not take. Therefore, to characterise the bill as decriminalising assisted suicide is slightly too broad a description, given the lack of clarity in the current law.

It is certainly arguable that greater clarity might be sought on what forms of assistance are necessary. As I understand Margo MacDonald's original intention, she felt that it was inappropriate to give a definitive list of specific acts that would count as assistance and be legally protected under the bill. That is because, obviously, we cannot foresee every scenario in which practical assistance might be necessary and nor can we foresee technological changes involving drugs or drug delivery systems that might require one form of assistance or another.

The approach was not to be prescriptive but to talk about someone assisting a person who has requested assisted suicide and who needs help in order to take the final act, which might be drinking from a cup or operating machinery such as an injection pump machine that delivers a drug intravenously. Margo MacDonald's intention was not to be overly prescriptive but to be clear about the distinction between giving someone assistance to enable them to take a final act and, on the other hand, taking that final act on behalf of somebody, which is outlawed under the bill. In many ways, the bill would give greater clarity than currently exists that such action is illegal in Scotland.

Rhoda Grant: I hear what you say about the clarity of the law, but we have received evidence that assisted suicide under the bill could be challenged and investigated in the same way if somebody was concerned about coercion or the like. However, I will park that for now.

I come back to the definitions of euthanasia and assisting someone with suicide. I will take an example that we know about, because we cannot prejudge what might happen in the future. If someone were to commit suicide by swallowing something, would it count as assistance to prepare medication for them to pick up and swallow, or would assistance go as far as putting the medication in their mouth to allow them to swallow it? Those are the areas that people are keen to have clarity on.

Some people would argue that, if a person does not have the ability to lift something to their mouth, putting something in their mouth does not give them a lot of choice, because they are unlikely to have the ability to spit it out. That distinction worries people and we need some clarity on that.

Patrick Harvie: I take the view that there is a clear answer to your first scenario: if someone cannot prepare medication and has someone assist them by preparing it, that counts as assistance, rather than taking the final act. The section that prohibits euthanasia—another person taking the final act on behalf of someone who has requested assisted suicide—would not be breached by a person who simply prepared a drug for someone to take.

It is understandable that, as in your second example, you are exploring scenarios where the line is finer. That is where directions and guidance to enable medical professionals and licensed facilitators to reach a proper understanding of how the legislation will operate in practice should be given. That is not something for the bill.

Rhoda Grant: If the bill states clearly that assisted suicide is legal and euthanasia is not legal, surely it must include the definition of each act. It should not be down to guidance to clarify what is legal or illegal.

Patrick Harvie: The basic principle is that the final act—that which causes the individual's death—must be taken by the individual themselves, rather than by another person.

There is case law in relation to Diane Pretty and Debbie Purdy about putting a drug into someone's mouth. That is seen as another person taking the final act. In the absence of legislation in England and Wales or in Scotland, the situation is unclear; the lack of clarity is far greater today than it would be if the bill were enacted.

In relation to Professor Chalmers's evidence, it is clear that the bill would not resolve the lack of clarity in all circumstances but, in some circumstances, it would provide a clear path to allow someone to know the conditions under which they were entitled to ask for assistance and to allow other people to know the conditions under which they were entitled to give assistance. If anyone sought to procure or instigate an assisted suicide outwith the terms of the bill, the courts would deal with the matter as they do today. The bill seeks to give clarity about a path that is acceptable and has legal protection.

Bob Doris (Glasgow) (SNP): I want to return to the earlier points about eligibility criteria for assisted suicide. The bill refers to:

> "(a) an illness that is, for the person, either terminal or life-shortening, or
>
> (b) a condition that is, for the person, progressive and either terminal or life-shortening."

There can be no definitive list of conditions that would fall under those criteria, but would liver disease, heart disease, diabetes, smoking and so on come under those definitions? I am concerned that the provisions are too broad, and I want to tease out how broad they might be. Have you calculated the number of people in Scotland today who would qualify, if they so wished, for assisted suicide under the legislation?

Patrick Harvie: As with definitions of what counts as assistance, given how medical science and our understanding of conditions and illnesses change, it would be inappropriate to produce a definitive list of such conditions, as it would be in danger of going out of date rapidly.

The arguments made by some witnesses seemed to interpret the eligibility criteria in a very—in fact, quite unreasonably—broad way. One witness suggested that everyone in Maryhill would qualify, which I think, given that we both represent Glasgow, would disturb you as much as it would disturb me.

The criteria in respect of terminal illness and life-shortening conditions are very clearly not the only parts of the eligibility criteria. With regard to your example of a person who smokes, smoking might shorten their life but it is not in itself a progressive condition; it would not necessarily give rise to a quality of life that the person might find unacceptable; and a medical professional would not be able to sign off on a first or second request in those circumstances, because the facts of the person's life would not be compatible with the test required under the legislation.

As for take-up and the likely numbers who would qualify, it is clear from many jurisdictions that have some form of assisted suicide that take-up is relatively low. In fact, the projection in the accompanying documents that Margo MacDonald produced on the bill's introduction is that the number would be somewhere in the region of 80 per year in Scotland. Obviously, we cannot be crystal-ball gazers on such a matter, but that figure is comparable with take-up in other jurisdictions. It is also clear that even in jurisdictions where the political decision has been taken to broaden the eligibility criteria—and where, as a result, the numbers have increased—the number involved still represents a very low proportion of overall deaths.

The only other thing that I would say is that I have a slight concern that focusing overly on the number who would take up assisted suicide almost implies that there is a right or wrong number. If we believe in the basic principle of empowering individuals to make decisions about their own lives, we should not be telling them that they have made the wrong choice or deciding that the wrong number of people have made that choice. It seems reasonable to assume that take-up would be comparable with that in other jurisdictions, but I am slightly cautious about taking a position that implies that there would be a right or wrong number.

Bob Doris: Having listened carefully to your response, I have to say that I was not suggesting that there would be a right or wrong number; I was simply asking how many people in Scotland today might in theory qualify under the criteria. Would, for example, type 2 diabetes count as a progressive condition that would allow people to apply for assisted suicide if they so wished? I genuinely do not know. We have heard evidence that the eligibility criteria are too broad, and I am looking for clarity about just how broad they are.

Patrick Harvie: It seems very clear to me that a mere diagnosis of type 2 diabetes would not satisfy the tests in the bill, which have been described by some witnesses as a high bar. Purely on the basis of such a diagnosis, a person would not be in a position to say that the quality of their life was unacceptable and a medical practitioner would not be in a position to countersign a first or second request.

10:15

Bob Doris: I am trying to get at where the clarity would be. Where would the guidance be for the medical practitioner? The bill states that the “illness” is “for the person” to decide on, so it is very much subjective rather than objective. For example, someone could go to their general practitioner and say, “Look, I’m living with this, but I don’t want to live with it any more. I don’t want to continue with it.” Is the decision a subjective one or are there objective criteria for the clinician? I am trying to get to the clarity within that.

Maryhill, where I stay, was mentioned in relation to the number of people who are on prescription antidepressants, the current high suicide rates and the fact that certain parts of the community have significant mental health problems and might be more predisposed to suicide because of other vulnerabilities. Let us not mention just Maryhill, because there are lots of places across Scotland that are like that.

Patrick Harvie: Of course.

Bob Doris: Maryhill is a wonderful place. However, there are lots of places across Scotland where someone, because of their life experience, might find it hard to cope with a life-limiting condition, and that is very much subjective. I am just looking for a bit of clarity on whether GPs and clinicians will be given some guidance on how to say, “Actually, no, I don’t agree with you,” if a person is saying, “Well, it is for me to make the judgment call. This is about autonomy and self-management of my condition. It’s about my independence, and this is the decision I’m making.” Could the clinician say “I don’t agree with that”? Where would the balance of power lie in that relationship? Would there be guidance for clinicians?

Patrick Harvie: Your points about the social context are absolutely understood and are well made in relation not only to geographic areas but to categories or types of people, and to life circumstances. It is important to acknowledge first that the phrase “for the person”, which you mentioned, is not simply a reflection of the individual’s opinion; it is intended to recognise that the same illness or condition can have a very different manifestation for, or impact on, different people.

Secondly, there is the question of whether the likelihood of the social context or the circumstances in which somebody lives shortening their life is what was intended. My understanding of the bill as drafted is that it is the condition itself that needs to be life-shortening rather than the social context in which a person lives.

On the balance between the subjective and objective aspects, under section 9 of the bill, when someone has made a first request, an endorsement of that is required through a medical practitioner’s statement. Section 9(2) states that a practitioner may make a statement endorsing the request

> “only if, in the opinion of the practitioner ... the person’s conclusion ... that the person’s quality of life is unacceptable is not inconsistent with the facts ... known to the practitioner.”

So, yes, there is an individual judgment about a person’s own quality of life, but in order to have a medical practitioner’s statement endorsing the first request, the facts must be consistent with the person’s judgment. It is important to recognise that although an individual’s judgment may be subjective, there is an objective test that the medical practitioner must be satisfied with in order to sign off the request.

Bob Doris: Okay. That is helpful, but would there be further guidance on what facts the practitioner should take into account when signing off a request?

Patrick Harvie: Yes. I have no doubt at all that there would be professional guidance in relation to many aspects of the process, including for the medical professionals involved.

Bob Doris spoke about vulnerability and social context. The only robust evidence that we have from other jurisdictions comes from the Netherlands and Oregon. That research looked at the vulnerability or perceived vulnerability of a range of groups, and found no evidence that more vulnerable groups were more likely to go through with assisted suicide. In fact, among those who chose that route those groups were less represented.

Again, we should look at what we can learn from the lived experience in other jurisdictions.

Bob Doris: That is really helpful.

You mentioned professional guidance. Are you assuming that any additional guidance, beyond the part of the bill that you read out, would be professional guidance that would be provided via the medical profession rather than statutory guidance in the bill?

Patrick Harvie: It has become clear that, in a couple of areas, we are unfortunately not able to step over the reserved nature of the regulation of the medical professions. Given the wide range of life-and-death decisions that medical professionals in Scotland make daily under the current law, it is clear that the non-statutory nature of existing guidance—on which this Parliament could not legislate even if it wished to do so—provides a proper context in which decisions of this nature can be made.

The Convener: On the point about guidance, you referred earlier to the basic principle of empowerment of the individual. It seems that, if the bill was passed, we would go back to a situation in which guidance was developed and drawn up by professionals. It would be professionals, rather than the individual, who would finally agree on how the process would work.

In that respect, is there an issue with the scope of the basic principle that you described? The decisions on how assisted suicide would be developed as a medical process would be signed off by medical professionals, thereby diminishing the power of the individual.

I might be getting it wrong, but it seems that we are heading back to a situation in which the professionals have the final say. I do not see how that meets the principle of the bill that you outlined earlier.

Patrick Harvie: I understand, but I do not think that it does what you say. We are talking about people whose lives are already intimately connected not just to medical care but very often to complex medical and social care. It seems inevitable that, if people are able to make these decisions, they will do so in the context of not only—one hopes—the loving care of their family but the professional and medical care of those who are working to support them.

The way in which medical professionals engage with that situation and relate to the decision-making process must absolutely be the subject of regulation. I do not think that I have met anybody who supports or opposes the principle of the legislation who would not agree that a test of capacity—for example, of someone's mental capacity to make a decision, and to understand the context in which they are doing so and the consequences—must be part of the legislation. It seems quite unreasonable that a medical professional should sign off on a first or second request in the absence of any guidance about how they apply the professional standards.

The Convener: We are talking about the context of eligibility. You used the phrase "intolerable suffering"—I do not know whether it is a new phrase—earlier this morning. It is not too far-fetched to imagine that someone might get advanced diabetes, which could involve going blind, undergoing amputations and intolerable suffering. I presume that you would wish to keep open the opportunity for that person to be eligible for assisted suicide.

Patrick Harvie: If it is their judgment that the quality of their life is unacceptable, it would be open to—

The Convener: How does that square with the principle that you outlined today, which is that the individual should have the opportunity, if not the right, to have the final say, contrary to the advice of professionals, and that they should have professional support to proceed according to their individual will? If those guidelines say, "We will not countersign anything other than something that accords with definitions that other jurisdictions are operating or propose to operate"—which would mean terminal illness—that would immediately mean that people with advanced diabetes or similar comorbidity problems who consider their lives to be intolerable would be excluded.

You want to keep things as open as possible, so the argument could be made for the inclusion of those people, irrespective of medical advice.

Patrick Harvie: I have been asked questions about specific scenarios and I have tried to explore that. It seems to me that, if the committee accepts the basic principle that some sort of legalised assisted suicide should be provided for in Scotland, it is up to the committee to determine whether it wants to restrict that to terminally ill people. I do not intend to make the case for that change although, if the committee reached that view, I might understand why that view had been reached.

It seems to me that the implication of what you are suggesting in terms of the absence of guidance for medical professionals would leave us open to the criticism that Richard Lyle said that some witnesses have made, which is that the proposal is simply about people who are fed up with life. The requirement must be that we are dealing with a serious decision that is made for serious reasons in circumstances in which society would accept that someone has the right to make a request for this assistance and that society has a duty to give that assistance. Most people would not accept that that should be done in the context of someone who is simply fed up with life.

The notion of someone deciding that the quality of their own life is unacceptable to them, and a medical professional accepting that and countersigning the endorsement of their request for assistance, based on a judgment that that person's conclusion is not inconsistent with the facts as known to that medical professional, seems to me to be the right approach.

Mike MacKenzie (Highlands and Islands) (SNP): As far as I am concerned, the most significant criticism that we have heard involves the possibility that the bill could result in people being coerced into making such a choice. Most of the critics of the spirit of the bill seem to proceed from the basis that the status quo is perfectly satisfactory. However, we have heard evidence that in legal terms it is not; we seem to be in a very grey area legally. Procurators fiscal decide whether a prosecution is in the public interest; it seems to me that one individual's decision in that regard might differ from that of another. Equally, we have heard evidence that it is perfectly legal for doctors to prescribe lethal doses of painkillers, in certain circumstances. It seems that we are reasonably happy for doctors and public prosecutors to make decisions but not for individuals to make those decisions about themselves. There is a significant concern about coercion, so does the status quo offer any safeguards against the possibility of coercion? Will the bill be neutral in effect, rather than give rise to that possibility?

10:30

Patrick Harvie: I do not believe that the current law adequately protects people from the possibility of coercion. It is estimated that dozens of terminally ill people commit suicide in ways that are clearly unsupported and no medical professionals or others can oversee them to ensure that they are free of coercion. The current law fails to give that protection.

One of the witnesses—I think it might have been the Care not Killing campaign organisation—argued that the most defensible laws are those that give a clear line on what is forbidden while allowing the courts broad discretion in determining whether compassion is required and whether prosecution would be legitimate. That gives people who are in difficult circumstances the absolute minimum level of clarity on what is permitted and what they may ask for or give by way of assistance, and on how they can access protection if they are under threat of any form of coercion.

Options exist for the committee if it is minded to find in favour of the general principles but feels that additional safeguarding against the possibility of coercion is required. The committee might even feel that, under the bill, a criminal offence of inducing or inciting someone to make a first or second request should be created. That would make it clearer what is against the law than does the current legislation, which is not even clear about whether the act of suicide is legal or illegal, or about the situation of those who assist or pressure someone into taking that action.

The committee can either endorse the provisions or strengthen them against coercion. It would be quite strange to imagine that coercion is not an issue either in the case of people who currently commit suicide in difficult circumstances, or who make other decisions about their medical care, such as the decision to refuse or end treatment or to undergo risky treatment. The possibility of coercion exists today. I am confident that the vast majority of medical professionals who provide care would treat it very seriously and be capable of identifying and addressing those concerns. The bill would create a much clearer legal context in which those issues could be addressed and additional protection provided.

Mike MacKenzie: I know that you have attended most of, if not all, the evidence sessions that we have had. How far do you think the discussions have been characterised by our society's disinclination to discuss the whole business of death? Our society has a cultural taboo around suicide in general, so we are not approaching the issue from a neutral or objective standpoint, and our perspective—and even that of some of the legal witnesses—is not as rational as it ought to be.

Patrick Harvie: That is a fair comment. Can any of us really approach any aspect of this subject with a completely neutral mind? I do not know how I would feel if I was in the circumstances that the bill envisages; I do not know what decision I would make. It is very difficult for any of us to think entirely objectively and neutrally, as though the question were merely academic. It is not—it is a question that engages with academic and legal analysis, but which also involves people's emotional lives. For some people, it relates to a very important religious or spiritual aspect of their life. For those reasons, people approach the issue with very different world views and attitudes to the meaning and impact of the decision, for themselves and for other people.

It is precisely because people approach the question with such different world views and attitudes that our society should respect people on their own terms. It should empower and support people to the greatest extent possible to make informed decisions—assuming that they are adults with the capacity to make those decisions. The only alternative is for society to decide what is right for everybody and to impose that decision on everybody.

The Convener: I would like more clarity in relation to Mike MacKenzie's question. We have heard evidence that we have an effective safeguard for protection of vulnerable people, which is to maintain the law of homicide, whereby someone who causes the death of someone else should reasonably be expected to be investigated and to have to justify their actions, and may have to face prosecution. We have heard in evidence that that is clear and unambiguous. The outcome depends on what motivated the person—whether there was wicked intent or whatever—and they can be charged with murder or homicide, or they may be able to justify their actions. Those arrangements are clear, and we have heard that they give protection to vulnerable people. That is what we would expect when something as serious as the death of an individual happens. What is unclear about that?

I am not questioning you, Mike; I am referring to the evidence and I am addressing my question to Patrick Harvie.

Mike MacKenzie: I would just—

The Convener: I am asking Patrick.

Patrick Harvie: There is clearly a very significant difference of opinion about the degree of clarity that the current law provides about what is legal, what is illegal and what might be prosecuted or not prosecuted.

In that context, we are left with a question about whose responsibility it is to give clarity. Do we leave it to the courts, as has been done south of the border? Some progress has been made, through court actions, in seeking prosecution guidelines from the director of public prosecutions, but that has not happened in Scotland.

Do we leave the matter for the courts to determine case by case, with people having to go through the most extraordinary efforts over prolonged periods while they face—as Mike MacKenzie rightly reminded us—profoundly challenging circumstances as they suffer either an illness that causes them intolerable suffering or one that will result in their death? Do we continue with people having to go to court and to ask time and again for clarity or a change in the law? Do we continue with the situation in which people who are wealthy enough or who have enough support and resources around them can make the trip to another jurisdiction where such action is legal, or should Parliament make a decision?

There are concerns about coercion and there are differences of opinion about the appropriate level of eligibility. However, it is clear that the overwhelming public mood—which has been shown consistently by opinion polling over many years—holds that people who, with the best of intentions, as acts of compassion, take action to end the suffering of a loved one or to allow the loved one to end their own suffering, at their request or instigation, should not be prosecuted, convicted, sentenced or imprisoned. Should we simply leave it to the courts to determine in every circumstance, or does Parliament have a responsibility? I think that it does: it is to set the expectation and to make it clear that there is a legal option—which will be defined, well regulated, monitored and supervised—to make such decisions in the context of their being supported.

It is Parliament's responsibility to make a decision. It may be that Parliament ultimately decides that people in such circumstances are all criminals and should be prosecuted. That would not be in keeping with public expectation.

The Convener: Could we, through the guidelines that you referred to, change how prosecutors and the law deal with such situations?

Patrick Harvie: Do you mean prosecution guidelines?

The Convener: Yes. We could change the guidelines to give a greater understanding and explanation of in what circumstances such action would be fair and justifiable.

Patrick Harvie: That is an option that the Lord Advocate might wish to consider. For the third time I will refer to Professor Chalmers's evidence, toward the end of which he mentions the decision of the Lord Advocate

> "not to take steps to issue a policy similar to that promulgated by the DPP."

Professor Chalmers said that

> "That approach was wrong. It remains wrong."

He goes on to question whether the lack of clarity about prosecution rules is even compatible with the European convention on human rights.

I still take the view that, whatever prosecution guidelines might say, it should be for Parliament to decide what the law says, rather than individuals having to go through a lengthy and stressful court process simply to seek clarity.

Nanette Milne (North East Scotland) (Con): You alluded briefly to the fact that a conscience clause cannot be included in primary legislation; I presume, therefore, that there could not be one in secondary legislation either. The matter would have to be dealt with in professional guidance which, as we know, is not legally enforceable. That has caused significant concern to a number of health professionals. In particular, the pharmacy representative who gave evidence felt very much that there should be a much stronger way than professional guidance of dealing with people not wanting to take part in such action, if the bill becomes law. Do you have any comments on that concern?

Patrick Harvie: I think I mentioned in relation to the capacity test that I have never met anybody who takes a view on the bill who does not agree that such a test is required. Similarly, I have met nobody who has taken a view on the bill—supportive or in opposition to it—who does not agree that it should have a conscience clause, if it is passed. We are for purely legal, or constitutional, reasons not able to include that in the bill. Whether their view is that it would be better on the face of the bill or not, it is clear from a number of witnesses that the provision of a conscience option in guidance would be acceptable. A number of witnesses have said that in writing, and I think that at least one or two of them made that clear in oral evidence at my questioning during the committee's earlier sessions.

Although the matter is clearly of great importance, especially to medical professionals who would not be willing to participate in assisted suicide, it is one of the more easily resolved matters. There is no disagreement in principle that individuals should be able to make the decision, and I do not think that there is any substantive disagreement that to place the matter in professional guidance will provide them with adequate protection.

10:45

Nanette Milne: We have had inevitable comparisons with the previously enacted law on abortion and the fact that courts can overturn guidance. In a recent court case, nurses who did not want to take part in abortions were, essentially, ruled out of order by the court. Does it trouble you that that could happen—down the line, admittedly—with the bill?

Patrick Harvie: No—because the intent and the consequences of that case have been somewhat misrepresented. What was sought in that case was not the overturning of the conscience clause in relation to abortion, but dramatic expansion of the protection in the conscience clause to include those who were not directly involved in providing abortion and who had more ancillary or tangential relationships with those who were providing abortion. It was, in effect, legal activism in order to reduce the ability of healthcare professionals to provide abortion services.

I do not see that that has any relevance to the issue that is before us today. The important thing is to ensure that medical professionals—perhaps they are a majority; perhaps not—who would be unwilling to play a role in providing, or, for example, signing off a request for assisted suicide, are able to decline to do so. That is not technically difficult to achieve and I do not think that there is any principled opposition to it.

I also suggest that, even if we were able to place a conscience clause on a statutory basis, if it were legally possible and competent for Parliament to put it in the bill—clearly, it is not, in relation to regulation of professionals—it would not have a material bearing on a case similar to the one that Nanette Milne mentioned, if such a case was to arise, although I see little likelihood that it would.

Nanette Milne: Okay.

The other thing that ties in with that is the feeling of medical people who oppose the bill that it could change the patient-doctor relationship. Assisted suicide might well become an alternative treatment option when someone presents with a terminal illness, and I can see that that would radically change the position of trust between the patient and their doctor. Do you see any ethical problem with that?

Patrick Harvie: There are certainly ethical factors to consider, as there are in many aspects of medical practice. Would it change the relationship between the doctor and the patient? That relationship is continuing to change. As I said earlier, there has been an on-going, long-term and very welcome change in that relationship, from what I might call in simple terms the "Doctor knows best" attitude, which was once common and was the normal expectation, to a position where autonomy, which is recognised as a non-absolute concept in philosophical terms, is an important part of that relationship. We now seek to take a view where individuals are informed and empowered to be a part of the decision-making process, and to be central to it. I see the proposal as a continuation of that change.

The most likely cultural change in the relationship between doctors and patients perhaps relates to what—I think—Mike MacKenzie said about our cultural reluctance to discuss death.

I see the bill as not guaranteeing that it will happen, but as opening up the possibility of it becoming much more normal for people who are fit and well to have a discussion about their general attitude, when they register with a GP, for example. Although I do not know what decision I might make if I faced such circumstances, I suspect that I would want to make a preliminary declaration and have it recorded in my medical records at an early stage, before seriously contemplating having to ask for assistance to end my life. To have a discussion openly with a doctor about the general attitude that one takes to the issue could be a positive and welcome change, and a continuation of the transfer of power and decision making about their lives to the people who are living those lives.

Nanette Milne: I absolutely agree with Patrick Harvie about the need to discuss one's ultimate death, but the same applies to palliative care. We know that Marie Curie Cancer Care feels strongly that there should be an open discussion from the time of diagnosis and that people should be looking forward towards the end. Some people feel that there is an incompatibility between promoting really good palliative care and the next treatment, which is certain death by one's own hand. I do not know what your thoughts are on that.

Patrick Harvie: As with the issue of uptake, we should look at the experience of other jurisdictions where some form of assisted suicide legally exists and where such provision is made. The evidence shows no impact that undermines palliative care in terms of its political importance, the investment that is provided for it or the quality of provision. In Oregon, for example, the quality of palliative care is considered to be excellent and the use of assisted dying legislation has been described as very low by researchers in that state, while in Belgium and the Netherlands, investment in palliative care has increased since their versions of the legislation were passed.

It is clear that the options are entirely compatible and that, if we seek to empower people and give them the ability to make their own choice on their own terms, we will ensure that both options are provided to a high standard and are regarded as having political importance. I see no evidence from around the world that suggests that those approaches to patient care are not compatible.

Nanette Milne: Thank you, convener. I shall leave it at that just now.

Rhoda Grant: I have a point that arises from the previous question. Patrick Harvie said that he envisaged a preliminary declaration being made during a first meeting with a GP. If, as we understand it, only 5 per cent of the medical profession are willing to engage with assisted suicide, only 5 per cent of people would be able to do that on initial contact with their GP—or is Mr Harvie suggesting that everyone's initial contact should be with a GP who is willing to assist with what is proposed in the legislation? That does not appear to me to be compatible with the conscience clause.

Patrick Harvie: Section 4 does not require the person's own GP to endorse the preliminary declaration. This is hypothetical to a certain extent, but let us say that the bill were to be passed and come into force and I had a discussion with my GP that made it clear that I wanted to lodge a preliminary declaration. If my GP was unwilling to do that because of a conscientious objection to the whole principle, but I was still happy with and wanted to stay with him or her, it would be perfectly reasonable for me to ask for a different medical professional to endorse that preliminary declaration. However, that would still leave open the possibility that I could have such a discussion in the knowledge that, ultimately, a decision would be legally open to me that previously would not have been open to me in such circumstances. I do not think that the approach to the preliminary declaration that I am suggesting conflicts in any way with the principle of a conscience clause.

Rhoda Grant: How would the GP know that you had had capacity at the time? If you had made the declaration so early on, the GP would not be able to judge whether your situation was intolerable. Do you understand what I am getting at? Just being able to put a declaration on the record does not seem to me to be a safety net.

Patrick Harvie: The endorsement of the preliminary declaration is not a statement that somebody has the capacity to request assistance to commit suicide; the capacity test comes later in the process. In the preliminary declaration, which is set out on page 12 of the bill, the note by the medical practitioner says:

> "I am satisfied that the above preliminary declaration and witness statement conform with schedule 1"

to the legislation. It goes on to say:

> "On the basis of the facts known to me, I have no reason to believe that anything stated in the above preliminary declaration or witness statement is false."

That does not say that someone can now proceed to an assisted suicide. There are significant further steps—the first and second requests—that a person would take when they felt ready or felt the need to request assistance to commit suicide. The preliminary declaration comes at an earlier stage and is simply recorded in the patient's records.

Colin Keir (Edinburgh Western) (SNP): Good morning. Something that has been going through my mind throughout the committee's deliberations is how the subject of assisted suicide is brought up, particularly if someone has not thought about it before and particularly in relation to a degenerative disease that has crept up over a number of years. A person with such a long-term illness might have been strong until a certain point and might then have been told about palliative care, but they might not have thought about going to their GP to make a preliminary declaration. Is it the position of the palliative care doctor to bring up the issue of assisted suicide, or should the option be brought up solely by the patient? The relationship aspect of palliative care seems a bit grey and murky to me, and I am just not 100 per cent sure how the issue of assisted suicide would be raised. Is it the place of palliative carers who are dealing with end of life to bring up the option?

Patrick Harvie: Colin Keir describes the relationship as grey and murky. I acknowledge that these are difficult discussions; indeed, they are discussions that are difficult to have now in relation to somebody's on-going care. When, for example, does someone discuss with a patient that they have a right to decide to end particularly critical treatment such as dialysis? When does someone mention that a person has a right to refuse nutrition or hydration, knowing that an inevitable consequence will be their death? When does somebody have the right to raise questions about the range of critical decisions that they might make, which might affect their prognosis and their likelihood of continuing to live—even questions about their attitude to pain relief, which would or could inform a subsequent decision about the double-effect doctrine and the impact that that would have on their life? If we take the view that people have a right to be central to that decision-making process, it is clear that people have a right to information and advice about the options.

11:00

I am sorry to keep mentioning Professor Chalmers's evidence, but it is very recent and for that reason has not been given much scrutiny. Whether we are talking about the interpretation that says that suicide itself is a criminal offence or the interpretation that says that it is not, Professor Chalmers makes it very clear that, under the current legislation, the provision of advice or information about suicide is unlikely to result in criminal liability or is not normally regarded as sufficient for liability. These are complex and difficult questions that in the current context have to be addressed with sensitivity in relation to a wide range of treatment and care options, and they would remain complex and sensitive issues to raise, in the most professional of contexts, in the scenario in which this legislation is passed. All that we would be doing would be ensuring that people were able to make this choice if they so wished, but they would certainly not be under any expectation or coerced to make that choice if they did not wish to make it.

Colin Keir: Given the nature of palliative care and the nature of suicide, should a doctor bring suicide up? The nature of suicide is that someone takes their own life; given that the basis of palliative care is longer-term natural deterioration until the end, is it correct for a palliative care doctor to bring up the option of suicide?

Patrick Harvie: I do not think that any of us would want a blanket assumption that in all circumstances a doctor must initiate such a discussion. On the other hand, we would not want a blanket prohibition on a doctor ever discussing assisted suicide.

Colin Keir: I was not talking about "discussing" the issue. My question was about whether doctors should instigate the conversation.

Patrick Harvie: I come back to my earlier suggestion that if there is a particular concern that merely talking about the subject or instigating such a discussion could be seen as a form of coercion, the committee might want to consider a further criminal safeguard against influencing a person to make a request. However, I disagree that merely having a discussion about the existence of this option would always be inappropriate. It is for care professionals to develop their relationships with the people for whom they care and to be able to give information and answer questions in an appropriate way on the basis of their patients' needs. That is the situation today. It is a complex and difficult matter, and it would continue to be complex and difficult, but it would not be any more complex and difficult than the other life-and-death decisions that are open to people who are being treated and cared for by professionals.

Mike MacKenzie: Do you agree that there are certain circumstances either at an early stage or when approaching end of life when someone's emotional, psychological and physical suffering is such that the decision to have this conversation with their GP and to seek to end their life in the form of assisted suicide is, to them, perfectly rational?

Patrick Harvie: I am not sure that I have met any perfectly rational people. Have you?

Mike MacKenzie: Perhaps striving for perfection is setting the bar too high. To put it in a more ordinary way, would you say that in certain circumstances such a decision would be rational and reasonable?

Patrick Harvie: In my personal view, yes. I can certainly see how, in certain circumstances, such a decision would be entirely understandable and one that our society ought to be able to respect and to acknowledge people's right to make on their own terms. To talk about a rational decision implies that we make decisions with only one part of our brain, but I am not sure that that is how we reach decisions on minor or life-critical choices. As whole human beings, we make our decisions not only internally but in the context of the relationships that we are part of.

Mike MacKenzie: That answer is not as helpful as I hoped it would be.

Patrick Harvie: I am sorry.

Mike MacKenzie: By that comment, I meant that we need to ask whether rationality should be higher up our hierarchy of considerations than the emotional or other dimensions in which such decisions might be made.

Patrick Harvie: I suppose—

The Convener: Perhaps I can save the day and move on to Dennis Robertson, who has been waiting patiently to ask a question. Patrick, do you want to respond briefly to Mike MacKenzie?

Patrick Harvie: I will be brief, convener. I come back to my previous argument that people approach these questions in very different ways, because we have fundamentally different world views and make our decisions in different ways. Some people are—or perceive themselves to be—more rational than others. Other people are much more in touch with or feel themselves in tune with an emotional or spiritual aspect of life. None of those approaches is wrong; it is just that people are different. That is the fundamental reason why the care that we provide for people in difficult circumstances should respect and reflect that diversity, allow people to reach their decision on their own terms and support them in doing so—bearing in mind, of course, the caveats about capacity and so on.

Mike MacKenzie: Thank you. That was helpful.

Dennis Robertson (Aberdeenshire West) (SNP): The majority of the line of questioning that I wanted to explore has been gone over. However, with the convener’s indulgence, I seek clarity on a couple of issues.

Good morning, Patrick. In a response that you gave some time ago to questions from Bob Doris, you used the phrase “known to the practitioner”. Did you mean that the condition would be known to the practitioner to enable them to make a decision? Alternatively, were you saying that the patient would be known to the practitioner, to enable the practitioner to move forward to the initial step?

Patrick Harvie: I was referring to section 9(2)(c), which relates to the endorsement of the first request. The endorsement of that request by medical practitioners’ statements comes after a person has made their preliminary declaration and their first request for assistance. Section 9(2) says, of the statement, that

> “the practitioner making it may do so only if, in the opinion of the practitioner”

a number of criteria are met. The third of those criteria, in section 9(2)(c) is

> “the person’s conclusion ... that the person’s quality of life is unacceptable is not inconsistent with the facts then known to the practitioner.”

To me, that suggests clearly that the practitioner must be aware of the facts of the person’s medical condition and make a judgment that the conclusion that the person has made about their own quality of life is not inconsistent with the facts.

Dennis Robertson: On the doctor-patient relationship, are you saying that the practitioner is aware of the conditions that are impacting on the patient’s life or of the patient as an individual?

Patrick Harvie: It seems to me that if a doctor was unaware of the conditions that a person was living in and their impact on that person’s life, the doctor would not be capable of satisfying the test in section 9(2)(c).

Dennis Robertson: That brings me to your answer to Rhoda Grant, in which you suggested that, if someone had a good relationship with their GP and wanted them to continue being their general practitioner but the GP did not agree with the initial endorsement, the person could move to another practitioner. Those two things do not seem compatible to me.

Patrick Harvie: The point that I was discussing with Rhoda Grant was about the hypothetical scenario in which somebody might wish to have a preliminary declaration recorded in their medical files long before they contemplated the realistic prospect of asking for assistance to commit suicide. If an individual was happy with their relationship with their GP in general but they knew that, because of a matter of conscience, they would not be able to turn to their GP to make the request should they ever need to do so, it would be down to the individual to decide whether to consider changing their GP. I would hope that that kind of change would not be felt to be necessary, given that a person’s relationship with their GP is about a wide range of issues and not just the one that is covered in the bill.

By the time that somebody made a first or second request for assistance, because of the scenario that they would be living in—we know from other jurisdictions about the circumstances in which people actually make such requests and seek assistance to commit suicide—they would already be in intimate contact with a wide range of medical professionals. They would not simply be going to their GP for the odd prescription. We are talking about two very different stages in life.

Dennis Robertson: That is a presumption, and it may actually be a fairly wide one.

I return to the point that, although a person might not be known to a GP, the condition or circumstances of a particular illness would be. The GP might not necessarily know the person or know their mental or emotional state.

Patrick Harvie: I am sorry, but I do not quite follow the question.

Dennis Robertson: Basically, I am saying that, in the circumstances that you have just described, the individual patient might well not be known to the GP. However, the GP would know about the medical condition and its impact, whether it be a long-term chronic illness or whatever, and so he could make a decision on that basis. However, he would not know the patient, so he would not be able to decide whether the patient had, to use Mike MacKenzie's term, come to a rational decision about wanting to end their life.

Patrick Harvie: It is certainly true that few people have as close and familiar a relationship with their GP as some fortunate people might once have had. The committee has had evidence about the historical context in which, in previous decades or generations, a GP who was familiar with a patient or their family—this might have been more common among wealthier parts of society—might have made a decision to end the patient's life. We know of a significant number of historical examples of that happening, with or without the patient's consent.

We have to recognise that that kind of close relationship to GPs is now less common in society. In trying to ensure that people are central to the decisions that are made about their lives, we have to recognise the reality of the medical care that is provided and the kind of relationships that they have. I see no difficulty in someone having a discussion with a GP about placing a preliminary declaration in their medical records without having an intimate and familiar relationship with that GP. It is purely the recording of a position.

I find it very hard to imagine that the much later scenario in which someone actively seeks assistance to end their life, given the circumstances that they are living with, will not be seen in the context of the care that is already being provided for detailed and complex medical conditions.

11:15

Dennis Robertson: We have heard in evidence that an individual might seek to end their life because they have become a burden to those who care for them. They would not necessarily be coerced into making such a decision, but the impact of their perhaps long-term condition—rather than the condition itself—on the people who care for them might lead them to decide to end their lives through the assisted suicide process. In other words, their decision would be a result not of their condition deteriorating but of the negative impact of their condition on others. How do we come to terms with that situation?

Patrick Harvie: I would answer that question in two ways. First of all, we need to look at the experience of other jurisdictions, which shows that the feeling of being a burden to others is low down the list of factors that are taken into account in such decisions. It is not one of the principal reasons that people cite.

Dennis Robertson: But it could be if this particular legislative framework existed.

Patrick Harvie: There is certainly the potential for that to happen. However, those who have cited that as a factor have cited it as one amongst other factors, and it is arguable as to whether it is the sole or driving motivation for seeking assisted suicide.

The second way in which I would respond to the question is to suggest that we look at how this cuts two ways. If a person decided that as a result of their on-going treatment—I mentioned dialysis earlier—they wanted a "Do not resuscitate" notice to be placed on their medical records or at the foot of their bed, and if that decision were motivated by a feeling that they were a burden, would we still respect it? Such decisions and factors have to be borne in mind today in a wide range of life-and-death situations.

I return to the argument that although the choice of allowing and legislating for a form of legalised assisted suicide, the choice of an individual to ask for it and the choice of another individual to offer such assistance are ethically complex, life-and-death decisions, they are no more ethically complex and life-and-death than other decisions that we already make, other laws that we already pass, other choices that we already allow people to make and other treatments and care that medical professionals, in particular, already provide. Such life-and-death decisions are already being made. The bill deals with one of those decisions, and the questions around coercion and people feeling that they are a burden are just as relevant today. I do not see why this issue is more relevant in the case of someone who might request assistance to end their life than it is for someone who might request the termination of treatment that sustains their life.

Dennis Robertson: Finally, in your opening statement, you mentioned empowerment and the fact that the relationship between patient and GP has changed. Obviously that is to be welcomed, but when you talked about empowering people to choose how to live their lives, did you deliberately not mention empowering them to choose how to die? In your opening statement, you mentioned living lives twice and you have also mentioned it in some of your responses to members. Did you take a deliberate line not to mention empowering people how to choose to die in your opening statement?

Patrick Harvie: Throughout the discussion, I like to think that I have been clear about what the bill is about. It is about the choice that people would have to seek assistance to end their life—to commit suicide—and whether someone would be able to provide that assistance. It is understandable to take the view that death is part of life, and to be, if not comfortable with that, at least in full acknowledgement of it.

One of the bill's critics, an ethicist who gave oral evidence to the committee, made the point that the name of the bill—the Assisted Suicide (Scotland) Bill—is more honest than the titles of previously proposed legislation. The name of the bill on the front page makes it very clear what it is about. I hope that I have not given the impression that that is being occluded.

The Convener: Several members wish to ask further questions and I just want to check that my list is correct. I understand that Richard Lyle, Bob Doris and Rhoda Grant have questions.

Richard Lyle: Thank you, convener; I have a couple of questions.

You spoke about "Do not resuscitate" notices. Many of us have been in a situation involving DNR notices; I experienced that with my father-in-law, when I did not know that he had requested not to be resuscitated. Would you say that, in a hospital, "Do not resuscitate" amounts to assisted suicide?

Patrick Harvie: No. There is a category distinction between someone's right to refuse a treatment or intervention and someone's right to seek a deliberate act that ends their life. The bill makes that distinction, particularly in the section prohibiting euthanasia, which makes it clear that the final act must be that of the person who wishes to die. It is important to understand that that is not the same as someone declining, refusing or seeking to end a treatment or intervention.

However, I take the view that the reasons for placing the decision in the hands of the individual are the same as those in relation to a positive act to end a life or to take control of the timing or manner of the end of a person's life. The reasons for putting such a decision in a person's own hands are in many ways the same as for placing individuals at the heart of decision making about treatments or interventions that they may want to accept or refuse.

Richard Lyle: As I have said a few times, we all know when we are born and we do not know when we are going to die, but through our lives we make decisions such as making a will or talking to our loved ones and telling them what we would like to happen to us after we die. Most people plan that and some people even pay for their funeral in advance. No one knows when they will die.

Many of us miss our loved ones. We could all turn round and say that we wish that we could have told our granny or grandfather about the baby being born and so on. We look back on the good times that we have had with our family.

What is your personal view on the scare stories that people have raised, such as the Shipman case, the suggestion that anyone can secure assisted suicide and that people will coerce their loved ones to die so that they can get hold of their assets? What is your view on the evidence that has been given to the committee in the past couple of weeks?

Patrick Harvie: You are quite right to say that none of us knows for sure when we will die or in what conditions. We all know that we will die and most of us find it difficult to talk about that and relate to it. That might be why some of these stories are very powerful.

Sally Foster-Fulton from the Church of Scotland is not a supporter of the bill, but she acknowledged that there is a wide range of views among members of the Church of Scotland. She made the case that there are powerful stories on both sides of the debate but that powerful stories do not necessarily make good legislation. As I said, Sally Foster-Fulton does not support the bill but I agree with that general point. Powerful stories can make us think and help us to reflect on how we feel about a range of scenarios, but they should not necessarily dictate to us what legislation should say. We should think carefully about the consequences of the legislation that we pass and whether it is consistent with the principles that we believe in.

The principle that I am asking the committee to consider is that of putting individuals at the heart of decision making about the life-and-death choices that they face.

Richard Lyle: In Belgium, the Netherlands and Oregon, 64.8 per cent of people who use such schemes have cancer or neurological disorders.

In Scotland, the figures for suicides are:

> "40-44 (98 per year on average)
>
> 45-49 (94 per year on average)
>
> 35-39 (82 per year on average)
>
> 50-54 (82 per year on average)
>
> 30-34 (72 per year on average)".

Patrick Harvie: You are talking about the breakdown by age group.

Richard Lyle: Yes. Many more people have committed suicide, sadly. You said earlier that you do not want to put a ballpark figure on it, but you said eventually that fewer than 100 people might take advantage of the bill if it is passed.

Patrick Harvie: That is what is anticipated in the bill's accompanying documents. It is consistent with a proportionate comparison in terms of population size and so on with other jurisdictions, albeit that some of those jurisdictions have different eligibility criteria, for example. The estimate is reasonable.

It is important to distinguish somebody's decision to seek assistance to commit suicide because of what they regard as an unacceptable quality of life from suicide more generally. Again, I ask the committee to consider whether any actual evidence exists in other jurisdictions of this kind of provision being incompatible with a proper and ambitious approach to reducing the incidence of suicide in the population more generally. The phenomena are very different. They happen for different reasons and in different contexts and I do not see any evidence from other countries that suggests that a proper approach to preventing and reducing the incidence of suicide in the general population is incompatible with a legal and well-regulated approach to allowing people to take control at the end of their life or in conditions of unacceptable quality of life.

Bob Doris: I started off by wanting to explore the possible scope of the provisions for assisted suicide, but I want to move on to talk about the civil and criminal liability that will be removed should the bill be passed.

As long as the process that is laid out in the legislation is followed, anyone who assists with a suicide is no longer civilly or criminally liable for that. There is also a savings clause in the bill. Terminology is used such as "acting in good faith" and "careless". It has been put to the committee by others who have given evidence that the savings clause has been drawn so widely that anyone who follows the bill's provisions will not be prosecuted, and anyone who does not follow the bill's provisions but is involved in an assisted suicide will not be prosecuted either. There is not enough detail to show when the savings clause would kick in and be appropriate. The "good faith" terminology seems to lace its way through that.

I would like to hear Patrick Harvie's views on whether the savings clause criteria are drawn too widely and whether, if the bill is passed, a case could be envisaged in which someone would be prosecuted for assisting a suicide in Scotland.

11:30

Patrick Harvie: I think that, if we accept the general principle and want some form of legalised assisted suicide to exist, very few people will want to see people prosecuted for very minor technical errors—for example, in the timing of a piece of paperwork. We would all acknowledge that minor technical errors could be made and that they should not necessarily give rise to prosecution as though they were intentional or seriously reckless abuses of the legislation.

I am not of the view that serious changes need to be made to section 24; it satisfies the need as it stands. Some of the slightly hyperbolic descriptions of it—one witness used the phrase "anything goes"—are not helpful or accurate. However, if the committee is minded to suggest changes to the section, I will look at them with an open mind and explore the intention behind them.

Bob Doris: I am trying to scrutinise the bill in the same way as we would scrutinise any other piece of legislation, irrespective of personal views. Can you flesh out the detail to give us a greater idea of what the savings clause would involve?

Under the current law the situation is unclear, as Mike MacKenzie said. However, a commonsense approach is often used to decide whether a prosecution should take place. No one will be seeking, either under the status quo or under the bill if it is passed, to prosecute vulnerable people in dire situations who may have assisted a suicide. That does not seem to be happening currently, and we and Mr Harvie would not expect it to happen if the bill was passed.

I did not use the expression "anything goes". However, if we are to codify the system for assisted suicide by setting out a clear process by which a person can assist someone to commit suicide and by using the catch-all expression "acting in good faith", it is reasonable for us, in scrutinising the bill, to ask for some examples of what would constitute "acting in good faith" and what would not. That raises questions about burden and coercion, and we need some clarity in that respect.

I am not saying that the savings clause means that "anything goes", but it is responsible for us to ask, in looking at the clause, what does go.

Patrick Harvie: If you are looking for a specific example, I suggest the final 14-day time limit after which a drug, if it has not been used, is supposed to be removed. If the facilitator, for whatever reason, has been unable to get there within 14 days—perhaps they are a couple of hours late—and has made every effort to ensure that the time limit is adhered to, I think that most people would accept that such a minor breach of the legislation ought not to require prosecution.

On the other hand, if the 14-day time limit remains—I do not know whether the committee wishes to discuss the time limit itself—and the bill is passed, and the decision is made autonomously to leave the drug available to the patient well after the 14 days in deliberate contravention of the time limit, that would be viewed as a very serious matter.

Is that helpful?

Bob Doris: It is helpful that you have given your thinking in relation to the savings clause, but the question is whether that is reflected and clarified in guidelines and in the legislation itself.

I want to move on to another matter—

Patrick Harvie: I just want to respond briefly on that point. The general argument would be that we very rarely—and possibly never—pass legislation that is entirely mechanistic in its application.

If you take the view that, at present, there is a lack of legal clarity and that this bill seeks not to provide complete legal clarity in all circumstances but to define one set of circumstances in which people have clarity that a particular course of action is legally permissible, then, even within that course of action, there will be judgments to be made about the application of the law, as there are judgments to be made about the application of any law that this or any other Parliament passes. However, the general argument is that we need to provide a path or course of action that is legally sanctioned and which gives people some degree of clarity that they have that route open to them.

Bob Doris: I understand the arguments about clarity; that is why I was asking for clarity on the scope of people who would, in theory, qualify for assisted suicide and clarity on when a savings clause would kick in. I personally felt that that clarity was perhaps not there.

I was going to ask a supplementary question earlier, but Dennis Robertson had been waiting patiently to ask a question so I forwent the opportunity to ask my question. At that point, people were talking about the potential medicalisation of assisted suicide—I think that Nanette Milne raised that issue. You can probably guess the question that I am going to ask, as I have been asking it consistently of witnesses over the past few weeks.

Leaving aside the issue of the conscience clause, if assisted suicide is potentially a treatment option—that might be the wrong terminology; I am not trying to use that terminology deliberately—and someone says to their GP, “I don’t think I can cope with this or live with this any more,” and the GP identifies that that person would, in theory, qualify for assisted suicide, should the GP say, “Actually, you have an option other than palliative care and chronic pain management, because you could go for assisted suicide”? Within the process for someone who is struggling to live with a life-limiting condition, should anyone—either a GP or someone else in the plethora of managed clinical networks in the NHS—say that they have another option? At what point would that happen?

I do not want to needlessly alarm people—I would be alarmed if that happened—but it is a reasonable question for me to ask. If you do not know that assisted suicide exists as an option, how can you access it? If it exists and you qualify for it, should you not be told about it? If so, whose job should it be to tell individuals about it?

Patrick Harvie: First, if Parliament passes this legislation, there will be broad recognition and acknowledgement in society at large. I think that the option will be general knowledge.

Secondly, if one of the consequences of our passing the legislation was the creation of a more open culture of discussing death and the end of life or the treatment options before someone is in the circumstance that we are discussing, fewer people would be in the position of not knowing about the option.

Finally, if Parliament has decided that giving people this option is the right thing to do and the legislation has been passed, I do not see any reason why someone who does not know about the option should not be provided with that information, just as I see no reason why someone who is on dialysis and finds the quality of their life unacceptable should not be informed that they have the option of not continuing with that treatment. The same applies to any other life-critical treatment.

Bob Doris: Do you not have any concerns about the possibility that, depending on which relevant medical professional raises the option, the relationship of trust that our constituents might have in that clinical professional might be undermined? They might have wanted that medical professional to have been punting for them to have as good a quality of life as possible, but that medical professional might feel obliged to say, “Actually, there is this other option.” Is there a danger of undermining patients’ trust in medical professionals?

Patrick Harvie: People can raise issues well or in a bad way—sensitively or insensitively. If a medical or care professional raises any options—either existing choices that people can make or a choice that they could make if the bill were passed—in a bad way, trust could be undermined. The way in which those options are raised can undermine or build trust.

I suppose the question is: what do you want to trust your doctor to do? Do you want to trust your doctor to make the decisions for you, or do you want to trust the doctor to give you all the information that allows you to make your own choices?

Bob Doris: Okay. Thank you, Patrick. I have listened carefully to what you have said.

The Convener: I have a quick supplementary question. Given your responses to Bob Doris on the savings clause, can I give you another example that you might want to address? What if someone took a decision or action in good faith regarding where the line is between assisted suicide and euthanasia? How would we deal with that issue?

Patrick Harvie: If somebody decided for themselves to take an action that was the final act that ended another person's life, under this legislation they would clearly be breaking the law. It is pretty clear that there will be a range of scenarios in which detailed regulation of licensed facilitators will be expected. There is provision in the bill for that to be a regulated activity, so regulations would apply to the licensed facilitators.

In terms of the primary legislation, we should focus on the category distinction between someone taking a final action that ends another person's life, which will remain a criminal act, and someone providing assistance for another person to take the final action themselves, on their own terms and in their own time.

The Convener: But what if a person committed an act of euthanasia in good faith?

Patrick Harvie: In my view, there is no ambiguity in the bill's meaning, because there is nothing in the bill that would allow euthanasia or decriminalise in any way the ending of a person's life by an act that they did not themselves take. In the savings section—section 24—subsection (1) has the wording:

> "If a person, when acting in good faith and in intended pursuance of this Act, makes an incorrect statement or otherwise does anything inconsistent with the Act".

Therefore, an action has to be something that is in "pursuance of this Act", and the eventual act will be about assisted suicide and very explicitly not about euthanasia.

The Convener: In your view, is there an ethical distinction between assisted suicide and euthanasia, given that you have suggested that the whole purpose and principle of the legislation is ultimately to give an individual a particular right?

Patrick Harvie: It is not only my view that there is such a distinction; probably every witness who has been asked the question has agreed that there is a very clear ethical distinction between euthanasia, which is the ending of someone else's life by a person's action, and assisted suicide—the provision of assistance for someone to take an act themselves, on their own terms and in their own time, that ends their life—just as there is an ethical distinction between that and the withdrawal of treatment.

The Convener: Should that not be reflected in the bill? Should there not be a legal distinction in the bill that makes that clear, rather than yet again leaving it to another set of guidelines?

Patrick Harvie: I think that section 18(1) does precisely that, because it states:

> "Nothing in this Act authorises anyone to do anything that itself causes another person's death."

I think that the prohibition of euthanasia is very clear.

The Convener: You described a scenario earlier involving a person claiming that they were asked by another person to end their life. Should there not be a definition in the bill to make matters clearer?

Patrick Harvie: If the person providing assistance to another person who had requested assisted suicide was then asked to take the final act, perhaps by pressing an injection plunger or taking some other final act that would cause death, they would break the law if they did that—that is very clear under section 18. Nothing in the bill authorises anyone to do anything that causes another person's death.

The Convener: So you believe that that is clear and that the action does not need defining in any other way. The text does not say that: it is a general provision, and the bill does not define that such an action would be illegal and would face—

Patrick Harvie: Even Professor Chalmers would accept that taking an action that ends another person's life is already illegal. Murder does not need to be criminalised; it is already criminal.

11:45

Rhoda Grant: I wish to ask about the licensed facilitator. The bill says that the person must be licensed and must be over the age of 16. It says that they should provide reassurance and that they should report the death. However, it is not entirely clear what their total role is. Are they the people who have the drugs that would be used for the suicide? Do they have to be there at the point when the person commits suicide? Are they the only people there at the point when the person commits suicide? It is not altogether clear what their role in facilitating it is.

Patrick Harvie: Under section 19, the licensed facilitator is expected to use their

> "best endeavours ... to be with the person when any drug or other substance or means dispensed ... is taken or used".

It is understandable that that might not always be possible. We are talking about a period of 14 days, at present, and we cannot expect someone to be physically present, awake and alert for that entire period. The person is

> "to use best endeavours ... to be with the person"

when that happens. They are also required,

> "as soon as practicable after the expiry of the period of 14 days ... to remove ... any such drug or other substance or means still in the person's possession."

Those are two of the more significant areas of clarity, in response to your question.

Section 19(b), which mentions "comfort and reassurance", is understandably subjective. That will mean different things in different circumstances, and it will mean different things to different people. For example, it would mean something very different in a scenario where someone is surrounded by their loved ones, who are also giving them comfort, reassurance and support at an emotional level, than it would in the situation of someone on their own, who has no family or friends around them and for whom the licensed facilitator might be a principal source of emotional support and comfort.

I hope that that goes some way towards answering the question. Some witnesses have argued for greater specificity regarding the role of the licensed facilitator, or for a precise definition particularly of the forms of assistance that are allowable, which we discussed some time ago. My instinct is still against a prescriptive list of specific physical actions that are permissible or not permissible. We are talking about scenarios that are different, that will be based on a wide range of different circumstances, and that might change over time.

Rhoda Grant: So, having a facilitator present would not stop family members being present or facilitating things, by preparing medication or whatever.

Patrick Harvie: I will pick up on the term "facilitator" first. That is one particular person, who is licensed and regulated. The bill does not prevent somebody else from offering assistance—propping the person up in bed being one of the more common examples of physical assistance, which somebody might need in order to ingest a drug that has been provided. The provisions do not prevent somebody else, for example a family member, from providing physical assistance.

Rhoda Grant: Even if the facilitator is not present when the suicide takes place, they still have to report it. Would they have to report the fact that they were not present? They might assume that the person took the drugs, but they might not have done.

Patrick Harvie: I do not think that there is a requirement for them to report that they were not present. That might be a reasonable change that the committee might feel that it wants to make. I mentioned in my opening statement that there have been several comments regarding the recording and reporting of information and whether it should be held centrally. I think that it would be reasonable to suggest that, if a facilitator was not able to be present at the time when a drug was ingested, for example, they should record that and perhaps the reasons why.

Rhoda Grant: There would be no witness at all to the drug being ingested, if that was the case.

Patrick Harvie: It is not required of the facilitator under the bill, but it might be a reasonable expectation that they would report the circumstances in that situation.

Dennis Robertson: Would it lead to a police inquiry if it was reported that a facilitator was not present, because there would be no proof of how the person was assisted in their last act?

Patrick Harvie: In the bill, the section after the section that introduces licensed facilitators is about reporting to the police, and it requires the licensed facilitator to report the facts of the person's assisted suicide

> "to a constable as soon as practicable."

There has been broad agreement from witnesses, including the police, that the report should go to the procurator fiscal in the first instance, and it would be for them to decide whether there were circumstances that required a police investigation. There is an understandable reluctance to have a situation in which every family, at this distressing time, would be subject to an immediate police investigation if they had clearly followed a legally sanctioned and well-defined path towards asking for this assistance and having it provided.

Dennis Robertson: You can see where I am coming from. If the licensed facilitator is not present at the time of death and they then report that, as has been suggested, how do we verify that the correct procedure was undertaken?

Patrick Harvie: The facilitator is required to make a report—let us assume that the bill will be changed so that the procurator fiscal receives it—where they believe

> "that the person for whom the facilitator has been acting has died as a result of taking or using any drug, substance or other means dispensed or otherwise supplied for the person's suicide, or ... that the person has attempted to commit suicide in that way but has not died".

That latter scenario is unlikely given the zero failure rate of organisations such as Dignitas in this area. The report is required when the licensed facilitator "knows or believes" that the person has died in this way. It is reasonable to—

Dennis Robertson: They would not know if they were not there. Does it come down to their believing that the process was carried out? That is a very grey thing, is it not? There is a lot of ambiguity there. If they are not there, they cannot know. Are you suggesting that they could submit a report saying that they believe that the process was carried out appropriately?

Patrick Harvie: Yes. The alternative would be that no report to anyone is required, and I do not think that anyone would support that. The argument for reporting and recording information about the process has been well made, and to not require a report to be made at all if the facilitator was not present when the drug was ingested would be rather remiss.

Dennis Robertson: Thank you.

The Convener: I thank Patrick Harvie, his colleagues and all colleagues who are here this morning. As previously agreed, we will now move into private session.

11:54

Meeting continued in private until 12:43.

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