

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Sixteenth Sitting

Tuesday 4 March 2025

(Morning)

CONTENTS

CLAUSE 4 under consideration when the Committee adjourned till this day
at Two o'clock.

No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

not later than

Saturday 8 March 2025

© Parliamentary Copyright House of Commons 2025

This publication may be reproduced under the terms of the Open Parliament licence, which is published at www.parliament.uk/site-information/copyright/.

The Committee consisted of the following Members:

Chairs: PETER DOWD, † CLIVE EFFORD, SIR ROGER GALE, CAROLYN HARRIS, ESTHER McVEY

- | | |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------|
| Abbott, Jack (<i>Ipswich</i>) (Lab/Co-op) | † Opher, Dr Simon (<i>Stroud</i>) (Lab) |
| † Atkinson, Lewis (<i>Sunderland Central</i>) (Lab) | † Paul, Rebecca (<i>Reigate</i>) (Con) |
| † Campbell, Juliet (<i>Broxtowe</i>) (Lab) | † Richards, Jake (<i>Rother Valley</i>) (Lab) |
| † Charalambous, Bambos (<i>Southgate and Wood Green</i>) (Lab) | † Sackman, Sarah (<i>Minister of State, Ministry of Justice</i>) |
| † Francis, Daniel (<i>Bexleyheath and Crayford</i>) (Lab) | † Saville Roberts, Liz (<i>Dwyfor Meirionnydd</i>) (PC) |
| † Gordon, Tom (<i>Harrogate and Knaresborough</i>) (LD) | † Shah, Naz (<i>Bradford West</i>) (Lab) |
| † Green, Sarah (<i>Chesham and Amersham</i>) (LD) | † Shastri-Hurst, Dr Neil (<i>Solihull West and Shirley</i>) (Con) |
| † Hopkins, Rachel (<i>Luton South and South Bedfordshire</i>) (Lab) | † Tidball, Dr Marie (<i>Penistone and Stocksbridge</i>) (Lab) |
| † Joseph, Sojan (<i>Ashford</i>) (Lab) | † Woodcock, Sean (<i>Banbury</i>) (Lab) |
| † Kinnock, Stephen (<i>Minister for Care</i>) | |
| † Kruger, Danny (<i>East Wiltshire</i>) (Con) | Lynn Gardner, Lucinda Maer, Jonathan Whiffing,
<i>Committee Clerks</i> |
| † Leadbeater, Kim (<i>Spen Valley</i>) (Lab) | |
| † Malthouse, Kit (<i>North West Hampshire</i>) (Con) | |
| † Olney, Sarah (<i>Richmond Park</i>) (LD) | † attended the Committee |

Public Bill Committee

Tuesday 4 March 2025

(Morning)

[CLIVE EFFORD *in the Chair*]

Terminally Ill Adults (End of Life) Bill

9.25 am

The Chair: Will everyone please ensure that their electronic devices are turned off or switched to silent mode? As I am sure the Committee is aware by now, tea and coffee are not allowed in the room.

Clause 4

INITIAL DISCUSSIONS WITH REGISTERED MEDICAL PRACTITIONERS

Amendment proposed (26 February): 278, in clause 4, page 2, line 16, leave out from beginning to “nothing” in line 16 and insert—

“(1A) No registered medical practitioner may raise the subject of the provision of assistance in accordance with this Act with a person if that person has made an advanced decision which has been recorded in their medical records that they will not in future wish to seek assistance under this Act.

(1B) The provisions in subsection (1A) do not prevent a person indicating to a registered medical practitioner that they wish to change their previous decision and seek assistance under the Act if they have the capacity to do so.

(2) Other than the condition in subsection (1A).”—(*Sarah Green.*)

This amendment would prevent a doctor from raising assisted dying with a patient if that patient had previously recorded an advanced decision that they would not in future wish to seek assistance under the Act.

Question again proposed, That the amendment be made.

The Chair: I remind the Committee that with this we are discussing the following:

Amendment 8, in clause 4, page 2, line 16, leave out from “practitioner” to end of line 20 and insert

“shall raise the subject of the provision of assistance in accordance with this Act with a person who has not indicated to that or another registered medical practitioner that they wish to seek assistance to end their own life”.

Amendment 124, in clause 4, page 2, line 16, leave out from “practitioner” to end of line 20 and insert

“shall discuss assisted dying with a person unless that matter is first raised by that person.”

The amendment prevents a registered medical practitioner from discussing the provision of assistance under the Act unless that matter is first raised by that person.

Amendment 319, in clause 4, page 2, line 20, after “person” insert

“who has attained the age of 18”.

Amendment 339, in clause 4, page 2, line 20, after “person,” insert

“, unless that person has a learning disability or is autistic, in which case—

- (a) the person must be provided with accessible information and given sufficient time to consider it; and

(b) at least one of a—

- (i) supporter, or
- (ii) independent advocate;

must be present for the discussion.”

This amendment would require that, if the person is autistic or has a learning disability, they must be given accessible information and sufficient time to consider it. Additionally there must be at least either a supporter or independent advocate.

Amendment 368, in clause 4, page 2, line 20, after “person” insert

“, unless that person has Down syndrome, in which case the registered medical practitioner must be acting in accordance with any statutory guidance issued by the Secretary of State under the Down Syndrome Act 2022 to meet the needs of adults with Down syndrome.”

Amendment 320, in clause 4, page 2, line 21, after “person” insert

“who has attained the age of 18”.

Amendment 270, in clause 4, page 2, line 25, at end insert—

“(3A) Before conducting a preliminary discussion under subsection (2) the registered medical practitioner must ensure that the person has no remediable suicide risk factors which pose a significant risk to their life.”

This amendment requires that the doctor ensures that there are no remediable suicide risk factors before proceeding to the initial discussion about assisted dying.

Amendment 276, in clause 4, page 2, line 31, at end insert—

“(4A) A medical practitioner must not conduct a preliminary discussion with a person under subsection (3) until a period of 28 days has elapsed, beginning with the day the person had received a diagnosis of the terminal illness.”

This amendment would mean a doctor could not conduct a preliminary assessment until 28 days from the day the person received a diagnosis of the terminal illness.

New clause 6—*Advance decision of no effect—*

“An advance decision, made pursuant to sections 24 to 26 of the Mental Capacity Act 2005, which stipulates that the maker of the decision, having become incapacitated, wishes to be provided with assistance to end their own life in accordance with this Act, shall be null and void and of no legal effect.”

The new clause prohibits an individual from making an advanced directive for voluntary assisted death in the eventuality he or she were to become incapacitated at a future date.

The Minister for Care (Stephen Kinnock): It is a pleasure to serve under your chairship, Mr Efford.

As I have stated previously, my remarks on behalf of the Government on these amendments will provide a factual explanation. I shall not offer a position on how the Committee should vote, as that remains a matter of conscience. The overarching theme of the amendments relates to the requirement on how and when a medical practitioner may raise the matter of assisted dying.

Clause 4(2), as drafted, provides that nothing prevents a medical practitioner from using their professional judgment to decide when to raise the subject of assisted dying. Amendment 278 seeks to prevent a doctor from raising the subject of assisted dying if the person has a recorded advance decision in their medical records that states that in future they will not want assisted dying.

The Mental Capacity Act 2005 enables a person with capacity to make an advance decision to refuse a specified form of treatment in future, should they lack capacity. A person who has lost capacity under the Mental Capacity Act would not be eligible for assisted dying under the Bill. Where such an advance decision is in place, the effect of the amendment would be to prevent

the doctor from raising the subject of assisted dying, unless the person indicates to the doctor that they wish to change their previous decision, that they wish to seek assistance under the legislation and that they have the capacity to do so.

Technically, amendment 278 appears unnecessary, because advance decisions under the Mental Capacity Act are not relevant to assisted dying. That is because advance decisions are about refusing treatment at a time when a person no longer has capacity, and assisted death would be available only to those who have capacity.

As drafted, clause 4(1) states:

“No registered medical practitioner is under any duty to raise the subject of the provision of assistance in accordance with this Act with a person”.

but clause 4(2) specifies that they may do so if, in exercising their professional judgment, they consider it appropriate. Amendment 8 would prevent a registered medical practitioner from raising with a person the subject of provision of assistance under the Bill, unless the person has indicated to that practitioner or to another registered medical practitioner that they wish to seek assistance to end their own life. The effect would be that any conversation on assisted dying will need to be patient-initiated, and not at the discretion of the medical professional within a wider conversation about end-of-life care.

The effect of amendment 124, as with amendment 8, would be to prevent a registered medical practitioner from raising with a person the subject of provision of assistance under the Bill. That would mean that the person will need to indicate to a registered medical practitioner that they wish to seek assistance to end their own life before an initial discussion can take place. The effect would be that assisted dying can be discussed only if the patient has initiated the conversation.

The Government’s assessment of amendment 319 is that, as drafted, it would not prevent the subject of an assisted death from being discussed with a person who is under 18. There is already a requirement that, to be eligible for the provision of assistance under the Bill, a person must be aged 18 or over at the time that they make their first declaration under clause 1(1)(b).

Amendment 319 would impose additional requirements on the approach that a medical practitioner must make if raising the subject of assisted dying with a person who has a learning disability or is autistic. It would require the person to be provided with accessible information and given sufficient time to consider it. It would further require that they must have a supporter and/or independent advocate present for the initial discussion. The amendment would require that a person with autism or a learning disability must have a supporter or independent advocate present for the discussion, even when they have capacity or are high-functioning. Autism is a spectrum disorder, meaning that autistic people have diverse and varying needs, so the effect of the amendment would vary among individuals.

It is already the case that all registered medical practitioners, in meeting their professional standards, are expected to communicate information clearly and effectively. That includes allowing sufficient time for the individual to consider and process the information provided. For example, the General Medical Council’s “Good medical practice” states that all GMC-registered clinicians

“must take steps to meet patients’ language and communication needs”

to support them to

“engage in meaningful dialogue and make informed decisions about their care.”

Amendment 368 would require registered medical practitioners, when deciding if and when it is appropriate to discuss assisted dying with a person with Down’s syndrome, to act in accordance with the Down Syndrome Act 2022. The Act requires the Secretary of State to issue guidance to relevant authorities on what they should be doing to meet the needs of people with Down’s syndrome. Although this work is being taken forward as a priority by the Department, no statutory guidance has yet been published under the Act.

The relevant authorities in scope of the Act are institutions such as NHS trusts. The Act does not provide for guidance to be prepared for individual doctors. The relevant authorities must have due regard to the statutory guidance, which enables them a degree of discretion in following it, but the amendment would require medical practitioners to act in accordance with the guidance. It might therefore create uncertainty as to how a doctor can comply with their obligations under the Bill.

Danny Kruger (East Wiltshire) (Con): I hear what the Minister says—the guidance does not exist and there is concern that the amendment may therefore induce some confusion—but would the answer not be to put a commitment into the Bill that the Secretary of State will issue guidance on how the 2022 Act could be applied in the context of the Bill?

In the light of our conversation at the Committee’s last sitting, I put on the record my intention to press the amendment if the Minister cannot give a commitment now to introduce an amendment later that the Secretary of State will introduce statutory guidance to ensure that proper care is taken of people with Down’s syndrome in accordance with amendment 368.

Stephen Kinnock: The challenge is the dissonance in how the guidance under the Down Syndrome Act, which is currently very close to publication, is directed towards authorities such as trusts, but there is no coverage around individual doctors. At this stage, without seeing a clear distinction between the two or how it would work for individual doctors, the Department’s concern is that it could create confusion as to the obligations on individual medical practitioners under the 2022 Act. I am obviously open to conversations about how to clear that up, but the lacuna between the authorities and the individual doctors is the problem being flagged by the Department.

Kim Leadbeater (Spenn Valley) (Lab): I take the Minister’s comments on board. Will he agree to a conversation with me and with the right hon. Member for East Hampshire (Damian Hinds), who tabled amendment 368, to take the discussion forward?

Stephen Kinnock: I am happy to have conversations with the hon. Lady and other hon. Members, but as things stand it is not clear to the Department or to me how the proposal would work in practice.

Kit Malthouse (North West Hampshire) (Con): I apologise for having arrived ever so slightly late, Mr Efford. In the Minister's view, is it conceivable that he or any future Minister—or, indeed, the current or any future chief medical officer—would not consult with groups representing those with Down's syndrome in drawing up the various guidelines on the Bill?

Stephen Kinnock: Extensive consultations have taken place with all the key groups and advocacy organisations on Down's syndrome in the drafting of the guidance. The guidance is very close to publication; once it is published, it will form the basis of a further consultation. It is an iterative process.

Kit Malthouse: Perhaps I was not clear. I meant the guidance on this Bill. Although the Minister may not necessarily be able to say what will be in it, is it conceivable that the CMO, in drawing up guidance as a requirement under the Bill, would not consult Down's syndrome groups? My point is that, given what has been expressed and the desire of the Committee, I cannot see that a CMO would not talk to Down's syndrome groups in any event.

Stephen Kinnock: I thank the right hon. Gentleman for that clarification and apologise for my misunderstanding; I thought he was referring to the guidance that we are currently working on under the terms of the 2022 Act. Yes, absolutely: the Bill currently specifies a two-year commencement period, within which a whole range of operationalisation work will need to be done. All of that will need to be consulted on; we will not do it all in an ivory tower from Whitehall or Westminster.

Danny Kruger: It is welcome that a commitment has been made to meet my right hon. Friend the Member for East Hampshire, who tabled the amendment, but a commitment to consult is not the same thing as specific protections in the Bill for people with Down's syndrome. What we really need is a commitment in the Bill that there will be statutory guidance. There will be opportunities for that later, so we may not need to press the amendment to a vote, but if we cannot have a commitment, we must press it.

Stephen Kinnock: It is absolutely the hon. Member's prerogative to press the amendment to a vote if he so wishes. As things stand, because of the baseline, which is the GMC guidance that I have just read out, we constantly go back to the Government's position that the current corpus of guidance, regulations, advice, training, expertise and professional judgment is, in essence, satisfactory to the Department. We believe in and rely on the professional judgment of the experts in the field. That remains our fundamental position.

The effect of amendment 320 would be that the safeguards in clause 4(4) in respect of the preliminary discussion apply only where the person seeking assistance is aged 18 or over. The amendment would not prevent a discussion with a person under 18. As the Committee will be aware, there is already a requirement that, to be eligible for the provision of assistance under the Bill, a person must be 18 or over when they make their first declaration under clause 1(1)(b).

Amendment 270 would make it a requirement for a registered medical practitioner to ensure that there are no remediable suicide risk factors before proceeding to the initial discussion about assisted dying. The amendment does not state what is to happen if the practitioner considers that there are remediable suicide risk factors. As the Committee will be aware, we rely on medical practitioners to make judgments in relation to their patients that draw on their training, experience and expertise. We would expect the judgment and skill of a medical professional to be brought to bear where there are remediable suicide risk factors.

Amendment 276 would mean that a person is unable to have a preliminary discussion or make a first declaration to be provided with assistance to end their own life until 28 days after receiving a terminal diagnosis. The amendment would add an additional pause into the process for a person who has received a terminal diagnosis in the preceding 28 days. The 28-day pause would apply regardless of the patient's prognosis, even if they had only one month left to live, for example.

New clause 6 would ensure that an advance decision to refuse treatment under the Mental Capacity Act 2005 cannot be used to seek assisted dying. Our analysis suggests that the new clause is not necessary, because an assisted death is available only to those with capacity, whereas advance decisions provide for a person to be able to refuse treatment at a future time when they have lost capacity. If a person still has capacity, they may be eligible for an assisted death. If they do not have capacity, they will not be eligible, irrespective of whether they have made an advance decision.

That concludes my remarks on this group of amendments. As I say, the Government have taken a neutral position on the substantive policy questions relevant to how the law in this area could change. However, I hope my comments and observations are helpful to Committee members in considering the Bill.

Rebecca Paul (Reigate) (Con): I appreciate the opportunity to speak briefly, Mr Efford. Many other speakers have already made excellent points in support of the amendments, so I will not repeat them, but I would like to put on record one pertinent point.

During these proceedings, there has been a tendency by some to speak as though assisted dying were another type of treatment or healthcare option being offered by medical practitioners, rather than a completely different and separate offering. I have grave concerns about that. The legal norm, and GMC guidance, is that patients should be offered all reasonable medical treatments. A medical treatment can be defined as something that combats disease or disorder. It is fundamentally about healing, relief of symptoms, recovery and cure. Straightaway, we have a conflict. Assisted dying ends the life of a person. It is not a treatment in the normal sense—

The Chair: Order. You need to speak to the amendments in this group.

Rebecca Paul: I am. It is relevant, because we are talking—

The Chair: You will need to explain to me how you are speaking to the amendments.

Rebecca Paul: We are talking about what a medical practitioner can and cannot say. During the debate, there was a lot of talk about whether it was a medical treatment or not. If so, guidance indicates how it should be treated, so whether it is a medical treatment or not is relevant and pertinent to the clause. I have an important point that I would like to put on the record; I am happy to raise it at a different point, but I honestly believe that clause 4 is the right place.

The Chair: The problem is that this is not a general debate on clause 4; it is a debate about a specific group of amendments. We may come later to a general debate on clause 4.

Rebecca Paul: I can wait until the stand part debate.

The Chair: If there is a stand part debate, that will be the right time to make a contribution about the general principles of clause 4.

Rebecca Paul: Okay. I will just put it on the record that whether or not something is a medical treatment is vital. It is possible to give medical treatments without consent, so we need to have that debate.

The Chair: That is for the wider debate. I call Kim Leadbeater.

Kim Leadbeater: It is a pleasure to serve under your chairship, Mr Efford. The amendments relate to the initial discussions with medical practitioners, and it is important to highlight that clause 4(1) states:

“No registered medical practitioner is under any duty to raise the subject of the provision of assistance in accordance with this Act with a person.”

However, subsection (2) states that

“nothing in subsection (1) prevents a registered medical practitioner exercising their professional judgement”.

Doctors and healthcare professionals, like any other group of people, hold a range of views on assisted dying. We need only reflect on the oral and written evidence to see that. However, the British Medical Association has a neutral position on assisted dying, and its representatives were very clear when I met them, and in oral evidence to the Committee, that they wanted an opt-in model for doctors to provide assisted dying, as well as the right to decline to carry out activities directly related to assisted dying, for any reason. These requests have therefore been incorporated into the Bill.

The BMA was clear in its submission that it opposes amendments 8, 124 and 276, as well as amendment 342, which we will come to later. It said that adding a prohibition or limiting factors in the Bill would

“create uncertainty and legal risks for doctors, which may inhibit effective doctor/patient communication and understanding.”

It welcomed the Bill’s provision that a doctor is not under a duty to raise assisted dying, which it felt was necessary to avoid any suggestion that doctors have a legal duty to raise it. It was concerned that these amendments would remove that provision, leaving doctors in a position of legal uncertainty. It said:

“If doctors are concerned that they may be legally obliged to raise assisted dying with all potentially eligible patients, this will impact on how, when, and by whom the issue is raised...It is essential that decisions about when and how to discuss assisted dying are made on the basis of what is best for the patient—rather

than to avoid legal challenge. All patients deserve to have this important and sensitive conversation with a doctor who is confident, competent and happy to have the discussion...Doctors should be able to talk to patients about all reasonable and legally available options; a provision that limits or hinders open discussion about any aspect of death and dying is likely to be detrimental to patient care. Doctors should be trusted to use their professional judgement to decide when and if a discussion about assisted dying would be appropriate, taking their cue from the patient as they do on all other issues.”

That is the BMA’s position, and I agree.

As Duncan Burton, the chief nursing officer for England, said in oral evidence to the Committee,

“it is clear that there is increasing discussion in society around death and dying, and I think that is important. It is important that we have discussions and support people with their choices at the end of life, so anything we can do to increase that is important.”—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 28 January 2025; c. 41, Q22.]*

Dr Ryan Spielvogel from California told us:

“People cannot make informed decisions for themselves if they do not know what their options are. While this is top of mind for all of you and for the doctors...even if this Bill becomes law, the general population is still not going to realise that it is an option.”—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 28 January 2025; c. 105, Q143.]*

He strongly advised against not allowing doctors to discuss patient choice, because in his experience that really hampers their ability to take care of patients. Dr Jessica Kaan of End of Life Washington reiterated the point:

“It is a huge burden to put on patients and their loved ones if they have to bring it up themselves. I would highly caution against any sort of language that requires that, because it is just not fair to them. They are already going through so much”.—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 28 January 2025; c. 106, Q143.]*

In the light of our recent discussions, I draw the Committee’s attention to the current BMA guidelines regarding patient requests for assisted dying. Those guidelines will obviously need updating if the law changes, but they are comprehensive and give us a much greater understanding of the approach that doctors take when speaking to terminally ill patients, as well as what these hugely sensitive conversations look like, which is really important to know.

The BMA guidance addresses situations in which patients make an explicit request for doctors’ assistance in or information about ending their life or hastening their death. I will refer to that guidance now. The guidance advises the doctors to

“Explore the patient’s feelings, emotions and thoughts...It might be helpful to discuss their understanding of their condition or their fears and concerns...If you feel that the patient is depressed or suffering from another mental health condition, or would benefit from more support, therapy or counselling should be offered.”

Doctors are also advised to

“Use the opportunity to address those concerns: you should also investigate whether other practical arrangements could help improve the patient’s quality of life. Involve a colleague: you might like to involve a more experienced colleague—making clear to the patient that this is what you will be doing.”

The guidance also talks about involving other sources of support:

“you might like to seek support and input from other members of the healthcare team, such as a specialist palliative care team, colleagues from mental health, or the chaplaincy or voluntary services.”

9.45 am

It is important to put on the record that these types of conversations happen now, so we are not starting from scratch. Indeed, similar guidance is given by the General Medical Council. Its guidance includes the obligation to “discuss with patients their treatment options (including the option of no treatment) and plans for future treatment.”

It encourages doctors to

“create opportunities for patients to raise concerns and fears about the progression of their disease and about their death and to express their wishes...listening to patients, providing them with information, and respecting their decisions and choices, are integral parts of good practice.”

Danny Kruger: The hon. Lady says that the GMC states that doctors have an obligation to raise the treatment options before them, and I think that she thinks that this is a treatment option. Surely the obligation is on doctors to raise assisted dying in all cases where it may be an option for the patient. Does the hon. Lady agree that doctors should offer assisted dying when that treatment may be appropriate for the patient?

Kim Leadbeater: I agree that, under the provisions of the Bill, the doctor will have a duty to lay out options available to the patient, if they meet the eligibility criteria—absolutely. That is the whole purpose of the Bill.

Danny Kruger: I am grateful to the hon. Lady for giving me a very clear answer. I just want to be totally clear that we understand each other. Is she saying that every doctor facing a terminally ill patient—someone who is eligible under the Bill—should make clear to them that they have the option of an assisted death?

Kim Leadbeater: Well, that is the purpose of clause 4: the doctor has to lay out the options available to the patient as long as all the criteria are met.

We can see from the guidance that currently exists that doctors take a very sensitive and patient-centred approach to end-of-life conversations. If the law were to change, that approach would continue with additional training specifically related to assisted dying, as has been discussed. It would also mean that the issues that doctors currently face around discussing assisted dying would be addressed.

As the BMA says, at the moment

“The law does not provide a clear definition of which actions might constitute assisting or encouraging suicide...What if a patient wishes to travel abroad for assisted dying? While the act of travelling abroad for assisted dying is not illegal, assisting, facilitating, or encouraging someone to do so is a criminal offence...doctors need to be aware of the possibility of legal and professional sanctions if they were to do so.”

I imagine that that must create a real sense of jeopardy for doctors. Similarly, the GMC recognises that doctors will face challenges in

“ensuring that patients do not feel abandoned”,

while ensuring that the advice or information that they provide does not encourage or assist a person to end their own life.

These are very difficult conversations for patients and doctors, but by legalising assisted dying in this country we can give clear guidance through a robust legal framework, and create the thorough, transparent process

that is currently lacking. These conversations provide a safeguard while the person is still alive. As the former director of public prosecutions, Sir Max Hill, told the Committee,

“In each of the 27 cases I considered, the deceased individual was already dead, and that is when the scrutiny started. The major advantage of the Bill, if I can put it that way, is that that will be reversed, and scrutiny will be before death.” —[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 86, Q111.]

Mark Swindells from the General Medical Council told us:

“We do get inquiries from doctors who are concerned that they are doing the right thing when it might become apparent to them that a patient wants to travel overseas to access assisted dying.” —[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 46, Q36.]

Bringing those conversations out into the open has to be better for the patient and the practitioner.

Lewis Atkinson (Sunderland Central) (Lab): With reference to amendment 8, and further to the intervention from the hon. Member for East Wiltshire, can my hon. Friend reflect on the provisions as set out in clause 4(1) and (2), which say that the issue relates to doctors’ professional judgment and that doctors are under no obligation to raise those issues in any situation?

Kim Leadbeater: Absolutely. This is about professional judgment, which is what the BMA is really clear about. Doctors have to be able to use their professional judgment. They are not under any obligation to raise the issue, but they are not under any obligation not to raise it. The BMA is really clear about that. I thank my hon. Friend for his intervention.

I welcome amendments 319 and 320 from my hon. Friend the Member for Bexleyheath and Crayford and I thank him once again for his positive engagement with the Bill. He raises a very valid point about the initial discussion. While the Bill is very clear that it applies only to terminally ill adults over the age of 18, in that someone would have to be over 18 to make the first declaration, it is not clear that the initial discussion could also not happen with someone under the age of 18.

We should not prohibit open conversations with terminally ill young people and their families, as they create openness, transparency and safeguards and provide much-needed support at what most of us can only imagine must be the most difficult time of anyone’s life. However, I think it should be made clear that the actual assisted dying process cannot be embarked upon unless someone is over the age of 18. I have taken advice about how best to incorporate that into the Bill from a drafting perspective. As a result, I have tabled amendment 418, which applies to clause 5, and states that regulations must provide that the first declaration contain, among other things,

“a declaration that they have had a preliminary discussion with a registered medical practitioner, that they were aged 18 or over when they had that discussion, and that they understand the information referred to in section 4(4)(a) to (c) that was provided during that discussion”.

As such, the aim of amendments 319 and 320 is achieved. I hope that that is to the satisfaction of my hon. Friend the Member for Bexleyheath and Crayford.

With regard to amendment 339, I have listened very carefully to the concerns of my hon. Friend the Member for Bexleyheath and Crayford, who tabled it, and the evidence from Mencap chief executive Dan Scorer, who suggested that for terminally ill people with learning disabilities

“that initial conversation has to be incredibly well supported and structured...the person should have accessible information in advance of that discussion so that they are fully informed about all their rights in terms of treatment options at end of life”. —[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 280.]

I absolutely agree with the intention of the amendment. I am seeking advice on the legal and technical implications, as I believe there is some tightening up that would need to be done around some of the phrasing, such as the concept of “sufficient time” or what would constitute a “supporter”. I therefore cannot support the amendment as it stands, but I am very happy to look at ways to take this forward and to meet my hon. Friend to discuss the amendment, which, quite rightly, gives special consideration to people with autism and learning disabilities. I know that my hon. Friend the Member for Penistone and Stocksbridge is also considering tabling amendments that would have a similar effect; perhaps we could all meet together.

I also reassure my hon. Friend the Member for Bexleyheath and Crayford that I am considering the involvement of people with learning disabilities, and groups representing them, in the development of guidance and training on assisted dying and end-of-life conversations. As Dan Scorer said,

“people with a learning disability should be involved in the development of that guidance” —[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 281.]

I absolutely agree.

Amendment 368, tabled by the right hon. Member for East Hampshire, has been discussed this morning. I sought advice about it as it was new to me. I believe that no statutory guidance has yet been published under the Down Syndrome Act, so we lack detail. That Act resulted from another private Member’s Bill; I am sure we can all agree what an excellent process this is for making important changes to the law. As the Minister said, the amendment is likely to be unworkable for doctors so I cannot support it. I would, however, be very happy to discuss the thoughts of the right hon. Member for East Hampshire and look at how we can meet his objectives—possibly through an addition to new clause 8, which is about the duty to consult and the Secretary of State consulting with the Equality and Human Rights Commission. At that point, the specific needs of not just people with disabilities but those with other protected characteristics will be represented. Alternatively, we could look at the codes of practice in clause 30.

I am happy to take those discussions forward and may even be able to speak to the right hon. Member for East Hampshire at the drop-in session he is doing this week with the National Down Syndrome Policy Group, ahead of Down’s Syndrome Awareness Week.

Kit Malthouse: As the hon. Lady will know, a number of our proceedings have been misinterpreted, shall we say, on social media. For complete clarity, with regard to the initial conversation, the Bill leaves to the discretion

of the doctor whether it is appropriate to raise the matter, given their knowledge of the patient. They have no obligation to raise it. If the patient themselves indicates a wish to raise the matter, then a doctor is under an obligation to lay out all the options available to that patient. We would not want to leave the outside world with the impression that, in all circumstances, the doctor is obliged to raise the option of assisted dying. It is only when they professionally think it is appropriate or if the patient raises it with them.

Kim Leadbeater: The right hon. Gentleman is absolutely right. As I have said, the BMA has been very clear that doctors should use their professional judgment. For example, if they had a patient whom they knew to be deeply religious and who had no interest whatsoever in an assisted death, it is highly unlikely that they would raise the possibility. It is up to them to use their professional judgment to accommodate the wishes of the patient. It has to be a patient-centred approach.

Danny Kruger: Will the hon. Lady give way?

Kim Leadbeater: I am done.

Sarah Green (Chesham and Amersham) (LD): We have had a good debate on the amendments in this group. I do not intend to push amendment 278 to a vote, and I have nothing further to add to my previous remarks. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 8, in clause 4, page 2, line 16, leave out from “practitioner” to end of line 20 and insert

“shall raise the subject of the provision of assistance in accordance with this Act with a person who has not indicated to that or another registered medical practitioner that they wish to seek assistance to end their own life”. —(*Daniel Francis.*)

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 17]

AYES

Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negated.

Amendment proposed: 124, in clause 4, page 2, line 16, leave out from “practitioner” to end of line 20 and insert

“shall discuss assisted dying with a person unless that matter is first raised by that person.” —(*Juliet Campbell.*)

The amendment prevents a registered medical practitioner from discussing the provision of assistance under the Act unless that matter is first raised by that person.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 18]

AYES

Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negated.

Amendment proposed: 319, in clause 4, page 2, line 20, after “person” insert

“who has attained the age of 18”.—(Daniel Francis.)

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 19]

AYES

Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negated.

10 am

Amendment proposed: 339, in clause 4, page 2, line 20, after “person,” insert

“, unless that person has a learning disability or is autistic, in which case—

- (a) the person must be provided with accessible information and given sufficient time to consider it; and
- (b) at least one of a—
 - (i) supporter, or
 - (ii) independent advocate;

must be present for the discussion.”—(Daniel Francis.)

This amendment would require that, if the person is autistic or has a learning disability, they must be given accessible information and sufficient time to consider it. Additionally there must be at least either a supporter or independent advocate.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 20]

AYES

Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negated.

Amendment proposed: 368, in clause 4, page 2, line 20, after “person” insert

“, unless that person has Down syndrome, in which case the registered medical practitioner must be acting in accordance with any statutory guidance issued by the Secretary of State under the Down Syndrome Act 2022 to meet the needs of adults with Down syndrome.”—(Danny Kruger.)

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 21]

AYES

Campbell, Juliet	Olney, Sarah
Francis, Daniel	Paul, Rebecca
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negated.

Amendment made: 182, in clause 4, page 2, line 21, after “person” insert “in England or Wales”.—(Kim Leadbeater.)

This amendment limits subsection (3) to cases where the person is in England or Wales.

Amendment proposed: 320, in clause 4, page 2, line 21, after “person” insert

“who has attained the age of 18”.—(Daniel Francis.)

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 22]

AYES

Campbell, Juliet	Paul, Rebecca
Francis, Daniel	
Joseph, Sojan	Shah, Naz
Kruger, Danny	
Olney, Sarah	Woodcock, Sean

NOES

Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	Tidball, Dr Marie
Malthouse, rh Kit	

Question accordingly negated.

Danny Kruger: I beg to move amendment 342, in clause 4, page 2, line 23, leave out

“may (but is not required to)”

and insert “must”.

This amendment would strengthen the requirement for a registered medical practitioner to conduct a preliminary discussion.

The Chair: With this it will be convenient to discuss the following:

Amendment 285, in clause 4, page 2, line 28, leave out paragraphs (a) to (c) and insert—

- “(a) the person’s diagnosis and prognosis, in consultation with a specialist in the relevant illness, disease or medical condition,
- (b) any treatment available and the likely effect of it, in consultation with a specialist in the provision of such treatment,
- (c) any palliative, hospice or other care, including symptom management and psychological support, in consultation with a specialist in palliative care.”

This amendment ensures that a specialist carries out the assessment of the patient, the treatment options available and the palliative care options available, since these may not be known to a doctor coordinating an assisted death.

Amendment 343, in clause 4, page 2, line 28, at end insert

“, including any relevant probabilities and uncertainties surrounding the person’s diagnosis and prognosis.”

This amendment would make clear that the doctor conducting an initial discussion is required to discuss the probabilities and uncertainties of any estimates of how long a person may have to live.

Amendment 344, in clause 4, page 2, line 29, at end insert

“, including the risks and benefits of such treatment, potential side effects, and the impact of the treatment on the person’s quality and length of life.”

This amendment would make clear that the doctor conducting an initial discussion is required to discuss the impact of any treatment available.

Amendment 275, in clause 4, page 2, line 30, leave out “any available” and insert “all appropriate”.

Amendment 108, in clause 4, page 2, line 31, at end insert

“and offer to refer them to a registered medical practitioner who specialises in such care for the purpose of further discussion.”

This amendment would require the doctor who has an initial discussion with a person about assisted dying to offer to refer them to a specialist in palliative, hospice or other care.

Amendment 183, in clause 4, page 2, line 31, at end insert—

“(and, accordingly, such a preliminary discussion may not be conducted in isolation from an explanation of, and discussion about, the matters mentioned in paragraphs (a) to (c)).”

This amendment emphasises that the initial discussion mentioned in subsection (3) may not be conducted without also explaining and discussing the matters mentioned in subsection (4).

Amendment 425, in clause 4, page 2, line 31, at end insert—

“(4A) Where a person indicates to a registered medical practitioner their wish to seek assistance to end their own life in accordance with this Act, they must be referred to a multidisciplinary team to explore options for relevant care and support.

(4B) The Secretary of State may by regulations specify the requirements for the multidisciplinary team under subsection (4A).

(4C) The regulations must include a requirement for the multidisciplinary team to include all of—

- (a) a registered medical practitioner or registered nurse,
- (b) a person registered as a social worker in a register maintained by Social Work England or Social Work Wales, and
- (c) a practising psychiatrist registered in one of the psychiatry specialisms.”

Amendment 53, in clause 7, page 4, line 8, at end insert—

“(ca) has relevant and available palliative care options.”

This amendment would mean that someone is only eligible for assistance in ending their own life under this Act if they have relevant and available palliative care options.

Amendment 54, in clause 7, page 4, line 17, leave out “(g)” and insert “(h)”.

This amendment is consequential on Amendment 53.

Amendment 426, in clause 7, page 4, line 26, at end insert—

“(4) The coordinating doctor may not take the steps set out in subsection (3) unless they receive confirmation from a multidisciplinary team that the person has had a meeting with that multidisciplinary team as specified in section 4.”

Amendment 286, in clause 9, page 5, line 36, leave out paragraphs (a) to (c) and insert—

- “(a) the person’s diagnosis and prognosis, in consultation with a specialist in the relevant illness, disease or medical condition,
- (b) any treatment available and the likely effect of it, in consultation with a specialist in the provision of such treatment,
- (c) any palliative, hospice or other care, including symptom management and psychological support, in consultation with a specialist in palliative care.”

This amendment ensures that a specialist carries out the assessment of the patient, the treatment options available and the palliative care options available, since these may not be known to a doctor coordinating an assisted death.

Amendment 424, in clause 40, page 23, line 37, at end insert—

“‘preliminary discussion’ means a discussion of a kind mentioned in section 4(3);”.

This is a drafting change.

Kit Malthouse: On a point of order, Mr Efford. I seek your guidance on the votes that we have just taken on the last group of amendments. If any Member, or any external person, were to attempt to misrepresent part of the debate on those amendments, what could we do? For example, in respect of amendment 368, tabled by my right hon. Friend the Member for East Hampshire, with regard to people with Down’s syndrome, somebody could imply or state on social media that the Committee has refused to look at accommodations for those people, therefore disregarding their welfare under the Bill. As you will be aware, that would be a serious misrepresentation of the debate and the intention of the Committee. If a Member of the House or somebody external did that, what measures could we take to correct it?

[Kit Malthouse]

The Chair: I suggest that you take the advice of the House on that, because what people say outside of the Committee is beyond my jurisdiction. The House has rules, and if those rules are breached, it is up to any hon. Member, including the Member himself, to raise that with the appropriate authorities.

Danny Kruger: On that ruling, Mr Efford, I concur that it is not your job to police social media but I respect the point made by my right hon. Friend the Member for North West Hampshire: it is important that we accurately reflect the debates held in this place. For my part, I will not be commenting externally that the House has disregarded people with Down's syndrome. I respect and appreciate the point made by the Minister and the hon. Member for Spen Valley that there will be an effort to engage with the Down's syndrome community in the drafting of further consultation and guidance. Nevertheless, the Committee did just choose to reject an amendment that would have required the Government to put into the Bill the protections specified by the Down's syndrome community and my right hon. Friend the Member for East Hampshire. I will be making that point, but I undertake to do so accurately and fairly.

I turn to amendment 342 and the other amendments in this group. There is a lot to discuss, and I will get through it as fast as I can. We are talking about the "initial discussion" and the "preliminary discussion". It might be helpful to clarify those terms, because clause 4 is confusing. The clause refers to an "initial discussion", which is when the doctor, or maybe the patient, raises the idea—it is unclear who will do that and how. The initial discussion does not actually need to take place at all, but if it does, then, according to the Bill, a preliminary discussion "may" be held, at which the topic is discussed in more detail and there is discussion of the requirements that need to be met, and so on.

I welcome amendment 342, which was tabled some time ago by the hon. Member for Shipley (Anna Dixon). It provides that if an initial discussion is held—that is to say, if the topic is raised as an option and the patient indicates their wish for an assisted death—then a preliminary discussion must also be held. Over the weekend the hon. Member for Spen Valley tabled amendment 419. That would amend clause 6, but I mention it here because it reaches back to clause 4 by stating that the co-ordinating doctor must either hold a preliminary discussion or see evidence that one has been held at an earlier stage.

I was alarmed that the Bill initially envisaged a situation in which someone could turn up to an assisted dying provider and pay their registration and administration fees, and the only thing the co-ordinating doctor would be required to do is check their photo ID. It is extraordinary that that was viewed as acceptable in the first place, so I welcome the tabling of amendment 419. My difficulty is that it leaves clause 4 quite vague and optional about whether a preliminary discussion would take place, and then it applies a retrospective compulsion at a later stage. It allows the preliminary discussion to be not very preliminary at all, because it might take place quite some time later, at the point the co-ordinating doctor is witnessing the first declaration. It could be weeks or months after the process has started, once the patient has found a doctor willing to do the assessment and the

paperwork for assisted dying. Rather than tacking the provision on to clause 6, which deals with proof of identity for the witnessing of the declaration later on, let us have it where it is needed—let us insist on it here at the outset of the process.

What should the preliminary discussion consist of? I will speak now to amendment 183 in the name of the hon. Member for Spen Valley, and amendments 343 and 344 in the name of the hon. Member for Shipley. In her explanatory statement to amendment 183, the hon. Member for Spen Valley suggests that it "emphasises" that the preliminary discussion must include a discussion of palliative care options. That is, I am afraid to say, repetitive of the sentence at the start of clause 4(4), which says that the practitioner conducting a preliminary discussion must discuss all the options listed. In the words of my right hon. Friend the Member for North West Hampshire, this is embroidery of the Bill—it is fine lacework, unrelated to the job of the clause itself. The statement in the clause that the doctor must discuss palliative care is, of course, already the law under the Montgomery judgment. There is a genuine obligation on the doctor to discuss all the options that the patient has, which will obviously include palliative care.

I welcome the amendments tabled by the hon. Member for Shipley, which would require the doctor to be clear about the uncertainties of the prognosis and the risks and benefits of the various treatment options. That is absolutely right. That is not embroidery. As a result, patients will make better-informed decisions with full awareness of what is known and, crucially, what is unknown about their prognosis. A requirement in the Bill leaves no room for doubt.

I am concerned by the suggestion that has been repeatedly made that adding obligations for doctors to do their job as guidance currently states is somehow unnecessary or harmful. Indeed, the selective approach of referencing only some elements of GMC guidance in the Bill increases legal uncertainty. Clauses 7 and 9 include only some elements of GMC guidance on the information that doctors must give to patients. There are five areas that the GMC says information should usually include, but the Bill omits

"uncertainties about the diagnosis or prognosis, including options for further investigation"

and

"the potential benefits, risks of harm, uncertainties"

and so on. The guidance explains:

"By 'harm' we mean any potential negative outcome, including a side effect".

Those are quotes from the GMC guidance that are not reflected in the Bill at the moment. Some parts are, but some are not. I think the fact that some guidance has been excluded would be treated as legally significant by the courts. I would be interested to know why the hon. Member for Spen Valley takes the position that those aspects of the guidance should be excluded, and whether she feels that uncertainties and risks of harm are not relevant to the discussion that doctors should have.

We are often told that this Bill is the safest in the world. Other jurisdictions that have inspired the Bill specify in more detail what informed consent should consist of. In Oregon, the doctor must cover the potential risks, the probable result of taking the medication and the feasible alternatives. In Victoria, the doctor is required

to discuss the potential risks—in fact there is a whole series of obligations on them. Interestingly, they are encouraged to inform the registered medical practitioner, so to tell the patient's doctor what is happening, if they do not know already. South Australia specifies all the same things. In his amendment 50, my hon. Friend the Member for Runnymede and Weybridge (Dr Spencer) is trying to mirror precisely that. That is exactly what should be in the Bill, and yet we are told that it is the safest legislation in the world.

Other amendments in this group address who should do the preliminary discussion or referral, and who else should be involved. Amendment 108 in the name of the hon. Member for East Thanet (Ms Billington), which would require the doctor to offer a referral to a palliative care specialist, is very helpful. It is significant that the Committee has already voted not to mandate referral to a palliative care practitioner at the early stage—that fork in the road that we debated earlier—so people will be facilitated down one fork in the road only. This is an opportunity to ensure that there is in fact a referral to a palliative care specialist.

10.15 am

Kim Leadbeater: I just want to let the hon. Gentleman and the Committee know that I met my hon. Friend the Member for East Thanet last night, and I am delighted to support her amendment 108.

Danny Kruger: I am very pleased to hear that. That is very encouraging news, because I have been concerned that the hon. Lady was resting her case on amendments to clause 12, which would not require a palliative care specialist. I am grateful to her for intervening to inform us of that.

Nevertheless, we need to go further. The amendments in the name of the hon. Member for York Central (Rachael Maskell) would require that a specialist, rather than just a GP, leads the initial assessment. The fact is that despite their enormous range of expertise, general practitioners are not qualified or confident in making prognoses of terminal illness. The written evidence from the Association for Palliative Medicine of Great Britain and Ireland cited a 2021 paper showing that over half of GPs were not consistent in how they applied their predictions to different patients. It is important that specialists in the relevant conditions should be involved in these assessments so that patients receive expert input with a lower risk of error.

It is significant that, during the Second Reading debate on 29 November, the House was unanimous in its appreciation of, and praise for, palliative care specialists. It seems strange that their expertise should not be considered essential to a terminally ill person's consideration for an assisted death. When we look at other countries, we see that it is not an exceptional safeguard. South Australia's Voluntary Assisted Dying Act 2021 specifies:

“Either the coordinating medical practitioner or each consulting medical practitioner must have relevant expertise and experience in the disease, illness or medical condition”—

we are not using that any more—

“expected to cause the death of the person being assessed.”

I urge the Committee to reflect on the South Australia model, which is good in this regard.

I turn to amendment 53, in the name of my hon. Friend the Member for Runnymede and Weybridge, and amendment 275, in the name of the hon. Member for Sunderland Central. The Bill currently requires doctors to discuss “available” palliative care options, but that may limit what patients are told. Amendment 275 would provide that patients should be informed of “all appropriate” palliative care alternatives, even if they are not readily available in their local area. We do not want patients choosing assisted dying simply because of unequal geographic provision of palliative care making them unaware of alternatives that could improve their quality of life.

I would go even further in support of amendment 53, which hits the nail on the head. Fundamentally, we have always said that assisted dying should be available only to people who palliative care cannot help. That is what amendment 53 entails: it states that assisted dying should be available only for people for whom the relevant palliative care is actually an option and, if they decline it, that would be their choice.

Finally, I will speak to amendments 425 and 426 in my name, which express the need for a proper multidisciplinary team at the right stage of the assisted dying process. The hon. Member for Spen Valley has emphasised the importance of multidisciplinary teams, and I welcome everything she said. It is very good to get her agreement, through the amendments that she has tabled, that two doctors working alone are not enough to protect and support every patient. I welcome that recognition.

Amendments to clause 12 attempt to fill this gap by introducing the expertise of a psychiatrist and a social worker, but they do not fulfil the role of a multidisciplinary panel. Rachel Clarke, one of the witnesses who told us to consider multidisciplinary assessments, has written subsequent to the amendments being tabled: “A ‘judge plus’ panel”—there will not actually be a judge, so perhaps we should call it a “lawyer plus” panel—

“is not an MDT...the panel's scrutiny comes only at the end of the process, not at the beginning, when a patient first asks for the intervention of assisted dying. Yet this is a moment of peak vulnerability.”

We will get on to the question of whether a judicial panel should replace a High Court judge, but I emphasise very strongly that the introduction of this process is not the equivalent of having a proper multidisciplinary team considering the application for an assisted death at the appropriate moment.

As the Association for Palliative Medicine said last week, the Bill

“does not align with the standard multi-professional team...decision-making process used across the health service.”

It said that the panel is too distant from the patient and comes too late in the process. It said that the Bill would be stronger if the initial assessments were

“carried within a multi-professional team model”.

It is at the stage we are debating here—in the initial assessments—that the MDT needs to apply. For the record, if it has not been properly noted before, I also state that when the hon. Member for Spen Valley quoted Dr Sarah Cox on the importance of multidisciplinary teams, Dr Cox was not endorsing clause 12, but explicitly arguing for earlier introduction of the multidisciplinary process.

Kim Leadbeater: To be clear on the multidisciplinary approach, the point that I was making in that contribution was that that happens already. We are misrepresenting what goes on in current practice with terminally ill patients if we say that there is not a multidisciplinary approach, as indeed various witnesses told us. It is important to acknowledge that.

Danny Kruger: The hon. Lady is absolutely right that that is what witnesses told us, but we need to ensure that it happens in all cases; the purpose of these amendments is to ensure that good practice is universal. In the case of assisted dying, bad practice would be terrible. Of course, good doctors seek the guidance of others and do not operate in isolation, but the Bill would allow them to do so. It is important to ensure that the system lives up to the good practice that she refers to.

Committee members will be glad to hear that I am not going to rehearse the arguments about capacity and coercion, but those concerns are why it is important to have a multidisciplinary team at an early stage. The Committee has rejected all attempts to strengthen the capacity test, but it could at least allow a psychiatrist to have an earlier role in the process of checking for capacity. We heard from multiple witnesses about the importance of doing that, and that is what National Institute for Health and Care Excellence guidance states. As the hon. Lady said, it is good practice, so as Professor House said in his evidence to us, it would not be “a terribly radical thing” to do it.

On coercion, as the social worker Jess Carrington wrote to us:

“The only people who are comprehensively trained to recognise signs of abuse, in particular, coercive control, are social workers.” According to research by Dr David Ross, doctors suspect less than 5% of cases of elder abuse. I will not rehearse the arguments around coercion, but I hope that the Committee will note that the only way—or the best way; it will not be foolproof—to ensure that coercion is spotted is by having a social worker at the very beginning of the process.

I think that is enough from me, Mr Efford—I am sure you agree.

Sean Woodcock (Banbury) (Lab): I rise to speak to amendments 108, 343 and 344. I am delighted that the promoter of the Bill, my hon. Friend the Member for Spen Valley, has said that she accepts amendment 108, which was tabled by my hon. Friend the Member for East Thanet. It would require a doctor who was having an initial conversation with a person about assisted dying to “offer” to refer them to a palliative medical specialist. That would give the patient a chance to discuss end of life matters in depth with somebody who has the necessary expertise.

We have spent much time in previous sittings on palliative care options, and there was some understandable concern about removing autonomy from those looking for assisted dying. I hope that amendment 108 strips away that concern, because it is about offering, not mandating, more information. When we are talking about autonomy, I think that all Committee members would agree that anybody making an autonomous choice could only benefit from more information, rather than suffer as a result of it.

The Bill says that when a doctor has an initial conversation with a person about assisted dying, they should explain and discuss

“any available palliative, hospice or other care, including symptom management and psychological support.”

The amendment aims to ensure that the patient has access to the best available information to make a decision about what they do next. It would act as a safeguard to prevent people from choosing assisted dying because they did not have a chance to have a thorough and accurate discussion about the care options available to them.

As I said, several people were concerned about autonomy, and providing people with the opportunity to meet a specialist. The written evidence from Hospice UK explains that there are currently wide misunderstandings about hospice care at societal level. It says:

“Implementation of assisted dying without care given to public awareness about palliative care is likely to worsen individuals’ ability to make decisions regarding their end of life. People will need access to information about the services and support available to them.”

That reminds the Committee that terminally ill people at the end of their life often may not know the options available to them. I am sure that every Member in the room wants to avoid that situation, and the option of a discussion with a specialist aims to ease some of that fear and provide accurate information.

In order to make palliative and hospice care a genuine choice, it is important that patients with concerns are able to speak to someone who can answer all their questions and offer accurate information. Marie Curie’s written evidence says:

“There must be clear recognition within the Terminally Ill Adults (End of Life) Bill that genuine choice at the end of life cannot exist unless dying people are able to choose to receive high quality palliative and end of life care”.

Unfortunately, we know that the state of palliative care in this country is not yet of evenly accessible quality. The amendment would not solve that problem—there is quite a lot of work to do in that regard—but it would at least improve the Bill. It would give every patient the option of a discussion about palliative medicine and would make some ground on access. We all want to ensure that those with terminal illnesses are given good support and confidence in their decision at the end of their lives. Amendment 108 would do that, and would give people the opportunity of a real, informed choice, which is why I am delighted that the Bill’s promoter, my hon. Friend the Member for Spen Valley, has agreed to it.

My hon. Friend the Member for Shipley, who tabled amendments 343 and 344, has a distinguished record in policymaking in health and social care. She served as chief analyst and director of quality and strategy at the Department of Health. Both amendments are very thoughtful, and we would do well to adopt them. It would be helpful to explain what they would do before I set out why I think that hon. Members should vote for them. Amendment 343 would change clause 4(4), on page 2, which reads:

“If a registered medical practitioner conducts such a preliminary discussion with a person, the practitioner must explain to and discuss with that person—

(a) the person’s diagnosis and prognosis”.

If the amendment were made, subsection (4)(a), on line 28, would go on to read

“, including any relevant probabilities and uncertainties surrounding the person’s diagnosis and prognosis.”

Amendment 344 would change paragraph (b) on the next line, which says that the doctor must discuss with the patient

“any treatment available and the likely effect of it”.

If the amendment were made, paragraph (b) would go on to read

“, including the risks and benefits of such treatment, potential side effects, and the impact of the treatment on the person’s quality and length of life.”

Like amendment 108, amendments 343 and 344 are both intended to improve the quality of information that patients receive when they have their initial discussion about assisted dying. The first amendment addresses what many of the expert witnesses have identified as a key problem with the Bill. Clause 2 requires a doctor to have prognosed that

“the person’s death...can reasonably be expected within 6 months.”

I will not go over the various arguments that we have already had in Committee about that, but many of the very senior doctors who gave evidence to the Committee have said that it is extremely hard for medical professionals to give a prognosis with such assurance.

The Marie Curie palliative care research department at University College London also submitted written evidence, numbered TIAB 39. Those experts said:

“The Bill’s requirement for a prognosis of death within 6 months could lead to significant errors, where individuals either receive assisted dying prematurely or are denied it when desired. The variability in prognostic accuracy, especially for non-cancer illnesses, may exacerbate inequities in patient care.”

They went on to say:

“We also question how the term “reasonably” will be interpreted by doctors, and this is likely to vary between doctors, but also by the same doctor with different patients”.

The Marie Curie palliative care research department also said that predicting someone’s death “too soon” can result in early palliative care, and that such early care is

“not a harm in the same sense as might be implied in the context of assisted dying.”

10.30 am

To take another example, Professor Katherine Sleeman, a very distinguished palliative care expert, said in her written evidence:

“Of note, estimating prognosis is extremely difficult to do accurately. A systematic review that synthesised data from 26 separate studies (including 25,718 estimations of survival) found doctors correctly identified people as having less than 6 or 12 months to live in fewer than half of cases.”

I underline what Professor Sleeman said: a thorough analysis of existing studies found that less than half of six-month prognoses were correct. Dr Sarah Cox, president of the Association for Palliative Medicine, also came before the Committee as an expert witness. She said,

“we also acknowledge that prognosis is incredibly difficult to assess accurately...The thing that I am really concerned about is how it is possible for these doctors, even with training, to have a good understanding of all illnesses in order that they can identify prognosis—neurological, cancer and every other.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 73-74, Q90.]

We have distinguished doctors telling us that there are significant uncertainties with prognosis, and I hope every member of the Committee agrees that patients considering assisted dying need the fullest information possible around the choice that they may make.

Let us think about the impact on people seeking assisted dying. I ask Members to put themselves in the position of a person who has been given a prognosis by their doctor of reasonably expecting to die within six months. That would be shattering news for anybody. We have heard evidence from the Royal College of Psychiatrists that patients who hear such prognoses often experience depression and, in some cases, a wish to hasten death—that is only understandable. Amendment 343 would ensure that the doctor giving that prognosis would also talk through the uncertainties of the six-month figure.

We know from the doctors who have spoken to us that such uncertainties exist—they have told us that the prognosis of a fatal illness is not an exact science—but the patients asking about assisted dying will not have had the benefit of written and oral evidence from some of the country’s leading doctors, as we have. They will hear that they can reasonably expect to have six months to live—perhaps less. That should not be all that these patients hear; they also deserve to hear from doctors how they made their prognosis. They deserve to hear what might be wrong with the prognosis and how likely it is that they may have longer to live—perhaps considerably longer than the six months that they have just been told. Members may object and say that it would be best practice for doctors to give patients that information anyway when giving a prognosis. I agree, but where is the harm in simply requiring doctors to follow something that we all agree is best practice?

I hope Members will not attempt to argue that the amendment would add complexity to the Bill. If we amend the Bill so that doctors are under a legal obligation to do something that we all agree they should be doing anyway, how is that adding complexity to their work? I also hope that Members will not say that this measure is cynical about doctors. We are very lucky in this country that we are served by skilled, dedicated and caring doctors. There are members of the Committee who have demonstrated their level of experience with very important contributions to our debates. We are also lucky to have dedicated public servants in many fields, including police officers, firefighters, nurses and members of the armed forces, but we can all think of occasions in which policemen, soldiers or nurses have got things wrong. That is not because they are bad people but because all humans make mistakes sometimes, especially politicians. Similarly, some doctors will occasionally get things wrong in initial discussions with patients about assisted dying. We reduce the chance of that happening if we write a strong safeguard into the Bill on the content of the initial discussions. This is not cynicism; it is us taking our responsibility as lawmakers seriously.

Amendment 344 would mean that the doctor having the initial discussion would have to talk about the risks and benefits of such treatment, potential side effects and the impact of treatment on the person’s quality and length of life. It is purely straightforward and again sets out what I think we can all agree is best practice for doctors when having the initial discussions. Patients considering assisted dying are on the edge of taking an enormous step. They may be right that they are facing pain that cannot be relieved or helplessness that cannot be removed, but they may also be wrong. This is not hypothetical; we know that there are patients who have been given a prognosis of six months to live, but have

gone on to live for years with a decent quality of life. We know, too, that people with a prognosis of pain and helplessness have gone on to have medical treatment that has given them a good quality of life.

Patients who are considering assisted dying have had terrible news. They have been told that they may well die within six months. They will be grieving, uncertain and very scared. These people deserve to know the full picture when they have their initial discussions, and these intelligent and constructive amendments would help to ensure that they had the full picture. I ask all members of the Committee to support them.

Dr Simon Opher (Stroud) (Lab): I will briefly go through my impressions of the amendments. A lot of amendments in this group call to mind one of the difficulties that we are having in Committee, which is about the role of professional integrity against what we should be putting down in law. One problem is that, if we state something in law and a professional does not do it, then they are acting in an illegal way—and that introduces a different concept into a medical consultation. We must be very careful about introducing to a medical consultation a load of requirements in law, therefore reducing the freedom of that consultation whereby the doctor and patient can decide on what is best for the patient.

Amendment 342 is in the name of my hon. Friend the Member for Shipley. I reiterate that all the amendments have been tabled in good faith, and I absolutely respect them. The amendment would mean that the initial doctor—who is likely to be a GP—to whom the person comes and wants to speak to about assisted dying “must” conduct a preliminary discussion, rather than “may (but is not required to)”.

The problem there is that some doctors will be conscientious objectors to assisted dying and we have to protect their integrity. We must not force them to do something that is against their will.

I note that amendment 341, which we will come to later, is about the obligation to give information to the patient if they ask for assisted dying. That is an appropriate amendment, but forcing a doctor who does not agree with assisted dying to discuss it is not fair on the medical practitioner. That is not what the Bill is about. In many other places, there is freedom for the medical doctor to avoid getting involved in discussions if they do not wish to. That is an incredibly important part of, and concept in, this Bill. Without that, I think the medical profession would not accept the Bill. That is very important.

Amendment 285 is about needing to consult a specialist in the relevant illness. I think we need to understand the process of what will happen under the Bill. Let us take an example of a patient under an oncologist—a cancer specialist. The oncologist will almost certainly say at some point during the consultation with the patient, “I think that there is no further treatment that is going to prolong your life, and you are likely to have six months or less to live.” That will be done by a specialist. I do not know general practitioners who would confidently predict a prognosis of six months or less; it would come from a specialist. Indeed, cancer care in this country, until the palliative phase, is generally run by specialists and hospitals. GPs are not generally involved, apart from to support the patient. However, if the oncologist feels that the patient has less than six months to live, they would

probably come to see the doctor under this legislation, and the initial discussion will then take place. They will already have a steer as to the likely prognosis.

Naz Shah (Bradford West) (Lab): I am trying to understand. My hon. Friend is saying that the oncologist is a specialist, but that they might not be the first doctor to have the first discussion; he said that they might not want to be a part of this process. I would like to understand that a bit more.

Dr Opher: As far as I see, under the Bill there is an initial discussion when a patient who is requesting assisted dying goes to see a medical practitioner. It does not specify what type of practitioner, which is good because it means they can ask either the oncologist or the general practitioner. That initial discussion is with a doctor, and then the doctor will refer for the first declaration, or they may do the first declaration themselves. That is how the Bill is set out, but the general practitioner will have had specialist opinions on the patient. They would not just say, “Well, maybe you’ve got less than six months to live—I don’t really know, but let’s have a guess.” This will be based on informed information from a specialist.

Danny Kruger: I do not want to labour the point, but does the hon. Member not acknowledge the Bill does not require that at the moment? He is saying that it will happen. Why will it happen—just because the doctors do their job well? Does he recognise there is no obligation to have this wide consultation with other specialists under the Bill? The doctor could do just as he has described and take a decision on their own.

Dr Opher: Again, this is a really interesting part of the Bill. If a doctor is routinely giving prognoses of six months where that is not appropriate, they will come up against the General Medical Council for being poor doctors, and the regulation around poor doctors is within the medical profession. If it is proven that someone has given a diagnosis that they cannot back up in any way, they would then be subject to their own professional standards. That is one of the things here: we cannot go through this Bill and specify the medical requirements at every stage, because that comes under a different format, which is called the General Medical Council. If someone has given a prognosis of six months or less, and if that is clearly inaccurate and would be contested by other doctors, they would be brought before the General Medical Council.

Lewis Atkinson: Does my hon. Friend agree that the provision of a further independent doctor assessment—both one and two—in addition to the doctor conducting the initial discussion, would provide a further safeguard for a diagnosis, if terminality could not be supported by other professionals?

Dr Opher: I absolutely agree. We are imagining that the doctors will all be independent and will not know anything about what other doctors have said, but there will be communication and access to medical records, and they will also tell the original doctor what their opinion is, and so on.

If we accept these amendments, we risk over-embroidering the Bill, which will make it almost impossible for doctors to say anything in a consultation. We must

leave that free, because that is a central tenet of medical care, and if we put laws around it, there will be legal process over the medical consultation, and doctors will be frozen with fear about breaking the law. They are regulated by the GMC, and we are all terrified of referrals to the General Medical Council for that very reason: because we are trying to operate at the best standard that we can. I truly understand the amendments, but I do not think they will make the Bill any safer, and that is what we are all here for.

Jake Richards (Rother Valley) (Lab): I am very sympathetic to the amendment and have thought long and hard about it. Can my hon. Friend explain to me, from his experience, but also from looking at the Bill and speaking to others, the effect of clause 4(4)(b)? As a non-clinician layperson, it appears to me that if a medical practitioner is discussing the likely effect of any treatment, then by its very nature that would lead to a discussion about prognosis, and the uncertainty and certainty around that.

Dr Opher: What my hon. Friend points out is absolutely true. The Bill's drafting is simple but very effective. For prognosis, for example, it says that it is "reasonably...expected within 6 months."

As we have discussed many times in this Committee, prognosis is not exact; it is an estimate. It suggests that the patient has a terminal illness—that is to say, the illness will lead to their death. All we are arguing about is exactly when that will happen. It is reasonable to say, as doctors already do, "It is likely that you have six months to live." That is not exact—as doctors, we cannot predict the future, even if people think we can. I totally accept that. However, we can make estimates as to what is likely to happen.

As my hon. Friend just mentioned, there are lots of really good news stories of people living longer than their prognosis. However, for the Bill to be effective, and to give relief to people who genuinely need it, we have to have a prognosis, based on medical evidence, of six months.

10.45 am

On the part of the amendment about the treatment available and the likely effect of it, those are the discussions we have. We sometimes say to people, "Well, you can go for further chemotherapy. It will often make you sick and you might lose your hair"—we give all the disadvantages—"but it might give you another couple of months of life." Those are the general discussions we have as medical practitioners.

Naz Shah: From what I hear, my hon. Friend is supportive of the amendment. Does he agree that it just sets out what he says is best practice? I am trying to understand the objection to setting out good practice on the face of the Bill.

Dr Opher: Again, I bring my hon. Friend back to the fact that this is a Bill in law, and what we have to guide us as doctors is the General Medical Council, which sets standards for doctors. That is how we do it. If we are hemmed in by legal matters, we can break the law without being aware of it, if we are not careful. If too many legal parameters are set around medical consultations,

the patient will get less good care because the doctor will not be free to offer it. I can see that my hon. Friend does not agree with that, but it is the case.

Danny Kruger: The hon. Gentleman is praying in aid the General Medical Council as if it is some sort of effective backstop. He says that the guidance does not need to be in the Bill because it is there hovering over doctors anyway, but the Bill makes explicit reference to GMC guidance—some of it is in there. If he objects to our suggestion to include the full GMC guidance in the communication that should be had, why does he support the presence of some of the guidance that doctors should give? The Bill does not include what the GMC requires: uncertainties about diagnosis or prognosis. Why not include the full GMC guidance in the Bill, seeing as we are including some of it already?

Dr Opher: I just do not think it will strengthen the Bill. I thank you for your intervention. It is a moot point.

The Chair: Order. I did not intervene.

Dr Opher: Sorry, Mr Efford. I do not deny that the hon. Member makes a good point, but if we embroider this too much, the Bill will not be safe. That has been the case throughout. Any good medical care is based on giving treatment, availability and the likely effects of that, and on giving prognosis and the chance of the prognosis being longer or shorter. That is all based in good clinical care.

On amendment 343, the uncertainties of estimates of how long a person has to live are covered in clause 2(1)(b): "the person's death in consequence of that illness, disease or medical condition can reasonably be expected within 6 months." "Reasonably" is part of the Bill. It suggests that one cannot say that the estimate is exact. The Bill does not say that it is exact; it says that it is a reasonable estimate of that person's life. I think that takes care of that amendment.

In amendment 344,

"the risks and benefits of such treatment, potential side effects, and the impact of the treatment"

are covered by

"any treatment available and the likely effect of it"

in clause 4(4)(b). My general point is that none of the amendments are actually wrong; they are just unnecessary. I would like to leave it at that.

Lewis Atkinson: I will be brief, as I am conscious that the Committee needs to make progress. I will speak briefly to amendment 275 in my name, which, as others have said, amends the current reference of "any available" to "all appropriate". Listen—people at the end of their life deserve the best. They deserve to know about and have the option to access all appropriate care. In my experience of the NHS, that is exactly what clinical teams ensure patients get. But we need to guard against any suggestion that the information given should be somehow filtered around availability, which I know is not the intention of my hon. Friend the Member for Spen Valley.

In my experience, views on availability are often incorrect anyway, so ensuring that "all appropriate" options are offered in information is the best thing to

[*Lewis Atkinson*]

do. If nothing else, it creates a level of societal pressure to ensure that all appropriate care is available, which I hope we can all support.

Naz Shah: Will my hon. Friend give way?

Lewis Atkinson: No, I am going to make some progress because I am conscious of the time, and we want to get through these provisions.

I want to speak in favour of amendments 108 and 183. Those two amendments, taken together with amendment 275, create additional safeguards and assurances on the points made by colleagues on Second Reading that this is not cannot be raised in isolation—as my hon. Friend the Member for Spen Valley has made clear should not be the case—and that referral should always be offered to specialists in palliative and wider care.

As others have said, those patients will almost undoubtedly be in touch with a variety of different multidisciplinary healthcare teams. The suggestion that there must be a further referral to another multidisciplinary team under the Bill, regardless of which teams an individual is seeing, is therefore not appropriate. I also refer Members to amendment 6 to clause 9, which states that a referral to a psychiatrist “must” be made. My hon. Friend the Member for Spen Valley has indicated that she is in favour of that amendment. That reinforces the fact that there will be a multidisciplinary approach, including psychiatric input, where there is any doubt before the third-tier stage of the panel.

For those reasons, I do not feel the other amendments—285, 343 and so on—are necessary. By accepting amendments 275, 108 and 183, we will be able to strengthen the Bill in the way that was set out to the House, and as we heard in oral and written evidence.

Sojan Joseph (Ashford) (Lab): I rise in support of the amendments, especially amendments 342 and 425. We have discussed various aspects of the Bill, especially capacity, coercion and medical practices, under many previous amendments. As somebody who worked as a mental health nurse for many years, and who worked as part of a multidisciplinary team, I think that amendments 342 and 425 are some of the most important.

Amendment 342 talks about the preliminary conversation with the medical practitioner with whom the patient makes contact. Do we not think that the doctor who knows most about that patient is the best person to have that preliminary discussion? They will have the most information about them. When the patient, who has gone through so much difficulty, goes to their doctor or to a GP who knows them well and says, “I would like to choose the assisted dying pathway,” would that doctor then say, “I do not want to discuss this. Somebody else will.”?

Kim Leadbeater: Is my hon. Friend not concerned about the concept of conscientious objection? The BMA strongly opposes amendment 342, because it does not think doctors should be obligated to have that initial conversation if they do not want to.

Sojan Joseph: There are other people who support this concept, and they are the people who will be having the conversation—we have both sides of the argument.

I believe that the best person to have that preliminary discussion would be the doctor who knows about that patient the most—about their circumstances, prognosis, family situation and pain. We talk about compassionate care, but where is the compassion in here? I am not saying that another doctor would deny that—but I am talking about compassion. Someone going through the most difficult time in their life would have the confidence to talk to the person who knows the most about them, which is why I fully support that the initial discussion should happen with them. I am not saying that they should say yes or no, but they should be talking about the care provisions and options available to the patient. Amendment 342 is one of the most important amendments we will debate.

I will move on to amendment 425. When I tabled amendment 1, my thinking was that a psychiatrist should be involved in these discussions, but I think amendment 425 will safeguard most of the concerns we have discussed in previous sittings. Amendment 425 talks about a “multidisciplinary team” and having a psychiatrist involved as well. Written evidence was sent to us on 29 January by the Royal College of General Practitioners, which recommended that a separate pathway that

“covered every stage of the process would ensure healthcare professionals of multiple disciplines...who wanted to do so could still opt in to provide assisted dying, but this would be arranged through a different pathway.”

The hon. Member for Sunderland Central spoke earlier about how patients may be going through many multidisciplinary teams already, but it could be that none of those multidisciplinary teams have talked with them about assisted dying. They could have been pharmacists or nurses talking about the patient’s care—not assisted dying. We are talking about setting up a multidisciplinary team with a mental health nurse, doctor and social worker who can look in detail at evidence of the patient’s capacity, whether they are choosing it because they feel they are a burden, and whether there is any coercion. I think that is a safeguard for most of the concerns we have discussed in previous sessions. I would love to see a psychiatrist involved, because psychiatrists deal with some of the most challenging patients, including those with suicidal thoughts, on a day-to-day basis. They are the most experienced people to carry out a capacity assessment and, if they are a part of the multidisciplinary team, it will safeguard the Bill.

I strongly support amendment 425 and I urge Members to consider it. It will reassure many people who are concerned about some of the discussions. I know it also talks about giving power to the Secretary of State to formalise who should be part of the multidisciplinary team, which would be a discussion for later. I thank the Committee for giving me the opportunity to speak in support of the amendment.

Naz Shah: I rise to speak to amendments 285 and 286, tabled by my hon. Friend the Member for York Central. On amendment 285, we have to understand that, in medicine, clinicians only retain the areas of expertise in which they have clear confidence. I am grateful to my hon. Friend the Member for Stroud, who made very powerful points that, if anything, actually support this amendment. This is why we have developed a health system with so many specialities. Although generalists have incredible knowledge, they cannot confess to the depth of understanding that someone who dedicates

their career to a speciality has. Therefore, the amendment seeks to draw on such knowledge rather than assume that a GP, for example, specialises in all fields of medicine.

Clause 4(4) would require a generalist to work alongside a specialist to secure the understanding of a patient's diagnosis and prognosis. Once again, I recognise that my hon. Friend the Member for Stroud suggested that that already happens and does not need to be tied up in law. However, I feel the amendment gives us more protections if we are to make the Bill safe. It would then enable specialist clinical advice to be provided in the conversation about treatment options.

11 am

The possible pathways a disease may take, and possible interventions and clinical trials available for the patient to access, secure the position with the patient's diagnosis. Without such knowledge and intervention, a general practitioner may depend on their own scope, competencies and knowledge, which may be out of date in this specialty; they may lack understanding of current practice, which may result in the unnecessary option of an assisted death when other interventions could have been possible. Therefore, this subsection makes the decision-making process more secure.

Subsection (4)(b) follows that by ensuring the doctor understands all available treatment options and gives an opportunity to explore them with a consultant and understand the details of their impact. In medicine, decisions are ordinarily co-produced, as we heard many times in evidence sessions. A multidisciplinary team is normally involved in decision making, case conferences are held concerning patients, and even specialists at times need to contact centres of excellence and colleagues in the same discipline practising elsewhere to discuss the patient and their treatment options. Therefore, the subsection places the Bill in the normal realms of medical practice and enables clinicians to determine the right response, and to evidence how they reached their conclusions.

That takes me back to what my hon. Friend the Member for Stroud suggested: that that is what normally happens. When somebody has a severe diagnosis, my understanding from familial experience is that there are usually case conferences. It might be a rare cancer, for example, and they might want to speak to a specialist who will not be the actual person who made the diagnosis, but who will have had the case referred on to them. That specialist might be the one who needs to have the conversation about what treatments there are, because treatment advances are quite good. In this country, our researchers, medics and NHS are really good at looking at new treatment options.

That is not to say that a GP does not have the skillset to have that conversation with a patient—not at all. I do not feel that that would, in any shape or form, undermine the relationship with the GP, who is the first doctor. What I feel that this amendment speaks to and what my hon. Friend the Member for York Central is trying to achieve is the strengthening of that process and ensuring that it is written on the face of the Bill. As pointed out earlier by the hon. Member for East Wiltshire, in this Bill we refer to the GMC in some instances but not in others, so there is also concern about having that consistent approach and not cherry-picking when it suits us, either moving towards assisted dying or away

from exploring palliative care options, which could then lead to somebody not seeking assisted dying. That is really important.

We have to remember that, with the science of medicine, decision making must be evidence-based. It is a daily practice of clinicians to go through that process, which the Bill fails to recognise throughout. Clause 4(4)(c) goes to the crux of the failings of this legislation. The Bill makes an assumption of a single pathway towards an assisted death. That moves against the whole practice of medicine, which is to sustain life and first do no harm. That is why the vast majority of those who work in end-of-life care oppose this legislation, because they know that it comes from the experience of poor care.

As the Labour party, we have spent 14 years highlighting the failings in the NHS and social care. We know better than anyone that patients are not getting the care they need and are having poor experiences. We hear about the scandals of poor care almost daily. In saying that, I know that most clinicians are working against the tide to ensure patients are getting good care; the systemic failures, which my right hon. Friend the Health Secretary is trying to fix, stem from the neglect of the NHS, the political mismanagement and a system placed under duress.

That is why the proposed amendment to clause 4(4)(c) is so important. People are not getting the palliative care that it is possible to deliver. We know that 100,000 people who need palliative care are not receiving any when they are dying.

I support amendment 275, which stands in the name of my hon. Friend the Member for Sunderland Central, but what I gently point out—I did try to intervene—is that although his amendment says “all appropriate”, the truth is that not everybody has appropriate palliative care. I have said it before in this Committee: there is a postcode lottery. Somebody in my constituency of Bradford West might not have the palliative care that there is in my hon. Friend's constituency. I do not object to his amendment per se, but that is an important point to note.

Hospices are currently consulting on closing beds, NHS trusts do not have 24/7 palliative care available and many people are left to manage their death in the community. When interventions are made, they are often made by people who do not hold the expert competencies that are needed: district nurses who have more patients than they can provide care for—the excellent end-of-life care that they know is possible—and clinicians who have not received the training or do not have the competence to maximise pain and symptom relief.

The Commission on Palliative and End-of-Life Care has already taken evidence on the many failings in the system and the opportunities that could be afforded to people for excellent care to the point of death and, for their families, beyond it. I will come back to this point in the debate on the next group of amendments, but it is important that we discuss what care pathways and treatment options are explored before going down the route of a potential assisted death.

The proposed amendment to clause 4(4)(c) would ensure that the registered medical practitioner conducts their investigation with a palliative care specialist and the patient, so that they can have a comprehensive

understanding of the practice of palliative medicine in supporting a patient's holistic needs at the end of their life.

It is not just about the practical knowledge that the specialist can bring. Specialists are also very experienced in how to hold a conversation with the patient to meet their needs. Without the amendment, it is clear that the patient would be denied the opportunity to explore the fullness of their disease, its impact, its pathway and the range of support that is available for them. I genuinely cannot see how the Bill can proceed without that.

My hon. Friend the Member for Stroud made some valid points. I do not feel that amendment 285 undermines what he said; I think his points actually strengthen the argument for the amendment, which would put the detail on the face of the Bill and would clarify a great deal. I do not expect it to tie us up in legal proceedings or to bring the fear of legal proceedings to doctors. As he said, the fear of being pulled up by the General Medical Council if they do something wrong already exists for doctors every day.

Danny Kruger: I am afraid the situation is even worse, because the fact is that under the Bill they will not be liable for mistakes made in pursuit of the scheme set out in the Bill. They will be exempt. They are indemnified against civil liabilities for malpractice in the course of their job. It is only guidance, and GMC guidance specifies that breaking the guidance is not itself necessarily considered a serious matter. The provisions are not strong enough at all.

Naz Shah: The hon. Member makes a valid point. That brings us to a very important question: do we wait for something to have happened? In this instance, people will have died.

If we were considering kidneys, for example, and the issue of consent, it would require somebody independent. It needs a specialist. We come back to the point about specialisms: whether they relate to diagnosis, coercion, the care pathway, palliative care or the drugs that bring a person's life to an end, which we will discuss later, these are specialisms. I know that later my hon. Friend the Member for Spen Valley will speak to her amendment about the panel, which is intended to require expertise. That is what amendment 285 speaks to, and I hope hon. Members will support it.

Amendment 286 would set out the requirements for the co-ordinating doctor and ensure that the standards are upheld throughout the process of assessment, so that the patient and clinician have the highest levels of advice available. Even though the co-ordinating doctor might already have sought the advice of specialists as part of their assessment, the purpose of having an independent doctor is to assess the patient without preconceptions influenced by the co-ordinating doctor's decision-making process. It is therefore important for the clinician to have access to the same level of advice to inform their clinical decision making.

In medical practice, should a second opinion be sought, the person providing that second opinion might consult a range of sources to establish an opinion. This measure would therefore be in line with normal medical practice. I hope that hon. Members will support the amendments.

Dr Marie Tidball (Penistone and Stocksbridge) (Lab)
rose—

The Chair: Would you like to speak?

Dr Tidball: Yes. I did indicate that I would.

The Chair: It is helpful if you stand in your place.

Dr Tidball: I did earlier.

The Chair: I am sorry. I did not see you.

Dr Tidball: With respect, I stood earlier and your colleague acknowledged it.

The Chair: You should stand at every occasion. Anyway, I call Marie Tidball.

Dr Tidball: I rise to speak in support of the hon. Member for Spen Valley. I thank her for driving amendment 183 forward and for taking on board my input and that of others on strengthening the language in the clause to include the amendment. I will set out why I support clause 4 overall, as augmented by the language in the hon. Lady's amendment 183, along with amendment 275 from my hon. Friend the Member for Sunderland Central, and amendment 108.

To ensure that there is a compassionate choice at the end of life, it is right that the Bill is tightly drawn around the final stage of terminal illness for adults and includes the strongest safeguards. In my speech on Second Reading, I said:

“The choice of assisted dying as one option for adults when facing six months' terminal illness must be set alongside the choice of receiving the best possible palliative and end of life care, or it is no choice at all.

Having analysed the Bill closely, therefore, there are changes I would want to see in Committee to strengthen those options and ensure the way that choice is presented by medical practitioners is always in the round.”—[*Official Report*, 29 November 2024; Vol. 757, c. 1052.]

I am satisfied that the amendments from my hon. Friends the Members for Spen Valley and for Sunderland Central will strengthen the Bill in that way, ensuring that choice for those seeking assistance is more efficient and effectively presented in the round by medical practitioners.

Amendment 183, in the name of my hon. Friend the Member for Spen Valley, emphasises that the initial discussion under clause 4(3) may not be conducted without also explaining and discussing the matters mentioned in subsection (4). It would ensure that the registered medical practitioner must explain to and discuss with the person their diagnosis and prognosis, any treatment available and its likely effect. Amendment 275, in the name of my hon. Friend the Member for Sunderland Central, would ensure that they also discussed “all available” palliative, hospice or other care, including symptom management and psychological support. I support amendments 183 and 275 because, having looked closely at barriers to access to healthcare for disabled people and others over the past 15 years, I believe in the need for transparency, accessibility and equality of choice of healthcare as a fundamental key principle.

The BMA's written evidence, at paragraph 5.6, sets out its support for clause 4. In particular, it expounds on the principle that there should be no prohibition on

a doctor initiating discussion with a patient about assisted dying. Doctors should be trusted to use their professional judgment to decide when and if discussion about assisted dying would be appropriate, taking their cue from the patient as they do on other issues. The BMA goes further, stating:

“Some patients find it difficult to bring up sensitive subjects in their consultations,”

Being able to have these discussions is necessary and helpful.

11.15 am

The evidence given to the Committee demonstrates that any kind of gag clause would undermine the value of transparency of available care. That is evident from paragraph 5.9 of the BMA’s evidence:

“Official bodies in New Zealand...and Victoria...have raised concerns about the impact of this provision in their legislation and have recommended that it is amended.”

The point was emphasised to us in oral evidence by Dr Chloe Furst, an Australian geriatrician and palliative care physician, on what is called the gag clause:

“In South Australia and Victoria, we are not allowed to bring up voluntary assisted dying with patients, and that is really, really problematic. From my perspective, it leads to poor provision of care. In medicine, when I am talking to a patient, in every other area, if they needed treatment, I would be obliged, and it would be good practice, to tell them about all the treatment options that are available to them. If someone had cancer, I would want to be telling them about good palliative care, potentially surgery, and radiotherapy and chemotherapy, yet voluntary assisted dying is the one thing we are not allowed to talk about and is taken off the menu. Some people may not know that voluntary assisted dying is available to them. They might be waiting for me as the doctor to bring it up to them. I have brought up every other option for them; why am I not able to talk about voluntary assisted dying?”—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 30 January 2025; c. 214, Q271.]*

Crucially—this is worth repeating—I believe that if we are to include clause 4, as the evidence has firmly persuaded me that we should, it must ensure that the option of assisted dying is discussed alongside other palliative and end-of-life options. I am therefore grateful to my hon. Friend the Member for Spen Valley for tabling amendment 183, which states that

“such a preliminary discussion may not be conducted in isolation from an explanation of, and discussion about, the matters mentioned in paragraphs (a) to (c)”

of clause 4(4).

Alex Greenwich, the New South Wales Legislative Assembly Member for Sydney, said in oral evidence:

“In our legislation we make it clear that the doctor has to make sure that the patient is aware of their palliative care options...All that is prescribed in the legislation.”—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 30 January 2025; c. 217-218, Q277.]*

Amendment 183 would enable us to mirror that provision in the Bill. It would achieve the strengthening that I sought on Second Reading, by ensuring that a preliminary discussion must include explanation and discussion of the person’s diagnosis, prognosis, any treatment available and its likely effect, as well as all appropriate palliative, hospice or other care, including symptom management and psychological support.

Danny Kruger: Will the hon. Lady give way?

Dr Tidball: I will make progress.

Clause 4 creates no duty to raise assisted dying, a point supported by the BMA. Keeping things secret is not helpful for the patient making such difficult decisions about how best to live their death with dignity and respect.

Naz Shah: Will my hon. Friend give way?

Dr Tidball: I will make progress.

In reply to a question from me about those who are seeking assistance, Dr Jane Neerkin, a consultant physician in palliative medicine, said:

“For them, it is about trying to regain some of that control and autonomy and being able to voice for themselves what they want. That is what I tend to see that people want back at the end of life.”—*[Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 29 January 2025; c. 201, Q263.]*

Importantly, amendments 183 and 275 would strengthen clause 4 to ensure that we avoid a situation that gives those with the most social capital more choice, while leaving those who might otherwise be unaware of all other options available to them without that choice. If the Bill is passed by Parliament without them, it will exacerbate health inequalities rather than abating them.

Together, the amendments expound and elaborate on the need for discussion of all appropriate palliative and other end-of-life options available to someone with a six-month terminal illness. I commend them to the Committee.

Stephen Kinnock: The amendments would make changes to the discussion between the medical practitioner and the patient. They are largely focused on clause 4, on the initial discussions, but several are thematically linked or related to later clauses.

Amendment 342 would impose a requirement on the registered medical practitioner to conduct a preliminary discussion with a person where that person has indicated that they wish to seek assistance to end their own life. As it stands, the Bill allows registered medical practitioners to opt out should they not wish to hold that conversation with someone, although they have an obligation under clause 4(5) to refer an individual to another medical practitioner for that discussion.

The amendment would remove that discretion and thus remove the opportunity for a medical professional to opt out of having the preliminary discussion. That may conflict with the principle set out in clause 23 that no registered medical practitioner or other healthcare professional is under any duty to participate in the provision of assistance. Our analysis suggests that in removing discretion as to participation, the amendment could interfere with an individual’s rights under article 9 of the European convention on human rights, on the freedom of thought, belief and religion, and article 14, on the prohibition of discrimination.

Amendment 285 would require the registered medical practitioner who conducts a preliminary discussion with a person on the subject of an assisted death to discuss with them, in consultation with a specialist, the person’s diagnosis and prognosis, any treatments available and their likely effects, and any available palliative, hospice or other care. The amendment would therefore require additional registered medical practitioners or other specialists to be consulted as part of the preliminary discussion under clause 4(4). The additional time required

[*Stephen Kinnock*]

for consultation with specialists would be likely to lengthen the period over which a preliminary discussion can take place.

I also note that clause 9, “Doctors’ assessments: further provision”, will already require the assessing doctor to make such other inquiries as they consider appropriate in relation to the first and second assessments.

Naz Shah: The Minister’s point speaks to what my hon. Friend the Member for Stroud and I have spoken about in relation to the amendment, so I wonder which bit he supports. The Minister says that there will be extra time, but my hon. Friend pointed out that doctors do this routinely, so the objection is only that it will be on the face of the Bill. I just want to understand the Minister’s position on that.

Stephen Kinnock: If I understood the point that my hon. Friend the Member for Stroud was making, I think it was that the basic provisions in place enable doctors to carry out their work based on their experience and expertise, whereas the amendment would require additional registered medical practitioners or other specialists, so that would be in addition to what my hon. Friend was talking about.

I turn to amendment 343. As the Bill stands, a registered medical practitioner undertaking a preliminary discussion with a patient is required to discuss the person’s diagnosis and prognosis. The amendment would require a registered medical practitioner also to discuss any relevant probabilities and uncertainties of a person’s diagnosis and prognosis. It would put an additional legal requirement on what needs to be discussed during the preliminary discussion with the patient. In considering whether the amendment is required, the Committee may wish to note that all doctors acting in accordance

with the General Medical Council’s “Good medical practice” are expected to discuss uncertainties about diagnosis and prognosis, and potential risks and uncertainties about treatment.

Under clause 4, the registered medical practitioner conducting the preliminary discussion must discuss any treatment available to the patient and the likely effect. Amendment 344 would require the registered medical practitioner conducting the initial discussion to discuss, as part of the conversation on the treatments available, the risks and benefits of such treatment, potential side effects and the impact of the treatment on the person’s quality and length of life. As with amendment 343, the Committee may wish to note, when considering whether the amendment is required, that all doctors acting in accordance with “Good medical practice” are expected to discuss the risks, benefits, uncertainties and the likelihood of success of treatment with a patient.

Amendment 275 would change the wording of clause 4(4)(c) to “all appropriate palliative hospice and other care”. That would require a registered medical practitioner who conducts a preliminary discussion with a person on the provision of an assisted death to explain and discuss palliative and hospice care on the basis of appropriateness for the individual, not on the basis of the care that is available. Clause 4(4) sets out that a registered medical practitioner who conducts the preliminary discussion on assisted dying must, as part of that discussion, explain and discuss the person’s diagnosis and prognosis, any treatment available and the likely effect—

The Chair: Order.

11.25 am

The Chair adjourned the Committee without Question put (Standing Order No. 88).

Adjourned till this day at Two o’clock.

