

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Seventeenth Sitting

Tuesday 4 March 2025

(Afternoon)

CONTENTS

CLAUSE 4 agreed to, with amendments.

CLAUSE 5 under consideration when the Committee adjourned till
Wednesday 5 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House.

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

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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

(Afternoon)

[PETER DOWD *in the Chair*]

Terminally Ill Adults (End of Life) Bill

2 pm

Danny Kruger (East Wiltshire) (Con): On a point of order, Mr Dowd. My understanding is that we are planning to sit a bit later today, which is fine by me. I wanted clarity from you that the Committee has no hard deadline—that although the intention is that Report stage will take place on 25 April, if the Committee wished to go further, it could. I was a little concerned by some of the remarks made in this morning's sitting about people being conscious of time; there is a sense of being asked to speed up as we go. Am I right in saying that the Committee can take as long as it needs to, and that in fact it should, to debate this very important matter?

The Chair: The short answer is yes. I think Members will inevitably deal with this in as sensitive and conciliatory fashion as possible, notwithstanding that point.

Clause 4

INITIAL DISCUSSIONS WITH REGISTERED MEDICAL PRACTITIONERS

Amendment proposed (this day): 342, in clause 4, page 2, line 23, leave out

“may (but is not required to)”

and insert “must”.—(*Danny Kruger*.)

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

Question again proposed, That the amendment be made.

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

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

When we broke at 11.25 am, I was talking about amendment 108. 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 of it...any available palliative, hospice or other care, including symptom management and psychological support.”

Amendment 108 would supplement that with a requirement for the registered medical practitioner also to offer to refer the person to a specialist in palliative, hospice or other such care for the purpose of further discussion.

The amendment would add an additional level of specificity to the preliminary discussion on palliative, hospice or other care, but would not in itself place a duty on the registered medical practitioner to make such a referral, or on the person to accept it. In considering whether the amendment is required, the Committee may wish to note that the General Medical Council’s good medical practice already requires doctors, when providing clinical care, to refer a patient to another suitably qualified practitioner when this serves their needs.

As the Committee is aware, the Government have worked with my hon. Friend the Member for Spenn Valley on several amendments to ensure that the Bill is legally and operationally workable and reflects her policy objectives. Amendments 183 and 424 are two such amendments.

The purpose of amendment 183 is to emphasise, not change, the existing provisions in the Bill that provide that the preliminary discussion held with the person by a registered medical practitioner must not discuss assisted dying in isolation. Rather, the discussion must reference the matters contained in clause 4(4), including

(a) the person’s diagnosis and prognosis...any treatment available and the likely effect of it...any available palliative, hospice or other care, including symptom management and psychological support.”

Amendment 424 seeks to clarify the meaning of “preliminary discussion” in clause 40, to align that with the description of the discussions in subsections (3) and (4) of clause 4. It is a drafting change. As per subsections (3) and (4), a preliminary discussion takes place between a person seeking the provision of assistance in accordance with the Bill and a medical practitioner, about the requirements that need to be met for such assistance to be provided. The preliminary discussion must include

“the person’s diagnosis and prognosis...any treatment available and the likely effect of it...any available palliative, hospice or other care, including symptom management and psychological support.”

Amendment 425 would introduce a requirement that a person seeking assistance under the Bill is referred to a multidisciplinary team to consider support and care for the person. The Secretary of State may provide regulations to determine what kind of professionals should make up such a team, but the amendment would require that at a minimum each team should include a medical practitioner or nurse, a social worker and a psychiatrist. The obligation to refer to the multidisciplinary team would apply each and every time

“a person indicates to a registered medical practitioner their wish to seek assistance to end their own life in accordance with this Act”,

so there could be multiple referrals. Finally, I note that the amendment might have wider resource implications, including for social workers.

Together, amendments 53 and 54 propose changes to clause 7—rather than clause 4, which we have been considering so far today—the effect of which would be that in carrying out the first doctor’s assessment, the co-ordinating doctor must, in addition to the other requirements, be satisfied that the person has relevant and available palliative care options. As such, the amendments would mean that people are eligible for assistance to voluntarily end their own lives only when they have relevant and available palliative care options. The amendments would create an additional criterion, which may reduce the number of people able to receive an assisted death, linked to the availability of palliative care services to any given individual.

Amendment 426 would prevent the co-ordinating doctor from finalising the first assessment process until they had received confirmation from a multidisciplinary team—as set out in amendment 425—that the person seeking assistance to end their own life had met with the multidisciplinary team. The Committee may wish to note that under the amendment there would be no requirement on the multidisciplinary team to provide that confirmation in a given timeframe. That might lead to delays in the co-ordinating doctor being able to make their statement and onward referral.

Amendment 286 would remove the requirements in paragraphs (a) to (c) of clause 9(2) and insert three new requirements. The three new conditions require the assessing doctor, for both the first and second assessment, to consult specialists in relation to the person’s diagnosis and prognosis, any treatments available and the likely effect of those treatments, and any palliative, hospice or other care, including symptom management and psychological support.

The Committee may wish to note that, as drafted, amendment 286 might have some unintended consequences. That is because by replacing clause 9(2)(a), (b) and (c), it would remove the words

“explain to and discuss with the person being assessed”

at clause 9(2)(b). Consequently, the amendment would remove the requirement for the assessing doctor to have a discussion with the person about the factors currently set out in clause 9(2)(b). The assessing doctors would also not be required to examine the person and their medical records, and to make other inquiries as they consider appropriate.

[Stephen Kinnock]

The amendment could also lead to a significant loss of essential discussion between the assessing doctors and the person seeking assisted dying. The removal of clause 9(2)(b) would eliminate the requirement to explain and discuss the diagnosis and prognosis, treatment options and palliative care. Additionally, the amendment would remove the requirement to discuss the person's wishes in the event of complications arising in connection with the self-administration of an approved substance, which may be seen as important for fully informed decision making.

I thank the Committee for its attention.

Kim Leadbeater (Spenn Valley) (Lab): I will try to keep my comments as brief as possible because we have had another very thorough discussion. First, my amendment 424 is, as the Minister said, a simple drafting change in clause 40 that confirms that “preliminary discussion” means a discussion as per clause 4(3).

Amendment 275 from my hon. Friend the Member for Sunderland Central would, in many circumstances, broaden the scope of the conversation that the doctor would have with the patient, and I am happy to support it.

I am also happy to support the very sensible amendment 108 from my hon. Friend the Member for East Thanet (Ms Billington). It is perfectly acceptable to ask the doctor to offer to refer the patient to a specialist, as they would probably do in most cases anyway, but the amendment is for clarity.

I refer colleagues to the comprehensive comments on my amendment 183 earlier in proceedings, and also to the support of the British Medical Association. Following Second Reading, I listened carefully to Members' concerns about the possibility of doctors only discussing assisted dying with patients. Even though the Bill states that that cannot be the case, for the avoidance of any doubt the amendment emphasises that the initial discussion mentioned in clause 4(3) may not be conducted without also explaining and discussing the matters mentioned in subsection (4). Accordingly, such a preliminary discussion may not be conducted in isolation from an explanation of (a) and discussion about the matters mentioned in paragraphs (a) to (c) of that subsection—that is, doctors cannot discuss the option of assisted dying in isolation but only in conjunction with discussion about all other available and appropriate treatment.

Indeed, Andrew Green of the BMA told us that

“some patients find it very difficult to bring up sensitive subjects with their doctors, even when those are the most important thing on their mind.”

He asked us to

“please do not pass legislation that makes it harder for doctors to understand their patients.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 42, Q24.]

That concludes my remarks.

Danny Kruger: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 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.”—(*Danny Kruger.*)

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

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 13.

Division No. 23]

AYES

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

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.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): I beg to move amendment 414, in clause 4, page 2, line 25, at end insert—

“(3A) If a registered medical practitioner conducts such a preliminary discussion with a person, the practitioner must first ensure the provision of adjustments for language and literacy barriers, including the use of interpreters.”

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

Amendment 413, in clause 4, page 2, line 31, at end insert—

“(4A) In Wales, a medical practitioner conducting a preliminary discussion under subsection (4) must also discuss with the person their preferred language of Welsh or English.”

Amendment 415, in clause 9, page 6, line 20, at end insert—

“(2A) When making an assessment under subsection (2), the assessing doctor must first ensure the provision of adjustments for language and literacy barriers, including the use of interpreters.”

Amendment 416, in clause 30, page 18, line 25, leave out paragraph (c)

This amendment is linked to Amendment 417.

Amendment 417, in clause 30, page 18, line 32, at end insert—

“(1A) The Secretary of State must, within six months of the passing of this Act, issue one or more codes of practice in connection with the arrangements for ensuring effective communication in connection with the provision of assistance to persons in accordance with this Act, including the use of interpreters.”

This amendment is linked to Amendment 416.

Liz Saville Roberts: I rise to speak to amendment 413, which would require a medical practitioner in Wales who conducts a preliminary discussion under subsection (4) to discuss with the person their preferred language of Welsh or English. Amendments 414, 415, 416 and 417, tabled by the hon. Member for Ipswich, relate to adjustments for language and literacy barriers. I will speak to those amendments, but it is not my intention to divide the Committee on them. Although I am supportive of the drive behind the amendments from the hon. Member for Ipswich, they refer to a situation very different from that of Welsh and English, because the use of Welsh and English has particular statutory implications.

This is the first time I have risen to speak about how we need to tease out the Bill's implications in the context of reserved and devolved powers, where justice and criminal law are reserved, while health and social care are devolved. Amendment 413 concerns the need, in my belief, to place in the Bill the requirement to determine whether a person wishes to use either Welsh or English in their initial discussions with registered medical practitioners. I firmly believe that this needs to be written into the legislation. Later amendments I have tabled to clauses 5 and 8, and new clause 18 and new schedule 2, also relate to the use of Welsh.

Sojan Joseph (Ashford) (Lab): I fully support the amendments, but they say that the practitioner conducting the preliminary discussion should use an interpreter. Should the interpreter not also be available for all the interactions that follow on from the preliminary discussion?

2.15 pm

Liz Saville Roberts: While I agree with the hon. Member in principle, I am operating within the law in terms of Welsh and English, because there are legal considerations with those two languages in particular.

In the matter we are discussing, the ability for the person to communicate as directly as possible is of the greatest importance. I wonder whether the Minister will respond by saying that the codes of practice in clause 30 will be sufficient, but I emphasise that I took advice from the Welsh Language Commissioner's office, and it was the Welsh Language Commissioner's officer who advised that I table the amendments. We are operating in unique circumstances with this being a private Member's Bill, and we need to have clarity on what is required in relation to how the legislation operates between England and Wales.

Sarah Green (Chesham and Amersham) (LD): The hon. Lady will know that the Welsh Language Act 1993 put the Welsh language on an equal footing with the English language in Wales. Does she agree that it would be helpful to have clarity on whether the provisions in that Act apply to the Bill?

Liz Saville Roberts: That is exactly what I am seeking to do, and I am seeking to do it as co-operatively and collegiately as possible. But we need to have clarity on this, and our discussions need to be thorough and exact in order to be accurate.

When it comes to the individual's right to use Welsh in their daily lives, two pieces of legislation are relevant to the Bill: the Welsh Language Act 1993, which predates

devolution, and the Senedd's Welsh Language (Wales) Measure 2011. The Welsh Language Act remains applicable for reserved matters, such as justice, and the Ministry of Justice operates a Welsh language scheme that enables people to use Welsh in courts, tribunals and other areas of justice. The Welsh Language Measure established the office of the Welsh Language Commissioner, who has the power to investigate complaints from Welsh speakers who assert that their freedom to use Welsh has been interfered with; created a Welsh language tribunal to hear appeals against the commissioner's decisions; and enabled the development standards, which are particularly significant here.

The Welsh Language Measure states that individuals in Wales should be able to conduct their lives through the medium of Welsh if that is what they choose to do. Under the Measure, the NHS in Wales has a statutory duty to deliver services to the public in both Welsh and English. The Welsh language standards are a set of statutory requirements that set out responsibilities to provide services, and they apply to health boards in Wales, as well as to NHS primary care services that are contracted by the health boards. The standards do not apply to independent providers, which since 2019 must follow six Welsh language duties, one of which is to establish and record the language preference of patients. That is where I have got the terminology used in amendment 413.

That is a summary of the relevant considerations but, before I close, it is important to say why this matters to Welsh speakers. I spoke recently to medical practitioners in Wales who wanted me to emphasise their concerns at the lack of specific mention of language rights. I also spoke to the Welsh Language Commissioner's officers, who advised me on the necessity of the amendments. There is a critique against providing Welsh language services that shrugs its shoulders and says, "Why bother? They all speak English anyway." That is to ignore how integral language use is to the individual.

We are drafting a Bill to do two things in a very delicate balance: to respect the autonomy of the individual and to safeguard people against abuse in any form. For many Welsh speakers, Welsh is the language of their emotions. It is the language in which they express themselves most fluently, and the first language of their feelings. It matters to this Bill. English is the language of authority, and many Welsh speakers are anxious not to challenge the authority of high-status people such as doctors. They do that out of ingrained politeness, and out of fear of not being able to access services if they put any barriers in the way. That is the way that language gets used. Welsh speakers do not use Welsh in the way that monolingual English speakers use English; monolingual English speakers use English because it is the only language they have. For anyone who is bilingual or multilingual, the use of language is very complicated and sophisticated, and we need to be alert to it in all its respects.

I return to the nature of the relationship between doctors and their patients. Doctors have high status, and a patient approaches a doctor seeking services, advice and context. That is not a power dynamic that we should allow to go unchecked, so I urge the Committee to consider the amendment. I do not intend to press it to a vote, but I want a response from the Ministers. Before Report, I want absolute clarity on its legal necessity or otherwise. I feel instinctively—especially

[Liz Saville Roberts]

because the Welsh Language Commissioner's office has told me this—that it should be in the Bill. I would also like a response from Ministers on amendment 414, tabled by the hon. Member for Ipswich.

Rebecca Paul (Reigate) (Con): I rise to speak briefly to amendments 413 and 414, which are very thoughtful and well-considered amendments. I thank the right hon. Member for Dwyfor Meirionnydd for setting out powerfully and persuasively the importance of the subject. I support the amendments, but in reality we probably need to go further by specifying exactly who would be interpreting and making sure that it is regulated reliably. We do not want just anyone coming in off the street and doing that. That would not be appropriate, so we need to think about whether we need to go further. However, the amendments are a great starting point and would move us closer to where we need to be.

There is much subtlety in this debate. We talked a little in the first week of this Committee about the importance of language and the words that are used. We always need to be cognisant that when we are imparting information to people, particularly in a healthcare context, it is vital that we use language that people understand so that the ramifications of what is being discussed are clear. That is where these amendments become really important, because for those for whom English is not their first language, some of the subtlety and nuance around what a term means could be lost. Interpreters could be an important part of adding the clarity required to ensure that everyone going through the process understands exactly what it involves.

A 2024 Nuffield Council on Bioethics survey found that 39% of people think that assisted dying means withdrawing life support, 19% think that it means providing people who are dying with drugs that relieve symptoms of pain or suffering, and 13% think that it means providing hospice care. That echoes our debate a couple of weeks ago about how assisted dying can be interpreted in quite a few different ways. It is really important that we are clear in the language we use and what we mean by it.

We also find that among ethnic minorities there is sometimes a greater misunderstanding about palliative care. A 2024 King's College London survey found that 6% of people believe that it is accurate that palliative care involves giving people medicines in order to shorten their life, but 18% of ethnic minority groups think that. We need to be cognisant of that. While 18% of people trust healthcare providers “not very much” or “not at all” to provide high-quality care towards the end of life, that figure increases to 30% for ethnic minority groups. While 6% of people say they have not heard of palliative care, that increases to 22% of people in ethnic minority groups.

It is important to recognise that the text of the amendment is much less stringent than that of section 7 of South Australia's Voluntary Assisted Dying Act 2021, which strictly regulates interpreters. That goes back to my initial point. Under the South Australian law, they must be

“accredited by a prescribed body”.

They cannot be a family member, cannot stand to benefit from the will and cannot be involved in the

patient's healthcare. It is really important to ensure that a recognised professional is involved in this most important of processes and information sharing.

I support the amendments, although I think they need to go a little further. I look forward to hearing what other hon. Members have to say.

Daniel Francis (Bexleyheath and Crayford) (Lab): I echo the points that have been made about the importance of the initial conversations, particularly for those who do not have English as their first language. I made a commitment to my hon. Friend the Member for Ipswich that in his absence I would press amendments 414 and 415 to a Division, as he requested.

I support the general principles of the amendments relating to those who are seeking or who need interpretation to explain aspects of assisted dying to them. I support the merit of that principle and the intention behind amendments 414 and 415.

Naz Shah (Bradford West) (Lab): Like the right hon. Member for Dwyfor Meirionnydd and the hon. Member for Reigate, I will not press the amendments to a vote, but I certainly want to speak to them. I do not think that they go far enough. Let us put ourselves in the position of people of colour: if the English language is seen as superior to or more powerful than Welsh, that means an extra layer of intervention that I do not think the amendments quite capture. We have not even talked about British Sign Language in our discussion of languages, but it is also really important.

I am a qualified interpreter from Urdu to English—in health, funnily enough—and I can tell the Committee that in Urdu there is not even a word for depression. The word for depression does not exist. In a previous life I chaired the largest mental health charity outside London for ethnic minority communities, and I am a former NHS commissioner, so when we talk about health inequalities and patient intervention, I understand acutely the nuances involved in translating from one language to another.

In the first instance, there is a language that someone does not understand. In the second instance, particularly for minority communities who speak languages from the south Asian subcontinent such as Punjabi, Urdu or Hindi, the words do not exist to translate the Bill literally or to talk about assisted death. That speaks to the point that the hon. Member for Reigate made about understanding what it means. I have the same stats that she cited, which show that people do not understand what assisted death is.

I would really value a response from the Minister and from my hon. Friend the Member for Spen Valley to these questions about the nuances of having such a difficult conversation. These are really brave conversations, both on the doctor's side and on the patient's. Take a woman from an ethnic minority background whose first language is not English and whose doctor is unable to translate their conversation with her. Would that conversation be disempowering? Would it be empowering? Would we be doing a disservice to that person, with the best will in the world from the doctor? I really would like to understand what consideration is being given to making this accessible, if it is to be a service and a piece of legislation that is open equally to all.

I have mentioned this point a few times and have raised it with the Minister, and I appreciate that the Minister has responded, but this is where my frustration—for want of a better word—comes from about not having an impact assessment in the first place. If we had had an impact assessment, the Government would have looked at these things. Even with small Bills, we go out to consultation for weeks and weeks. With this Bill, we have not spoken to anybody during Committee stage about the nuances of the provisions on languages and what they will mean for patients. Although I support the essence of what the amendments are attempting to achieve, they fall short of providing the necessary protections. I do not know how the Government will address that.

2.30 pm

Perhaps the Minister can enlighten me on this point: if there is an impact assessment once the Committee has gone through the Bill, how can we use it to affect the clauses that we have been through, as we will not be able to comment on them again? I do not know how it works. Many Members here are on a Bill Committee for the first time. My understanding is that the process is usually very different.

If the Government go out and conduct an impact assessment that sheds light on whether the amendments are workable or will complicate things, where will we be? Where will that leave the Committee in its attempts to strengthen the Bill? Will it all be done in the wash-up stage? Will it be done on Report? I am not sure, so I would really like to understand that.

I will not press the amendments to a vote, but I think they would be a step in the right direction. Would that address my concerns? Unfortunately not. It still leaves a lot to be desired.

Stephen Kinnock: This group of amendments focuses on language and literacy barriers, including discussion of the use of interpreters and translations. If amendment 414 is agreed to, a registered medical practitioner who conducts a preliminary discussion with a person will first have to ensure the provision of adjustments for language and literacy barriers, including the use of interpreters. It may be helpful to note that, in all areas of practice, registered medical practitioners must uphold the standards in the GMC's "Good medical practice", which includes the provision of adjustments for language and literacy barriers.

The purpose of amendment 413 is to require medical practitioners in Wales who are conducting the initial discussion outlined in clause 4 to

"discuss with the person their preferred language of Welsh or English."

It may be helpful to note that under the Welsh Language (Wales) Measure 2011, the NHS in Wales has a statutory duty to deliver its services to the public in both Welsh and English. The Measure, which gives the Welsh language official status in Wales, states that

"persons in Wales should be able to live their lives through the medium of the Welsh language if they choose to do so."

The Welsh Government's active offer for health is intended to support all staff across NHS Wales to provide a service in Welsh for patients, without their having to ask for it.

Technically, I would note that the amendment does not require the medical practitioner to conduct the initial discussion in the person's preferred language, or to refer the person to another medical practitioner who can conduct it in the person's preferred language, if they are unable to do so themselves. I have discussed that point with the right hon. Member for Dwyfor Meirionnydd and am more than happy to have a further discussion about how her amendment might work. The concern that I simply flagged was that we have the 2011 Measure and, as with so many of these things, there is a law of unintended consequences. An amendment that may be designed with the best possible intentions could end up disrupting the system and causing confusion or uncertainty, which I am sure she would not want. As with all these things, that is the challenge.

Liz Saville Roberts: We have raised already in the Committee the need for an impact assessment. I have also raised with the Minister the need for an impact assessment in Wales. The fact that we are having this conversation shows that there is an element of uncertainty about exactly whether it is necessary for this provision to be included in the Bill. I am concerned that it could be in a code of practice; I share the concern expressed by the hon. Member for Bradford West that we do not know how such codes of practice will operate, or whether we will have any say over how they operate. However, as the Minister has come to this in a spirit of co-operation, I hope that we will find some clarity. If it appears that it is better for Welsh language speakers that such a provision be set out in the Bill, I hope that he will agree in that respect.

Stephen Kinnock: I am happy to have that discussion, to better understand how it might all work in practice.

If amendment 415 is agreed to, it will mean that an assessing doctor making an assessment under subsection (2) must first ensure the provision of adjustments for language and literacy barriers, including the use of interpreters. As with amendment 414, the Committee may want to note the existing standards that all medical practitioners must uphold, which include requirements for the provision of adjustments for language and literacy barriers.

Amendments 416 and 417 would amend clause 30, which states that the Secretary of State may issue codes of practice on a number of matters, including on arrangements for ensuring effective communication and the use of interpreters. The amendments would impose a duty on the Secretary of State to issue one or more codes of practice in connection with arrangements for ensuring effective communication, including the use of interpreters, and to do so within six months of the passing of the Act. The requirement to issue any such code of practice within six months may prove unworkable. Under clause 30, it would be necessary to consult on the code of practice, make regulations to allow for the code of practice to come into force, have the regulations approved by both Houses of Parliament and then issue the code of practice, all within a six-month period after the passing of the Act.

As I have said, the Government will continue to remain neutral on whether or how the law in this area should change. As I have made clear, that is a matter for the Committee and for Parliament as a whole. However,

[Stephen Kinnock]

I hope that these observations are helpful to members of the Committee in considering the Bill and the amendments tabled to it.

Kim Leadbeater: On amendment 413, from the right hon. Member from Plaid Cymru—with apologies, I will not embarrass myself by trying to pronounce the wonderful name of her constituency—I am very sensitive to issues around devolution. We have had many conversations about it, which I am very happy to continue. The Minister has confirmed, as I understand it, the issue around the Welsh language, in that it would be covered by the Welsh language legislation, which states that individuals in Wales

“should be able to live their lives through the medium of the Welsh language if they choose to do so.”

I am very supportive of that. I am also happy to continue those conversations, where necessary, with the Minister.

I turn to amendments 414 and 415. I think several Members of the Committee have had the same message from my hon. Friend the Member for Ipswich, who was clearly struggling to get here on time. I, too, would be happy to move them in his name. They seem very sensible amendments, and I am happy to support them. Along with the GMC’s “Good medical practice”, which sets out the principles, values and standards of professional behaviour expected of doctors, it is a belt-and-braces approach to an issue that is very important, for reasons that several hon. Members have set out.

I cannot support amendments 416 and 417, however, because the timeframe that they would impose would not fit with the rest of the Bill. In reference to the two-year implementation period, that would just not be workable or possible.

Liz Saville Roberts: I will not press amendment 413, because I anticipate further conversations on these matters.

Amendment 414 agreed to.

Amendment proposed: 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.”—
(*Naz Shah.*)

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.

Question put. That the amendment be made.

The Committee divided: Ayes 7, Noes 14.

Division No. 24]

AYES

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

NOES

Abbott, Jack	Malthouse, rh Kit
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

Question accordingly negated.

2.45 pm

Amendments made: 275, in clause 4, page 2, line 30, leave out “any available” and insert “all appropriate”.—
(*Lewis Atkinson.*)

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.”—(*Sean Woodcock.*)

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)).”—(*Kim Leadbeater.*)

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).

Danny Kruger: I beg to move amendment 71, in clause 4, page 2, line 31, at end insert—

“(4A) The practitioner must, following the preliminary discussion under subsection (3), refer that person to the Assisted Dying Agency if the person asks them to do so.”

This amendment is consequential on NC4 and would establish a pathway by which a person is referred to the Assisted Dying Agency.

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

Amendment 72, in clause 5, page 3, line 16, leave out paragraph (b) and insert—

“(b) has been assigned to the person by the Assisted Dying Agency,”

This amendment is consequential on NC4 and provides that the coordinating doctor must have been assigned to the person by the Assisted Dying Agency.

Amendment 73, in clause 7, page 4, line 21, leave out paragraphs (b) and (c) and insert—

“(b) provide the person who was assessed and the Assisted Dying Agency with a copy of the statement.

(3A) Upon receipt of the statement specified in subsection (3)(a), the Assisted Dying Agency must assign to the person, as soon as practicable, another registered medical practitioner who meets the requirements of section 8(6) for the second assessment (“the independent doctor”).”

This amendment is consequential on NC4 and would require the coordinating doctor to send a copy of their statement to the Assisted Dying Agency. That Agency must then to assign an “independent doctor” to the person.

Amendment 75, in clause 8, page 5, line 9, leave out “coordinating doctor” and insert “Assisted Dying Agency”.

This amendment is consequential on NC4.

Amendment 74, in clause 8, page 5, line 16, at end insert—

“(ba) has been assigned to the person by the Assisted Dying Agency.”

This amendment is consequential on NC4 and provides that the independent doctor must have been assigned to the person by the Assisted Dying Agency.

Amendment 76, in clause 9, page 6, line 14, leave out paragraph (e).

This amendment is consequential on NC4.

Amendment 77, in clause 11, page 7, line 18, after “appointment,” insert

“by the Assisted Dying Agency”.

This amendment is consequential on NC4.

Amendment 78, in clause 14, page 10, line 7, leave out from “person)” to end of line 12 and insert “the Assisted Dying Agency”.

This amendment is consequential on NC4.

Amendment 79, in clause 16, page 11, line 18, leave out subsections (2) and (3) and insert—

“(1A) The Assisted Dying Agency must, as soon as practicably possible, record the making of the statement or declaration.”

This amendment is consequential on NC4.

Amendment 80, in clause 17, page 11, line 36, leave out subsections (2) and (3) and insert—

“(1A) The Assisted Dying Agency must record the cancellation.”

This amendment is consequential on NC4.

New clause 4—Assisted Dying Agency—

“(1) There shall be a body known as the Assisted Dying Agency (“The Agency”).

(2) The purpose of the body is to coordinate requests from people to be considered for assisted dying, including assigning, at the appropriate junctures, a coordinating doctor and independent doctor for a person seeking assistance to end their own life.

(3) Where a person has previously been referred to the Agency, no future referral relating to that person can be proceeded with by the Agency unless it considers there has been a material change in the person’s circumstances.

(4) The Secretary of State must make regulations setting out—

- (a) the staffing and remuneration of such staff,
- (b) the procedures of the Agency, and
- (c) the means by which the Agency can pay coordinating doctors and independent doctors for services rendered under this Act.

(5) The Agency’s expenditure is to be paid out of money provided for by Parliament.

(6) The Agency must, for each financial year, prepare accounts in accordance with directions given to it by the Treasury.

(7) The Agency’s chief executive is its accounting officer.

(8) As soon as reasonably practicable after the end of each financial year, the Agency must prepare a report about the performance of its functions during that year and lay that report before both Houses of Parliament.

(9) Regulations under subsection (4) are subject to the affirmative procedure.”

This new clause would create a new body that was principally responsible for coordinating and recording statements and declarations in relation to a person’s request for assistance to end their own life.

Danny Kruger: Although these provisions may seem irrelevant to the Bill—I do not think any of us wishes to see the creation of an assisted dying agency—I am nevertheless grateful to my hon. Friend the Member for Runnymede and Weybridge (Dr Spencer) for tabling them. He is playing his usual role of keeping us honest.

It is extraordinary that nowhere does the Bill lay out exactly how the assisted dying service would be delivered—whether it would be an NHS service, a private service or some mix of the two. I am therefore grateful to my hon. Friend for being clear in his suggestion that it should be a non-NHS service and that, if we are to pass this law, we should establish a bespoke agency for the explicit purpose of delivering that service. It is a rather macabre but logical way of delivering on the proposal in the Bill.

The fact is that many doctors, faced with the prospect of being asked to participate in assisted dying, have expressed their preference for it to be delivered outside the NHS. In its written evidence, the British Medical Association, which has been cited a number of times today, says:

“There is nothing in the Bill about how an assisted dying service might be delivered, although the possibility of a separate service is mentioned in the explanatory notes.”

The BMA’s view is that assisted dying

“should not be part of the standard role of doctors or integrated into existing care pathways”.

I stress that point, because it has often been suggested in the course of debate that the way assisted dying will work will be as part of a holistic range of options—pretty indistinguishable from palliative care or other treatment options put before patients. The BMA is clear that assisted dying

“is not something that a doctor can just add to their usual role.”

The Royal College of General Practitioners has also pointed out in evidence that the shape of the service is not set out in the Bill.

Kit Malthouse (North West Hampshire) (Con): On a point of order, Mr Dowd. In his opening sentence, my hon. Friend said that none of us wanted to see the creation of an assisted dying agency. My interpretation of our speaking to a particular amendment is that we have to address what it intends to do in the Bill. My hon. Friend said that he does not want what the amendment intends and that he is speaking more generally about the delivery of the service. Could we have your guidance as to whether that is in order? One of our problems is that we are having very expansive debates, and previous Chairs have sought to keep everyone in order. I am anxious that my hon. Friend does not exhaust himself by straying from the central point in the amendment.

The Chair: The fact of the matter is that the hon. Member does not have to agree with the amendment, so he is perfectly entitled to speak in that regard.

Danny Kruger: I am grateful to you, Mr Dowd, and to my right hon. Friend for his concern for my welfare, which is much appreciated. However, he will be relieved to know that I have plenty of energy and can keep going.

To speak seriously, it is very germane to the Bill that the amendments are considered. As I was explaining, GPs and other medical practitioners have been concerned

[*Danny Kruger*]

about the absence from the Bill of clauses to specify the delivery of the service, so I am grateful that we have this opportunity to discuss that and to hear from the Minister and the sponsor how they imagine the Bill would operate and whether it would, indeed, be appropriate to establish some kind of agency along the lines proposed. The reason I object to an assisted dying agency is that I object to assisted dying, but I see the logic of the proposal if we are to proceed with the principle of the Bill.

It is extraordinary that this crucial question is not set out. In his evidence to us, Chris Whitty said rather airily that it was for Parliament to decide how the service should be delivered. I would stress that most medics involved, particularly in palliative care and care for people at the end of life, are very hostile personally to the suggestion that they should participate in assisted dying. The BMA's 2020 survey of its members found that 76% of palliative medicine doctors would be unwilling to participate if assisted dying were legalised. The Royal College of Physicians 2019 members' poll found that 84% were opposed.

Kit Malthouse: This is not in order; it has nothing to do with the amendment.

The Chair: If the right hon. Gentleman wishes to make a point of order, he should feel free to make a point of order.

Kit Malthouse: On a point of order, Mr Dowd. I am grateful to you, and I am sorry to interrupt. I do not mean to be rude, but I cannot see how this is germane to the amendment. We have a lot of amendments to deal with in detail, and expanding the debate into a wider one about whether the medical profession agrees with assisted dying does not seem to me to address the question of whether we should include the amendment in the Bill, which is what we are here to decide.

The Chair: The right hon. Member is perfectly entitled to express his view, and I respect it. I will make a judgment in due course as to whether the hon. Member is stepping outside the latitude of the issue. He will no doubt bear in mind your intervention and my response to it.

Kit Malthouse: I am grateful, Mr Dowd.

Danny Kruger: I, too, am grateful, Mr Dowd. I stress that I am discussing the suggestion in the amendment that assisted dying be taken out of the NHS and not be part of the normal pathways doctors are invited to participate in. It strikes me as relevant that most doctors, were the law to be passed, would wish for something along the lines of the amendment to be included.

We do not know exactly how that would work. We know that it could potentially be private, according to the scheme set out in the amendment, or it could be within the NHS. We know from the references in clause 40 that private provision is envisaged, because of the talk of reasonable remuneration for the provision of services. So it would be outside the normal service expectation of medical professionals employed by the NHS; indeed, we know that it could be a lucrative market.

Sojan Joseph: Does the hon. Member think that, if we bring in an agency from outside the NHS—from the private sector—this will become like a business?

Danny Kruger: The hon. Gentleman is absolutely right. The opportunity is there in the Bill for private businesses to be established to deliver assisted dying services. Indeed, it would be quite a lucrative money-making enterprise. Estimates have been given of between 5,000 and 17,000 assisted deaths per year, depending on how they are arrived at. If the charges employed by Dignitas—which is in a sense the model being proposed here—are anything to go by, it could be in the region of £5,000 to £10,000 per patient. Even a small proportion of that would be significant—a multimillion-pound business would be possible under the Bill. Advertising would also probably be possible; we saw TfL suggest that the Dignity in Dying adverts in the tube before Second Reading were compliant. There is no prohibition in the Bill on advertising or on people making money from it.

However, the Bill also specifies that this would be a state-protected service, so if it were to be a private enterprise, it would have all sorts of state protections that would not normally apply to private providers of anything. Under clause 25, the providers would be exempt from any civil liability for providing assistance under the Bill. Under clause 29, a death would be exempt from investigation under the Coroners and Justice Act 2009. Clause 30 says that a failure to comply with any code of practice

“does not of itself render a person liable to...criminal or civil proceedings”.

The only monitoring that would be done would be undertaken by the voluntary assisted dying commissioner, who is not an independent figure, but the person responsible for setting up the panels that approve the deaths.

The Chair: Order. We need to get back to the assisted dying agency. Can the hon. Member keep to that, please?

Danny Kruger: I shall—I am winding up now, Mr Dowd. These amendments go to the heart of this great absence—this blank space—in the middle of the Bill, which is how on earth it will be delivered. Who would deliver it, and under what regulation? What would be their terms of engagement? All of that represents quite a scandalous gap in the Bill, and my concern is with that enormous gap.

I want to conclude with a reflection on that lack of clarity. Elizabeth Gardiner, who I understand was the very experienced parliamentary drafter who contributed her time to draft the Bill, talked on the Hansard Society podcast of the opportunity that drafting has to change the law. She noted that if the law

“is a restriction that would curtail the ability of this to be delivered through the National Health Service, the Bill could change that.”

So it has been suggested that the Bill would require changes to the National Health Service Act 1946 to remove what the Hansard Society calls the “duty to protect”.

The Chair: Order. The hon. Gentleman heard what I said earlier, and I do not want to reaffirm it, but can we get back to the substance of the assisted dying agency provision, please?

Danny Kruger: I have one last point to make, Mr Dowd, which I hope you will regard as in order because, as I said, it goes to the heart of things. At the moment, the Bill does not specify how these things should be done, and Elizabeth Gardiner, the drafter behind it, said on the radio:

“we didn’t have time to go into all the detail of how those regimes work and to make the provision on the face of the Bill. And so there are regulation making powers there, which enable that provision to be set out”—

I believe that that is in clause 32. Enormous Henry VIII powers are being established. I deeply regret the gap in the Bill, and I am grateful to my hon. Friend the Member for Runnymede and Weybridge, who tabled these proposals, for enabling us to have this debate.

The Chair: Order. I remind the hon. Member to keep to the issue that we are discussing, because if he or any other Member does not, and goes beyond the scope of what they really should be sticking to, I will take a much less lateral approach in future. I say that gently and with the best intention.

Stephen Kinnock: I will speak to this group of provisions as one, given that amendments 71 to 80 are consequential on new clause 4. The purpose of these provisions is to create a new statutory body—the assisted dying agency—which has the purpose of co-ordinating requests from people to be considered for assisted dying. The provisions provide for various functions and duties of the agency, including assigning a co-ordinating doctor and an independent doctor to a person seeking assistance to end their own life.

The agency would be responsible for accepting referrals, replacing registered medical practitioners with the roles of assigned co-ordinating doctor and assigned independent doctor, and receiving and recording declarations, statements and cancellations made by co-ordinating doctors, independent doctors and those receiving assistance under the Bill.

That would be a change from the current provisions in the Bill, which place a number of those duties on the individual co-ordinating doctor and independent doctor. One effect of the proposed new clause is that a new agency would have to be established by the Government. If it passed, we would have to work to assess how that might be possible in practice.

I hope my brief remarks are helpful to Committee members in considering the Bill, the amendment and the new clause.

Kim Leadbeater: I have nothing to add, other than to agree with the hon. Member for East Wiltshire; I do not think any of us on the Committee are keen on the implementation of the assisted dying agency.

Danny Kruger: Will the hon. Member give way?

The Chair: Too late.

3 pm

Danny Kruger: I really regret that we have had such a small debate on the enormous question of how on earth assisted dying would actually be delivered. We are leaving it to Ministers, subsequent to the passage of the Bill, to design this service. The clear possibility is that a private enterprise could run the service. It might be an NHS service. The fact that that is unclear in the Bill is shameful, but I am grateful we have had the opportunity to debate the matter, sort of, and I am not going to press the amendment to a vote. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 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.”—(*Naz Shah.*)

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.

The Committee divided: Ayes 7, Noes 14.

Division No. 25]

AYES

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

NOES

Abbott, Jack	Malthouse, rh Kit
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

Question accordingly negatived.

Sean Woodcock (Banbury) (Lab): I beg to move amendment 345, in clause 4, page 2, line 31, at end insert—

“(4A) If a registered medical practitioner conducts such a preliminary discussion with a person, the practitioner must record and document the discussion and the information provided to the patient in their medical record and provide a copy to the patient.”

This amendment would add a requirement ensuring that the preliminary discussion is recorded and forms part of the patient’s medical record.

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

Amendment 288, in clause 4, page 2, line 36, at end insert—

“(6) All efforts to dissuade the person from ending their own life must be recorded in the clinical records and subsequently made available to the medical examiner.”

This amendment would require the coordinating doctor to record efforts to dissuade the person from taking their own life and subsequently make this available to the medical examiner.

Amendment 297, in clause 7, page 4, line 3, at end insert—

“(1A) Any consultation as part of the assessment must have a full written transcript as its record of the conversation.”

This amendment would require all consultations for the first assessment to have a full written transcript.

Amendment 295, in clause 7, page 4, line 26, at end insert “, and

(d) collate all evidence provided regarding the condition of the patient in a document to be provided to the Medical Examiner and the relevant Chief Medical Officer after the person has received assistance to die in accordance with this Act.”

This ensures that the documentation that will be required by the Medical Examiner will be available when required.

Amendment 300, in clause 8, page 4, line 30, at end insert—

“(1A) Any consultation as part of the assessment must have a full written transcript as its record of the conversation.”

This amendment would require all consultations for the second assessment to have a full written transcript.

Amendment 302, in clause 8, page 5, line 10, at end insert “and

(c) provide details of the way the assessment was conducted and the written transcript of any consultation to the relevant Chief Medical Officer and the person’s own GP, maintaining a copy to be supplied to the relevant Medical Examiner after the person’s death.”

This amendment will ensure that medical records are in line with procedures for presentation to the Medical Examiner.

New clause 19—*Recording of preliminary discussion*—

“(1) This section applies where a registered medical practitioner (‘the practitioner’) conducts a preliminary discussion with a person.

(2) Where the practitioner is a practitioner with the person’s GP practice, they must, as soon as practicable, record the preliminary discussion in the person’s medical records.

(3) In any other case—

(a) the practitioner must, as soon as practicable, give a written record of the preliminary discussion to a registered medical practitioner with the person’s GP practice, and

(b) that registered medical practitioner must, as soon as practicable, include the record in the person’s medical records.”

This new clause requires a practitioner to include, in the person in question’s medical records, a record of a preliminary discussion under clause 4.

Sean Woodcock: Amendment 345 was tabled by my hon. Friend the Member for Shipley (Anna Dixon); I referred earlier to her record in this area. The amendment would ensure that medical practitioners record and document preliminary discussions with a patient about assisted dying and provide the patient with that information. I welcome the amendments from the Bill’s promoter to make records of the first and second doctor’s assessments. Those safeguard patients and the process. It is important that we have transparency and clarity on such weighty decisions.

Several people raised in their written evidence the importance of good documentation. These amendments meet those concerns. I assume that not including a record

of the preliminary discussion is merely an oversight by the Bill’s promoter. The amendment seeks to do what she says she wants to do—protect patients and doctors—by making records of the discussions.

In written evidence TIAB55, Professor Allan House suggested that

“It should be required as it is in all other areas of medical practice, that specific written records are kept of this assessment and of procedures followed to end life—not just the substances used. The written record to be included in the person’s medical record so that it is available to the Medical Examiner. Records also to be available at appraisal to enable assessment of the quality of the process.”

Kim Leadbeater: I thank my hon. Friend for his comments. Will he take note of my new clause 19, which is in this group and states that the preliminary discussion has to be recorded?

Sean Woodcock: I am grateful for that intervention, which goes to the heart of my next question: why would we record and document later conversations, but not the initial one? That conversation could be one in which coercion takes place and without a record of it happening, patients and doctors are at risk. We have acknowledged that patients can be influenced by their doctors, whether consciously or unconsciously. We also noted how certain groups lack trust in the healthcare system. Dr Jamilla Hussain, in her written evidence, TIAB252, explained that the various inequalities faced by certain communities “contribute to mistrust in health and social care services” and that

“minority patients frequently express fear of having their lives shortened by healthcare providers, especially at the end-of-life with medication such as morphine and midazolam.”

In situations where patients are uncertain or lack trust in medical professionals, a record of the initial conversation is important to protect everyone involved. As Professor House stated, documenting the process and making records is common medical practice, so why would we differ here? We must protect patients and doctors, and making clear records at every stage of the process contributes to that.

Naz Shah: I rise to speak to amendments 288 and 295 tabled by my hon. Friend the Member for York Central (Rachael Maskell), both of which would improve the quality of records kept about people applying for assisted dying. Their aim is to make parliamentary and public scrutiny of the system easier and better. Amendment 288 would insert a new subsection at the end of clause 4, on page 2, line 36, reading:

“All efforts to dissuade the person from ending their own life must be recorded in the clinical records and subsequently made available to the medical examiner.”

That recognises that a doctor may follow existing guidelines and seek to dissuade the person from ending their life. It would ensure that such efforts are recorded to improve understanding of the Bill and its interaction with suicide prevention. As Professor Allan House noted in his written evidence, the National Institute for Health and Care Excellence guidelines apply

“in other areas where it is important to explore thoughts about life not being worth living”.

After an episode of self-harm or instances of suicidal thoughts, the medical professionals will explore

“current and recent personal and social circumstances, recent adversities, psychological state beyond merely assessing mental capacity and the presence of severe mental illness.”

In line with this suicide prevention strategy, a doctor may feel the need to explore those psychosocial factors and seek to dissuade the person from ending their life. We know that suicidal thoughts and depression are particularly common among terminally ill people. Dr Annabel Price, a member of the faculty of liaison psychiatry at the Royal College of Psychiatrists, gave oral evidence that among people who need palliative care at the end of their life,

“20% will have diagnosable depression, around 10% will have a wish to hasten death, and around 4% will have a more persistent wish to hasten death.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 270, Q351.]

She went on to say:

“Those who had a wish to hasten death were 18 times more likely to also feel suicidal”.—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 275-276, Q359.]

Terminally ill people are therefore at particular risk, and it is vital that the Bill does not diminish wider suicide prevention strategies. The amendment would record instances where the medical practitioner may try to dissuade the person from ending their life. Some doctors may take the view of Professor Allan House, who said in his written evidence,

“a statement about wanting to end one’s life cannot be simply taken as the result of a straightforward rational decision to choose one type of end of life care over others.”

Furthermore, this amendment would also address some of the concerns about unconscious bias. Recording efforts to dissuade the person from ending their life would show when doctors assume a person should have an assisted death where others should not. Fazilet Hadi of Disability Rights UK spoke about this in her oral evidence:

“We often find that doctors, because they cannot treat or cure us, do devalue our lives. We have had disabled people who have actually had it suggested to them or their families that their lives are expendable, when actually those people have got a lot of years to give.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 180, Q234.]

Providing records of a doctor’s efforts to dissuade the person from ending their life will address some of these concerns. It will ensure that there can be a more meaningful review of the impact of the Bill on different groups, so that the right to die does not become a duty to die.

In conclusion, amendment 288 would strengthen the safeguards in the Bill by ensuring transparency and accountability in doctor-patient discussions by requiring the documentation of efforts to dissuade individuals from ending their lives. We would lessen the impact of the Bill on wider suicide prevention strategies and provide evidence for meaningful review at a later date.

Amendment 295, also tabled by my hon. Friend the Member for York Central, is about enabling public and parliamentary scrutiny of the assisted dying system. It will ensure that, if the Bill passes, there are good records of all applications for assisted dying and that they are readily available to the medical examiner. Some Members will know exactly what the medical examiner does, but I

note for the record that it is a newly created public office, in operation since 2024. The task of the medical examiner is to examine any deaths within the context of healthcare, whether NHS or private, that are not being examined by a coroner.

In light of the magnitude of the decision being made, it is important for records to reflect that. It is equally important that those who will depend on the evidence can access the same evidence on which the co-ordinating doctor made their determinations. Therefore, it is essential that the basis of the decision making is accurately recorded, along with the evidence from other practitioners. For instance, if a palliative care specialist, a clinical consultant and a psychiatrist or psychologist have been consulted, evidence of what they did and said must be readily available, and it is essential that that sits with the record of the co-ordinating doctor. The information must be gathered for the medical examiner to be able to come to their determination with all the evidence before them. It is also vital for the reporting mechanisms to be deployed for the process by which the chief medical officer compiles their report. That is ultimately what Parliament will be able to scrutinise.

Both these amendments would greatly improve the quality of records kept on assisted dying. If I recall correctly, the role of the medical examiner was brought into legislation following Shipman, to tidy up and tighten the records we keep—because clearly we had lessons to learn from them. Also, we have heard in evidence that some other jurisdictions keep good medical records, especially when that speaks to people who are potentially coerced. In one jurisdiction, we had somebody who said that they had never felt a burden, but there were many more who said that they had felt a burden.

There is no doubt that these services will continuously need improving. If we keep these records and understand that these conversations have been had then, ultimately, should this Bill become law, these records would form part of the data collection that we could rely on as parliamentarians and for those service improvements. The amendment speaks not just to the Bill itself, but to ensuring that it continues to do what it is intended to do going forward.

These amendments improve equality in assisted dying. That, in turn, will make it far easier for us in Parliament, for our constituents and for the media to find out what is happening with any assisted dying system. In this country, we believe in open justice and open Government. Assisted dying is much too important to be allowed to operate without strong scrutiny by the press, the public and ourselves in Parliament. I therefore urge hon. Members to vote for both these amendments.

3.15 pm

Sojan Joseph: I rise to speak in support of the amendment. The documentation in our healthcare system is a very important matter. It helps us to share good practice and to learn from mistakes. Whether in secondary care, primary care or nursing homes, the quality and the safety of our patient care is monitored by the Care Quality Commission, which uses clinical documentation to carry out its process of monitoring that quality and safety. It is important that any conversation had with patients by the doctor, or by any medical professional or multidisciplinary team, is documented clearly. That will help to safeguard our patients.

Stephen Kinnock: This series of amendments relates to the various discussions and assessments that registered medical practitioners, co-ordinating doctors and independent doctors will have with individuals seeking assistance to end their life in accordance with the Bill. In particular, they seek to amend the requirement for recording information about those discussions. As I have done throughout, I will limit my remarks to comments on legal and practical impacts of amendments. In executing our duty to ensure that the legislation, if passed, is legally robust and workable, the Government have worked with the hon. Member for Spen Valley on amendments to the Bill, including new clause 19 in this group.

Amendment 345 would require the registered medical practitioner, following a preliminary discussion with a person, to record and document in that patient's medical records the discussion and any information provided to the patient, and it would require them to provide a copy to the patient.

Amendment 288 adds an additional requirement on the registered medical practitioner who conducts an initial discussion with the person on the subject of an assisted death to record all efforts to dissuade a person from ending their own life in the person's medical records, and subsequently to make those records available to the medical examiner. As drafted, it is not clear whether the wording "all efforts" is intended to include efforts made by the registered medical practitioner alone, or to include efforts made by others that could be reported to the registered medical practitioner. Further clarity would be needed to establish the practical implications of the amendment. The amendment does not require this information to be recorded at a specific time. I would also note that, operationally, medical examiners are not involved in scrutinising all deaths. Some deaths are investigated by coroners. Clause 29 will consider inquests and death certifications in relation to assisted death.

Amendment 297 requires a full written transcript to be produced for any consultations that occur as part of the first assessment undertaken by the co-ordinating doctor. That would potentially add some operability challenges and, if passed, we would want to explore those further. For example, there could be situations in which the person seeking assistance does not want there to be a written transcript. Further clarity is also required on whether the amendment intends to capture only consultations between the co-ordinating doctor and the patient, or whether it also intends to capture conversations with relevant persons other than the person seeking an assisted death.

I turn now to amendment 295. As the Bill stands, if, having carried out the first assessment, the co-ordinating doctor is satisfied that the person being assessed has met all requirements in clause 7(2), the co-ordinating doctor must:

“(a) make a statement to that effect in the form set out in Schedule 2, and sign and date it,

(b) provide the person who was assessed with a copy of the statement, and

(c) refer that person, as soon as practicable, to another registered medical practitioner who...is able and willing to carry out the second assessment”.

Amendment 295 seeks to add an additional requirement for the co-ordinating doctor to

“collate all evidence provided regarding the condition of the patient in a document to be provided to the Medical Examiner and the...Chief Medical Officer after the person has received assistance to die”

in accordance with the Bill. The aim of the amendment is to ensure that the documentation will be available when required by the medical examiner.

Naz Shah: The Minister referred to a patient not wanting to keep a written record. How does that fare if there is a potential issue of negligence later on? Is that not a requirement of every NHS service that we provide? For example, in the case of a kidney donation where an independent assessor was needed, the details would have to be kept. I am just a bit confused. I wonder if the Minister might comment on that.

Stephen Kinnock: The challenge we found with amendment 297 is that it is not entirely clear what would happen if the person were to say expressly that they did not want a written record. That eventuality is not baked into the Bill as it is currently drafted, so I think it would require a lot of thinking through—again, we are back to the law of unintended consequences—about the impact the amendment would have in certain circumstances if, for example, someone were to say expressly that they did not want a written record. That is the question: the impact of the amendment is not clear.

Naz Shah: If that is an issue, then it is my understanding, being new to Bill Committees, that it is not because the provision is poorly drafted, but because the outcome is not clear. Can the Government not clarify that on Report or Third Reading? I have heard nothing from the Government, even where they are supportive of amendments, about going away and looking at them. There is none of that conversation coming from the Government. Perhaps the Minister will comment on that.

Stephen Kinnock: As my hon. Friend knows, there will be an impact assessment on the Bill once it has cleared Committee. The Government's impact assessment would be based on the Bill as it cleared Committee, so it would include the amendment we are discussing, if it were to pass. As things stand, I cannot tell her what the impact of the amendment would be in the event that it passed, because that has not been thought through from all the different angles, including if someone were to expressly say that they did not want a written transcript.

I turn to amendment 300, which would require a full written transcript of the second assessment as a record of the conversation. This goes further than the requirement that the Bill currently places on the independent doctor, which is to make a statement in the form in schedule 3. As with amendment 297, further clarity is required on whether the amendment is intended only to cover consultations with the patient, or whether conversations with other individuals should also be transcribed.

Amendment 302 would require the independent doctor to provide details of the way in which the second assessment was conducted alongside a written transcript of any consultation to the relevant chief medical officer and the person's GP.

Naz Shah: The Minister is being very generous with his time. I want to understand the idea that someone might say that they do not want a written transcript, when everybody in our country who uses the NHS has a written medical record. Why, in this instance, are the Government of the view that we should stray from normal practice?

Stephen Kinnock: I think it reflects the fact that, as the Committee has agreed, we are in uncharted territory on a whole range of issues here. I think it is best to think through the implications of every amendment. If it passes, every clause of the Bill will have to be assessed for its potential impact. I have other questions about amendment 297 in my notes. Does it intend to capture only the consultations between the co-ordinating doctor and the patient, or does it intend also to capture conversations with relevant persons other than the person seeking an assisted death? That is not clear from the amendment. What I am saying is that it poses more questions than it answers.

Kim Leadbeater: I might be wrong, but my understanding is that a patient could ask for access to their medical records at any point. On the basis that new clause 19 requires the doctor to record a preliminary discussion, presumably, if a patient wanted to see that record, they would be able to.

Stephen Kinnock: I agree with my hon. Friend on that point. As I stated at the start of my comments, officials have worked with her on new clause 19, which I think goes a long way to clearing up many of the points that have been raised, including hers.

Juliet Campbell (Broxtowe) (Lab) rose—

The Chair: Order. The Minister is in the middle of responding to a particular question. Will Members wait until he has done so before standing up to ask a question on a question, please?

Stephen Kinnock: Thank you, Mr Dowd. I have answered the question from my hon. Friend the Member for Spen Valley and am happy to take another intervention.

Juliet Campbell: Throughout the debate, we have spoken consistently about things that happen normally within medical practice, but the amendment we are discussing would move us away from ordinary practice. Could the Minister explain why we would do that?

Stephen Kinnock: As I have set out, officials have looked at amendment 297 and raised a couple of flags or questions about it. One is what we have discussed about the transcript. The other is that it is not clear whether other people should be included in the consultation. I do not think it is so much about departing from common practice as about the questions that the amendment raises. As always, the Government are neutral. The Government trust that if the Committee, in its wisdom, sees fit to pass the amendment, it will be workable, but as things stand it raises a number of questions. That is all I am flagging.

Naz Shah: The Minister is being generous with his time. I am even more confused now. Originally, the Minister suggested that a patient might not want a transcript, but in response to the question from my hon. Friend the Member for Spen Valley, he mentioned that under new clause 19 people will have access to their written records. That appears to be a contradiction. I just want to nail this down. What will it be? If a patient does not want a written record, we would not have a written record to access, so that contradicts the Minister's response. I want to understand exactly what the Minister is suggesting.

Stephen Kinnock: The Government have worked with my hon. Friend the Member for Spen Valley on new clause 19. The Government's view is that if the Committee accepts it, then that new clause will provide the level of robustness and resilience that the system requires. The Government are not convinced that, on its own, the amendment that my hon. Friend the Member for Bradford West is talking about would provide the level of robustness and resilience we would be looking for. As things stand, the choice has been made to work with my hon. Friend the Member for Spen Valley on new clause 19, and we are satisfied that that would provide us with the operational integrity we need.

Amendment 302 would require the independent doctor to provide details of the way in which the second assessment was conducted, alongside a written transcript of any consultation to the relevant chief medical officer and the person's GP. The independent doctor would be required to maintain a copy of that record to provide to the relevant medical examiner.

As I have mentioned, in executing our duty to ensure that the Bill, if passed, is legally robust and workable, the Government have worked with my hon. Friend the Member for Spen Valley on new clause 19. The new clause would require a practitioner to include a record of a preliminary discussion having taken place under clause 4. The record of the preliminary discussion must be included in the person's medical records. Where the medical practitioner is a member of the person's GP practice, they must make such a record in the person's medical records as soon as practicable. Where the medical practitioner is not a member of the person's GP practice, they must, as soon as practicable, provide a written record of the preliminary discussion to a medical practitioner at the person's GP practice, who will then be required by the new clause to include it in the person's medical records as soon as practicable.

The Committee may wish to note that amendment 424 would add a definition of "preliminary discussion" to the Bill that would make it clear what discussion medical practitioners would be required by law to record.

That concludes my remarks on this group. I thank the Committee for its attention.

Kim Leadbeater: I rise to speak briefly to my new clause 19, which refers to the recording of the preliminary discussion. It would require the practitioner to include in the medical records of the person in question a record of a preliminary discussion under clause 4. The initial discussion with the patient is very important and, as such, should be recorded in their records. I hope that colleagues agree and will support the new clause.

Sean Woodcock: I would like to press amendment 345 to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 14.

Division No. 26]

AYES

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

NOES

Abbott, Jack	Malthouse, rh Kit
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

Question accordingly negated.

Amendment proposed: 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 registered medical practitioner or registered nurse,
- a person registered as a social worker in a register maintained by Social Work England or Social Work Wales, and
- a practising psychiatrist registered in one of the psychiatry specialisms.”.—(*Danny Kruger.*)

The Committee divided: Ayes 8, Noes 14.

Division No. 27]

AYES

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

NOES

Abbott, Jack	Malthouse, rh Kit
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

Question accordingly negated.

The Chair: Order. I will suspend the sitting for 15 minutes.

3.35 pm

Sitting suspended.

3.50 pm

On resuming—

The Chair: Before I call Danny Kruger to move amendment 412, I remind Members to keep within scope and to ensure that any points raised are relevant and not repetitive, or I will intervene.

Danny Kruger: I beg to move amendment 412, in clause 4, page 2, line 32, leave out subsection (5).

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

Amendment 341, in clause 4, page 2, line 33, leave out from “subsection (3)” to the end of line 36 and insert

“is not required to refer the person to another medical practitioner but must ensure that the person is directed to where they can obtain information and have the preliminary discussion.”

This amendment would provide that a registered medical practitioner who is unable or unwilling to have the preliminary discussion with a person must provide information to the person about where they can have that discussion, but that this need not take the form of a referral.

Amendment 338, in clause 4, page 2, line 34, leave out from “so” to end of line 36 and insert

“direct them to another registered medical practitioner or the independent information and referral service established under section [*Independent information and referral service*]”.

This amendment, which is linked to NC13, would mean that a registered medical practitioner who was unwilling to have preliminary discussions would direct the person to another registered medical practitioner or an independent information and referral service.

Amendment 287, in clause 4, page 2, line 34, leave out from “practitioner” to end of line 36, and insert

“who is qualified to undertake such a preliminary discussion, and set out palliative medicine options to provide the patient with appropriate end of life care, including referring them to a palliative medicine expert.”

This amendment means that the medical practitioner who is unwilling to have an initial discussion with a person must, both refer them to another registered medical practitioner and set out the palliative care options including referring them to a specialist.

New clause 13—*Independent information and referral service—*

“(1) The Secretary of State must, by regulations, make provision to establish an independent information and referral service to—

- provide information to persons who are, or may be, eligible for assisted dying in accordance with this Act, and
- where requested, facilitate the person’s access to assisted dying in accordance with this Act.

(2) Regulations under subsection (1) are subject to the affirmative procedure.”

This new clause would require the Secretary of State to make provision for an independent information and referral service.

Danny Kruger: I rise to speak to this important group of amendments, which are all relevant to the duty to refer, whereby a doctor who does not want to advise a patient on assisted dying is obliged to send them to somebody who does. In different ways, we each seek to provide more protections for those medical professionals.

There are two main reasons why doctors may not want the obligation to refer that is in the Bill. The first is the central point that this is not a healthcare treatment, as is traditionally understood. Assisted dying does not

address the condition or treat the illness; it treats only the symptoms, in the sense that it obliterates the existence of the patient. Like the advert for bleach says, it “kills all known germs”—it kills every experience that the patient has or could have. It is not part of the range of treatments that a doctor should have to offer, as clause 4(1) makes clear.

That point similarly relates to the question of referring to somebody who can offer that discussion. I suggest that the act of referring is an act of endorsement, just as offering the intervention itself is an act of endorsement. Dr Green from the BMA made it clear during oral evidence that the BMA does not like the word “refer”, as it implies assent to the option that is being offered. Indeed, the hon. Member for Spen Valley, in conversation with Dr Green during evidence, accepted that the word “refer” was “not...quite right”, as she put it, because it has the particular implication and expectation of a form of endorsement.

We have heard the same opinion from multiple witnesses in written and oral evidence to the Committee, particularly from Muslim medical professionals and their trade body. Those representing pharmacists also expressed significant concern that they might find themselves included in the definition of medical practitioner. The Association of Anaesthetists and the Royal College of Nursing were worried as well. A range of professional bodies and representative organisations share my concern that imposing a duty to refer—an obligation to assist somebody to have an assisted death by finding them a doctor who will conduct the preliminary discussion—is itself a breach of their rights of conscience.

The second reason follows from the first. Doctors may reasonably conclude that being in a position to help with assisted dying puts them in a totally different relationship with their patients. That is why the BMA is so unhappy and has asked for the requirement to be removed. It has an alternative, which some of these amendments also propose. It said:

“We urge the committee to remove the referral requirement and, instead, make it clear that the doctor’s duty is to direct patients to where they can obtain information”.

That is what amendment 341, in the name of my hon. Friend the Member for Sleaford and North Hykeham (Dr Johnson), would do. The BMA suggests that

“this should be an official body set up to provide individual information and advice to patients, to which patients could be referred or directed to, or could self-refer.”

My preference would be not to have any obligation on doctors to make any kind of referral, but I respect the aspiration of the amendment, which is to ensure that there is an independent body to give advice that patients can seek out themselves or that they can be advised of, so there is no expectation of a referral to a doctor who can facilitate the assisted death.

The Royal College of General Practitioners is also unhappy about the provision. It suggests that instead of expecting doctors

“to refer directly to a medical practitioner who is ‘willing and able to conduct that discussion’”—

as per the Bill—

“the doctor’s duty would be to direct patients to an official service where they can obtain objective and accurate information”.

I think we should pay heed to the advice of the professionals.

As ever, I would like to refer to the experience of foreign jurisdictions, because we are constantly told that this Bill is the safest in the world. None of the legislation in Australia or New Zealand, or the legislation currently going through in the Isle of Man, puts an obligation to refer on to doctors. Victoria and South Australia’s legislation says that a doctor has the right to refuse to participate in the request for assistance process and to give information about voluntary assisted dying, so there is no duty to refer—not even a duty to provide information.

I conclude with an observation that was submitted to us by Dr David Randall, a consultant nephrologist. It was very telling that he said in written evidence:

“I would not be willing to act in accordance with Section 4(5) of the Bill. I am a doctor in good standing with the GMC, and who has always striven to provide the highest standards of care to patients. Passage of this Bill would place my practice in direct opposition to the criminal law.”

He talks about “moral injury”, which is a very important principle. We have an obligation to protect the conscience and human rights of medical professionals.

We are still unclear whether this process will take place within the NHS or outside it. Nevertheless, the obligation to refer in the Bill would be a direct breach of doctors’ rights and would impose a moral injury on them. My preference is to remove clause 4(5) altogether, as that would be consistent with the Abortion Act 1967 and similar legislation on assisted dying in other countries. If we are not prepared to do that, we should at least restrict the obligation and provide more protections, as per the amendments in the names of other hon. Members.

Rebecca Paul: I rise to speak in support of amendment 341 in the name of my hon. Friend the Member for Sleaford and North Hykeham. It would provide that a registered medical practitioner who is unable or unwilling to have the preliminary discussion must provide information to the patient about where they can have that discussion, but that need not take the form of a referral.

One of the messages that we heard loud and clear in the evidence sessions was that medical practitioners do not wish to be put under an obligation to refer a patient to another registered medical practitioner by the Bill. “Referral” has a very specific meaning in medicine, and it is that word and the corresponding action required of it that many doctors have an issue with. A referral puts a patient on a pathway, whereas the provision of information merely indicates where such a pathway can be found. During oral evidence, Dr Green said:

“The word ‘referral’, to a doctor, means writing a letter or communicating with another doctor to see, but some doctors would find themselves not able to do that. For that reason, we believe that there should be an information service for the doctor to direct to.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 48, Q41.]

We are well aware that assisted dying is a complex issue and a matter of conscience for many. It is therefore important that we respect the personal views of medical practitioners. One of the points that I have made several times in these proceedings is that assisted dying affects not just the patient but other people participating and supporting. Some medical practitioners will be comfortable with it, but many others will not. It is therefore vital that we recognise their rights and needs, not just the patients’, when formulating this law. If for whatever

[Rebecca Paul]

reason a doctor does not want to refer a patient, they should not have to. Their legal responsibility should be limited to directing the patient to where they can find the relevant information that they need. Doctors should have no further obligation.

4 pm

Clause 4(5) would place many doctors in an impossible position. Referral would mean writing a letter to, or putting the patient in touch with, another doctor. For many, doing so would be tantamount to involvement with assisted dying, and would not be something they are comfortable with. Dr David Randall, a consultant nephrologist at the Royal London hospital and honorary senior lecturer at Queen Mary University of London, states in written evidence:

“The Terminally Ill Adults (End of Life) Act will cause significant damage to the healthcare workforce by: imposing a duty of ‘effective referral’ on medical practitioners who object to direct involvement, an obligation which will drive some from the profession and impose moral injury on those who remain”.

The BMA also raised concerns about clause 4(5) in its written evidence:

“We urge the committee to remove the referral requirement and, instead, make it clear that the doctor’s duty is to direct patients to where they can obtain information and have that discussion. We suggest elsewhere that this should be an official body set up to provide individual information and advice to patients, to which patients could be referred or directed to, or could self-refer.”

The Royal College of General Practitioners is also unhappy about the provision. Its written evidence states:

“In order to further protect those medical practitioners who are unwilling to conduct the preliminary discussion, we would support an amendment to Clause 4(5) to make it clear that instead of expecting them to refer directly to a medical practitioner who is ‘willing and able to conduct that discussion’ the doctor’s duty would be to direct patients to an official service where they can obtain objective and accurate information, and have a preliminary discussion.”

None of the legislation in Australia or New Zealand, or the legislation currently going through the Isle of Man, has a duty to refer. For instance, Victoria and South Australia’s laws state that a doctor has the right to refuse not just to participate in the request for assistance process, but to give information about voluntary assisted dying. There is no duty to refer in either law. In American states, doctors are generally not obliged to give information, let alone make referrals. It is also relevant that there is no statutory duty to refer under the Abortion Act, and indeed there is no duty to signpost to information, although BMA and GMC guidance rightly requires a medical practitioner to ensure that the patient has the relevant information that they require.

I therefore support amendment 341, which seeks to remove the requirement to refer and replace it with an obligation to direct the patient to where they can obtain information and have the preliminary discussion. The amendment is in line with the written evidence we have received, so I hope that some Committee members will join me in supporting it.

Kim Leadbeater: I thank the hon. Member for those important points. I reassure her, and possibly other Committee members, that I am minded to support amendment 341.

Rebecca Paul: I thank the hon. Lady for that intervention, which I welcome.

Lewis Atkinson (Sunderland Central) (Lab): I will be brief. I am pleased to hear my hon. Friend the Member for Spen Valley confirm that she is minded to support amendment 341. It is incumbent on all of us, but perhaps particularly those in favour of the Bill, to place on record our appreciation and recognition of the fact that many people who work in our health services have strongly held religious beliefs, or beliefs of conscience—however they are motivated. As is the case for a range of other procedures and medical interventions, the law has to allow them scope to continue to practise. They make a valuable contribution to our health service and national life, and we should not do anything to impinge on that.

There is already strong guidance from the General Medical Council about personal belief, and that applies, as the hon. Member for Reigate mentioned, to the Abortion Act, as well as to the Human Fertilisation and Embryology Act 1990, the Female Genital Mutilation Act 2003 and other procedures. It is not for any of us to second-guess someone’s conscience.

Naz Shah: I would like to add that there is nothing about female genital mutilation in anybody’s religion. It is not a religious belief; it is cultural, and it is actually child abuse. That is what it is—there are no ifs or buts about it.

Lewis Atkinson: I do not disagree with my hon. Friend. I gently say that the GMC guidance specifically references that Act, so that is what I was referring to.

I am pleased to see amendment 341, which I believe would bring the legislation into line with that GMC guidance, ensuring that removing the duty to refer would absolutely not be a licence for people to be left without access to care. The GMC is very clear, as the hon. Member for Reigate said, that people must be given sufficient information and be empowered to seek the options and information that they need. Therefore, I am pleased to support the amendment.

Daniel Francis: It is a pleasure to serve under your chairmanship, Mr Dowd. I note that my hon. Friend the Member for Spen Valley has said that she is minded to accept amendment 341. I will, however, still briefly speak to amendment 338 and new clause 13, which stand in my name.

The British Medical Association has said that it strongly urges MPs to support the amendments, which would remove the referral requirement in relation to preliminary discussions and establish an official body to provide factual information to patients about the range of options available to them. As the hon. Member for East Wiltshire mentioned, Dr Green, in his oral evidence, said:

“The provision of information would be very useful, because in a situation where a doctor was unwilling to have an initial discussion with the patient, it would provide a way for the patient to get that information that was in no way obstructive.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 46, Q37.]

He went on to say:

“I do not believe that it is ever appropriate for a doctor to recommend that a patient goes through an assisted dying process.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 48, Q40.]

He also said:

“The word “referral”, to a doctor, means writing a letter or communicating with another doctor to see, but some doctors would find themselves not able to do that. For that reason, we believe that there should be an information service for the doctor to direct to.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 48, Q41.]

The BMA’s position is that the proposal is analogous to doctors’ professional legal obligations regarding abortion, and consistent with the Bill’s inclusion in clause 23 of a right to refuse, for any reason, to carry out activities directly related to assisted dying. It has said:

“In tandem, we believe creating an official body to provide individual information and advice to patients, to which doctors could direct (rather than refer) patients, would ensure that the doctor’s views are respected, whilst also—crucially—ensuring that patients can easily access the information and support they need. Currently, whilst the Bill acknowledges the need for accurate, impartial information and advice for patients, it gives no indication of how this might be delivered—generic published information would not be sufficient. Patients would need individual advice, guidance, and support so that they can make informed decisions, and an independent information service could meet this need.”

As the hon. Member for Reigate mentioned, a member of the Royal College of General Practitioners also said:

“The BMA referred to the word “refer”—referring to a colleague, for those who did not want to do it. We agree that signposting is a better process.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 279, Q365.]

He went on to say:

“Similar to other services, such as termination of pregnancy, we think that the best option would probably be that the GP could signpost to an information service, such as something like what the BMA suggested the other day. They would not have to do anything more than that, and they would not withhold any option from the patient.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 273, Q354.]

Therefore, I commend amendment 338 and new clause 13 to the Committee.

Naz Shah: It is a pleasure to follow my hon. Friend the Member for Bexleyheath and Crayford. I rise to speak to amendment 287, tabled by my hon. Friend the Member for York Central. Clause 4(5) currently says:

“A registered medical practitioner who is unwilling or unable to conduct the preliminary discussion mentioned under subsection (3) must, if requested by the person to do so, refer them to another registered medical practitioner whom the first practitioner believes is willing and able to conduct that discussion.”

If this amendment was to be adopted, it would read:

“A registered medical practitioner who is unwilling or unable to conduct the preliminary discussion mentioned under subsection (3) must, if requested by the person to do so, refer them to another registered medical practitioner who is qualified to undertake such a preliminary discussion, and set out palliative medicine options to provide the patient with appropriate end of life care, including referring them to a palliative medicine expert.”

Put simply, the amendment would mean that if a doctor met with a patient with a severe illness who might die within six months, but the doctor was themselves unwilling to have an initial discussion on assisted dying, they would still have to refer the patient on to a doctor who was willing to have that discussion. The patient’s decision to explore assisted dying would not be obstructed;

the main change would be that that doctor would now have to discuss palliative care options with the patient. That is surely a measure that would increase the patient’s welfare.

Let us think about the kind of patient who can apply for assisted dying. They must have a diagnosis of a serious illness and a prognosis that they are likely to die within six months. The Bill’s supporters have said many times that they are worried about any changes that will reduce the autonomy of people seeking assisted death. This amendment quite obviously does not in any way reduce people’s autonomy, nor does it in any way place an unreasonable burden upon doctors. If a patient has a diagnosis of a serious illness, and if they have themselves asked for a conversation on assisted dying, then it surely must be good practice for that doctor to discuss palliative care options.

It is also only good practice that one of those options would be for the doctor, if the patient wishes, to refer the patient to a palliative medicine specialist who is more able to talk about such options. That means that the amendment would not place any undue burden on either the doctor or the patient. The doctor ought to be offering such advice on palliative care. The patient may or may not decide to take the doctor’s advice on palliative care, but they have had it, and the patient may well benefit from having had advice on palliative care.

Given the conversations we had this morning, I can foretell one objection to this amendment: that since good doctors will do this anyway, it is unnecessary to have a provision on the face of the Bill to ensure it. This seems to me a very weak objection. Let us be honest, the doctors that we have in this country are of extremely high quality. They are dedicated, skilled and compassionate men and women. We are lucky to have them, but we cannot say that every doctor participating in all the processes that they currently undertake always follow best practice.

Similarly, we simply cannot say that in any assisted dying process doctors will always automatically follow best practice. People make mistakes. That includes people who are highly trained and extremely compassionate. I would be astonished if we could find a doctor who said they had always got everything right. As lawmakers, we have to guard against the fact that even some of our most admired professionals can and sometimes will make mistakes. One way that we will guard against that is to set out duties that they have to follow. This amendment does just that.

I hope that we will not hear the objection that we have heard to a great many good amendments: that it will somehow make the Bill more dangerous by adding complications. The amendment simply adds a small step, by placing a duty on a doctor to give palliative care advice to a patient with a diagnosis of serious illness. Surely the Bill cannot be so lacking in robustness that such a small change would make it dangerous.

In summary, the amendment is a sensible change. It would in no way block the ability of adults who meet the conditions set out by this Bill to explore assisted dying, nor would it place any burden at all upon doctors. It would simply place upon them a duty to follow what we can all surely agree is best practice, and it would greatly improve the early access to palliative care advice for patients with a diagnosis of serious illness. That

[Naz Shah]

would improve those patients' chances of receiving good palliative care. I therefore urge hon. Members to support the amendment.

4.15 pm

Stephen Kinnock: Amendment 412 would remove the duty in clause 4(5) on a registered medical practitioner who is unwilling or unable to conduct the preliminary discussion to, upon request, refer the person to another practitioner whom the first practitioner believes is willing and able to conduct that discussion. Guidance for medical professionals requires that, where a practitioner objects to performing a procedure, they must refer the patient to a practitioner who can meet their needs.

Amendment 341 removes the duty on a registered medical practitioner who is unwilling or unable to conduct the preliminary discussion to, upon request, refer the person to another registered medical practitioner whom they believe is willing and able to conduct that discussion. The amendment requires the registered medical practitioner who is unwilling or unable to conduct the preliminary discussion with the person to instead ensure that the person is directed to where they can obtain information and have the preliminary discussion.

New clause 13 would introduce a requirement for the Secretary of State to create, via regulations, an independent information and referral service for individuals who are, or may be, eligible under the Bill for assisted dying services. The accompanying amendment 338 would require a registered medical practitioner who is unwilling or unable to conduct the preliminary discussion to direct the person, upon that person's request, to another registered medical practitioner or to the information and referral service, as set out in the new clause. The effect of this amendment is to remove the obligation in clause 4(5) for the registered medical practitioner to refer the person to another registered medical practitioner whom the first practitioner believes is willing and able to conduct the initial discussion. This amendment would make it more likely for a person seeking assistance to be referred to someone who is unwilling or unable to help. In addition, these amendments could carry an operational impact, as the new service would need to be designed and brought into existence.

Amendment 287 would mean that, if the first practitioner is unable or unwilling to conduct the preliminary discussion, they must, upon request, refer the person to a registered medical practitioner who is qualified to undertake the preliminary discussion. They must also set out palliative medicine options to provide the patient with appropriate end-of-life care, including referring the person to a palliative medicine expert. This amendment removes the duty in clause 4(5) to refer to a practitioner whom the first practitioner believes is willing and able to conduct the preliminary discussion.

As with previous amendments, this language could make it more likely for a person seeking assistance to be referred to someone who is unwilling or unable to help. It is not clear what

“qualified to undertake such a preliminary discussion”

is intended to mean. In addition, the term “palliative care expert” is not a defined term. Palliative medicine is a designated speciality of the General Medical Council

and a doctor can apply to be entered on to the GMC specialist register for this speciality, provided they have the specialist medical qualification, training or experience. I hope these observations are helpful, and I thank the Committee for its attention.

Kim Leadbeater: I rise to speak to amendments 341, 338 and 412 together, and I welcome the debate on these important amendments. Choice is one of the key tenets of the Bill, primarily—but not exclusively—for terminally ill adults with a limited time to live. Choice is also very important for medical practitioners, and I am very respectful of, and acknowledge the importance of, conscientious objection for doctors. When it comes to assisted dying, I believe that they should also have choice. Indeed, the Bill is written so that they can choose not to participate in the process for any reason. That is the BMA's view, and I agree with it.

The BMA has a position of neutrality on assisted dying, and there are a range of views within medical professions, as there are within all groups of people. That is why I have adopted its position of an opt-in model for the purposes of the Bill. Nevertheless, the process must remain patient focused at all times, and that means enabling them to have a discussion on such an important matter. It would not be right to rely on online advice or even the best-designed written materials. As we have already established, doctors are used to having sensitive and compassionate discussions with people who are terminally ill, and there can be no substitute for that. While a doctor may not wish to participate themselves, and I fully respect that, they still have a responsibility towards their patients, and that should include ensuring that they can speak to a properly qualified medical practitioner at such a difficult time.

I understand that the BMA and others would not be comfortable with the word “refer”, which I understand to have a special meaning within medical practice. The GMC guidelines use different language. They talk about where a doctor has a conscientious objection, in which case they are advised that they must make sure that arrangements are made for another suitably qualified colleague to take over their role. The BMA's guidance says that patients must be able to see another doctor, as appropriate, and that it need not always be a formal procedure. It is not, however, sufficient to simply tell the patient to seek a view elsewhere—I agree completely.

The BMA supports amendment 341, which says that a doctor

“must ensure that the person is directed to where they can obtain information and have the preliminary discussion.”

I am therefore happy to support the amendment today and, if it were to need further adjustment, I am very happy to consider alternatives based on existing best practice. I would be very happy to meet with the hon. Member for Sleaford and North Hykeham, who is herself a doctor, to discuss her thoughts and draw on her considerable medical experience.

Danny Kruger: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment made: 341, in clause 4, page 2, line 33, leave out from “subsection (3)” to the end of line 36 and insert

“is not required to refer the person to another medical practitioner but must ensure that the person is directed to where they can obtain information and have the preliminary discussion.”—(*Rebecca Paul.*)

This amendment would provide that a registered medical practitioner who is unable or unwilling to have the preliminary discussion with a person must provide information to the person about where they can have that discussion, but that this need not take the form of a referral.

Juliet Campbell: I beg to move amendment 125, in clause 4, page 2, line 35, leave out from start of line to end of line 36 and insert

“who is on the Register of Assisted Dying Medical Practitioners.”

This amendment provides that only a medical practitioner who is on the Register of Assisted Dying Medical Practitioners as provided for in NC7 would have a person referred to them.

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

Amendment 126, in clause 23, page 15, line 5, at end insert—

“(1A) Medical practitioners who wish to provide assistance under this Act must “opt-in” to the Register of Assisted Dying Medical Practitioners under clause (Register of Assisted Dying Medical Practitioners).”

This amendment provides that any medical practitioner who wishes to provide assistance under the Act must have opted in to the Register of Medical practitioners.

New clause 7—Register of Assisted Dying Medical Practitioners—

(1) The Secretary of State must, by regulation, establish a Register of Assisted Dying Medical Practitioners.

(2) A medical professional may only carry out the role of co-ordinating doctor or independent doctor under this Act may if they are listed on the Register of Assisted Dying Medical Practitioners.

(3) Initial discussions under section 4 may only take place with a registered medical practitioner if they are listed on the Register of Assisted Dying Medical Practitioners.

(4) Regulations made under subsection (1) must provide that the Register of Assisted Dying Medical Practitioners includes all registered practitioners other than those to whom the conditions in subsections (5) and (6) apply.

(5) The condition in this subsection is that only medical practitioners who have completed such training as required by the Secretary of State by regulation must be listed on the Register.

(6) The condition in this subsection is that only medical practitioners who wish to provide assistance under the Act must “opt in” to be listed on the Register.

(7) Regulations under subsection (1) and subsection (5) are subject to the affirmative procedure.

(8) Before making regulations under subsection (1) and subsection (5), the Secretary of State must consult such persons as they consider appropriate.

(9) Regulations under subsection (5) must be laid within six months of the passing of this Act.

(10) Regulations under subsection (1) must be laid within twelve months of the passing of this Act.”

This new clause requires the Secretary of State, by regulation, to create a Register of Assisted Dying Medical Practitioners. Only those who are on the register would be able to hold initial discussions or act as a co-ordinating or independent doctor, or hold initial discussions under section 4 of the Act. Only those who have had training as specified by the Secretary of State in regulations can be on the Register. Registered medical practitioners would only appear on the register if they had “opted in”.

Juliet Campbell: I will speak to amendments 125 and 126, which are linked to new clause 7. Given the discussion we have just had, and given that amendment 341 has been made, I will not push amendment 125 to a vote. Amendment 126, however, provides that any medical practitioner who wishes to provide assistance under the Bill must have opted in to a register or a service for practitioners who are comfortable with providing care related to assisted dying. In other conversations, my hon. Friend the Member for Spen Valley has said that the opt-in model is provided within the Bill. The challenge is that it is not explicit in the Bill, and I would like to see it so.

The BMA wrote in its evidence to the Committee:

“The Bill should be based on an ‘opt-in’ model, so that only those doctors who positively choose to participate are able to do so. Doctors who opt in to provide the service should also be able to choose which parts of the service they are willing to provide (e.g. assessing eligibility and/or prescribing for eligible patients)...An opt-in model is not explicit in the Bill...We urge the Committee to make it explicit in the Bill that this is an opt-in arrangement for doctors.”

The BMA says that it wants it explicit in the Bill, and at the moment it is not. The Royal College of General Practitioners aligned with this viewpoint, stating that an explicit opt-in system is completely necessary in the Bill. It is my hope that members of the Committee will support amendment 126, which I intend to push to a vote.

Kit Malthouse: I am afraid that I will disappoint the hon. Lady by rising to oppose her amendments, although I understand why she has tabled them.

It was clear from the BMA’s evidence that it opposes the creation of a list of registered providers, which the hon. Lady proposes to create with these amendments. The BMA’s opposition and my opposition are based on two or three—

Juliet Campbell: Based on the fact that we agreed on amendment 341, I am prepared not to press amendment 125 to a vote. It is amendment 126 that I am proposing.

Kit Malthouse: I understand that, but amendment 126 also refers to a register of appropriate medical practitioners being maintained. Of course, new clause 7 would similarly create such a list. We are debating all three proposals, so I wanted to explain why I oppose them, as indeed the BMA does.

As has been outlined in previous speeches, the Bill creates an opt-in model effectively, whereby people who want to be the co-ordinating doctor or indeed the second doctor have to opt in and be trained, and therefore become accredited, so by definition they would be approved for that service.

However, the Bill does not envisage that the initial conversation is necessarily with the co-ordinating doctor. There might well be other medical personnel or practitioners—we have talked a lot about semantics in this debate—who are presented with the situation where a desperate person, somebody who has been given some extremely bad news, wants to talk about their situation and what their options might be. We hope and believe that training will spread throughout the NHS to those who want it. Nevertheless, we have to leave open the option that someone may not be accredited and that they may need to pass on someone, by whatever means the Bill determines, to a doctor who is accredited, who

[*Kit Malthouse*]

can act as the co-ordinating doctor, who has had the appropriate training and opted in, and I am afraid the register would not allow for that.

The second thing that concerns me slightly, and which we need to avoid for the benefit of both the patient and the system, is any kind of “doctor shopping”—the notion that there is a list of doctors that I can shop around and choose from. I worry slightly about that.

My hope is that these types of conversations, which are necessarily private and sensitive, will take place in an environment of embrace and familiarity between doctor and patient. We have talked a bit about whether doctors have to refer or provide information—obviously, we have just accepted an amendment that seeks to set out how that will work. What I would oppose, for two reasons, is the creation of a list that people can move up and down on, and pick somebody they like the look of, or who they think might be handy for them. First, I am not sure that it would be entirely reputable; secondly, we have to remember who we are dealing with here. These are dying people who may not have long left to live—we are talking about six months as a minimum, but actually they might have only two or three months to go. We need to create a sense that this is something that will be provided to them in an environment that is familiar. They will not have to spend their time finding a doctor on a list, and their phone number, then ringing up their office and saying, “This is what I want to do. Can I make an appointment?” There is a privacy aspect to it.

My third objection is, to be honest, about privacy—not just that of the patient, but that of the doctor. The hon. Lady will know that unfortunately—I do not know whether she thinks it is unfortunate, but I do—there are some people who object so strongly, for example, to abortion that they are willing to go and protest outside clinics that provide that service. This House has legislated to balance the rights of those who want to avail themselves of that service and those who want to protest. That has been a source of conflict.

I am afraid that a public list of doctors who provide this service would raise questions about the privacy of doctors, about patient privacy and about access to that service. I am concerned about it from that point of view.

Naz Shah: I hear what the right hon. Member says, and I get his point, but we already have lists of specialists. With Choose and Book, for example, although it is for treatments, the NHS provides a list of doctors, so why would this be any different?

Kit Malthouse: We do not necessarily have specific registers. People are members of professional bodies, and within those professional bodies, people become accredited because of their training. As the Minister referred to earlier, there is no such thing as a list of palliative care specialists; it is not defined in that way. Creating a list in this way would present problems for the privacy of doctor and patient as they go about what I hope we all acknowledge is a very sensitive and private process at the very end of someone’s life. I will conclude at that point and say that, unfortunately, with great respect to the hon. Member for Broxtowe, I oppose these amendments.

4.30 pm

Stephen Kinnock: As amendments 125 and 126 are consequential on new clause 7, I shall speak to them as a whole and not in turn. The purpose of the amendments appears to be twofold. First, they seek to restrict the role of medical practitioners who can hold an initial discussion to those who have completed training. That training would be specified by the Secretary of State in regulations and would make them eligible to be listed on the register of assisted dying medical practitioners.

Secondly, the amendments seek to apply the same principle to the co-ordinating or independent doctor. In addition, they would place a duty on the Secretary of State to make regulations that would create the register to sit outside or alongside the current system of registration of medical practitioners and set out the training requirements to be eligible to be listed on the register.

Both sets of regulations are to be subject to the affirmative procedure, and the Secretary of State must consult such persons as they consider appropriate before making them. The regulations making provision for the relevant training requirements must be laid within six months of the passing of this Act. The regulations establishing the register must be laid within 12 months of the passing of the Act.

Although the purpose of the amendments is clear, our assessment suggests that the drafting would not achieve the desired effect, because the register would include only those doctors who have not undertaken the specified training or who have opted out of the assisted dying service. Additionally, the suggested timeframe for laying regulations is unworkable, given the need to work with regulators and the proposed duty to consult. There are also significant operability concerns regarding the creation of a new register for a subset of registered medical practitioners.

I hope that the Committee has found those observations helpful. I thank Members for their attention.

Kim Leadbeater: I have nothing to add.

The Chair: For clarity, amendment 125 is not being pressed to a Division, as I understand it. If the hon. Member for Broxtowe withdraws amendment 125, there will be an opportunity to vote on amendment 126 and new clause 7 later.

Juliet Campbell: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 288, in clause 4, page 2, line 36, at end insert—

“(6) All efforts to dissuade the person from ending their own life must be recorded in the clinical records and subsequently made available to the medical examiner.”—(*Sean Woodcock.*)

This amendment would require the coordinating doctor to record efforts to dissuade the person from taking their own life and subsequently make this available to the medical examiner.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 14.

Division No. 28]**AYES**

Campbell, Juliet
Francis, Daniel
Joseph, Sojan
Kruger, Danny

Olney, Sarah
Paul, Rebecca
Shah, Naz
Woodcock, Sean

NOES

Abbott, Jack
Atkinson, Lewis
Charalambous, Bambos
Green, Sarah
Hopkins, Rachel
Kinnock, Stephen
Leadbeater, Kim

Malthouse, rh Kit
Opher, Dr Simon
Richards, Jake
Sackman, Sarah
Saville Roberts, rh Liz
Shastri-Hurst, Dr Neil
Tidball, Dr Marie

Question accordingly negated.

Question proposed, That the clause, as amended, stand part of the Bill.

The Chair: I understand that the hon. Member for Reigate wishes to make a point on clause 4 stand part. I am minded to allow a debate on clause 4 stand part, but I remind hon. Members that I do not expect relitigating or rehashing. The debate will have a very narrow scope; it will not be an opportunity to rehash. The Question is simply whether the clause, as amended, should stand part of the Bill. With that caveat, I call Rebecca Paul.

Rebecca Paul: I very much appreciate the opportunity, Mr Dowd. I will attempt to be brief.

First, I welcome the acceptance of amendment 414, in the name of the hon. Member for Ipswich; of amendment 108, in the name of the hon. Member for East Thanet; of amendment 275, in the name of the hon. Member for Sunderland Central; and of amendment 341, in the name of my hon. Friend the Member for Sleaford and North Hykeham. The amendments strengthen the clause, so I thank Committee members for accepting them.

I have one pertinent point to put on the record about clause 4. The clause deals with what is and is not included in the initial discussion with registered medical practitioners, so the definition of assisted dying, as well as what it actually is, becomes relevant to understanding what guidance does and does not come into play. During these proceedings, there has been a tendency to speak as if assisted dying were another type of treatment or healthcare option being offered by medical practitioners, rather than a completely different and separate offering. It has been said many times that assisted dying should be treated in the same way as any other treatment and that the existing guidance from the GMC sets out appropriate best practice and should be applicable and relied on. I have some concerns about that, which I wish to put on the record.

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, so straightaway we have a conflict. Assisted dying ends the life of a person; it is not a treatment in the normal sense of the word. It is important that it is not a treatment, so that doctors are not obliged to offer it in the same way that they would offer another, more normal, medical treatment.

The Association for Palliative Medicine's written evidence covers the point:

"A crucial question is whether or not assisted death by lethal medication is considered to be a medical treatment. Given that doctors are required to assess eligibility for, prescribe, and be present at the administration of the medication, AD might be considered to be a 'medical treatment'. If this is the case then either assisted dying should be offered to all people meeting the eligibility criteria, or doctors need to behave differently towards this medical treatment than to all other treatments. Both of these approaches are contrary to all prior medical practice and public expectation, and laden with risks of unintended consequences.

The APM recommends that if AD is implemented in England & Wales it is done outside of 'usual medical practice' and is not regarded as medical treatment."

This is because there are detrimental consequences from classifying assisted dying as treatment and relying on guidance. First, it could undermine the doctor-patient relationship by confusing the distinction between healing and ending life. Patients who are used to looking to their caregivers for help may worry that they will instead be put on a pathway to an assisted death. That could deter them from seeking medical help when they need it. Dr Jamilla Hussain spoke powerfully on that point, so I will not repeat it.

Secondly, the word "treatment" currently has largely positive connotations. If the word starts to be used for assisted dying, its meaning will change entirely. I wonder about the intersection with other pieces of guidance and law that refer to treatment, for example where treatment can legally be given without the consent of the patient. We all agree that assisted dying should never be administered without consent, but that is why we must be careful with our language and definitions. In certain situations, treatment can lawfully be given without consent, so it must follow that, to protect against the risk of unintended consequences, assisted dying is not deemed to be a treatment.

I ask the Minister's view on that risk—I note that there is no reference in the Bill to assisted dying being a treatment, which is really good news—and his advice on how best to ensure that assisted dying is not and will never be considered a treatment as a consequence of the Bill or of any other statute or guidance. I also ask his view on the appropriateness of relying so heavily on GMC guidance for best practice, as I imagine that that guidance could change at any point without the consent of Parliament.

The Chair: At this point, I will not necessarily call Members, including the Minister, unless they particularly want to speak. If Members do wish to speak, will they please bob?

Danny Kruger: I think that we are just concluding one of the most important debates that the Committee will have: the debate on clause 4. I welcome the concession from the hon. Member for Spen Valley, particularly her commitment to modify the obligation to refer. That is welcome and will make the Bill a little safer.

In our debates on the clause, there has been clear confusion, as my hon. Friend the Member for Reigate has just mentioned, about the extent to which assisted dying is a healthcare treatment. That speaks to the question of whether there is an obligation on doctors to offer this treatment—as there should be, if it is a treatment

[*Danny Kruger*]

that is one of a range of options for which the patient is eligible—or whether it is something that they are not obliged to offer. That confusion, which was present in the Committee's exchanges, remains. I want to record in hon. Members' memory the fact that that question was unresolved. In my view, that is extremely unsatisfactory.

Despite some welcome concessions, the Committee has just decided to reject a series of amendments that would have protected both doctors and patients. Most concerning, we rejected an amendment to give children the right to be protected from the suggestion of an assisted death before they are even eligible for it.

I will conclude by referring to evidence, which I do not believe has been referred to so far in the debate, on the question of how assisted dying is received as a suggestion or offer, particularly by marginalised groups. I was very concerned by the oral evidence that we took from Professor Ahmedzai, who supports assisted dying. In written evidence, he has said explicitly that he especially wants the option to raise assisted dying with

“patients who are poorly educated, ill-informed or seem to be unaware of the option”.

He has explicitly required and requested the opportunity to put it to these disadvantaged, marginalised patients: “poorly-educated, ill-informed” people. Compassion in Dying, the sister organisation to Dignity in Dying, which supports the Bill, makes the same point: that marginalised people will need to be “directly prompted” with the offer.

I am afraid to say that, in rejecting the amendments, the Committee has endorsed the approach that people who are particularly marginalised and disadvantaged need to have this suggestion explicitly made to them. I am astonished that the Committee proposes to proceed on that basis, which completely misunderstands the dynamic of vulnerable people in the face of authority. I am very distressed to find that the Committee thinks that acceptable, and I am very sorry that apparently we are proceeding with the clause. I do not propose to put it to the vote, because the Committee's will to proceed is fairly clear, but I hope that everybody is fully aware of what they are doing.

4.45 pm

Naz Shah: I rise briefly to put on the record my disappointment. In our debates today on various amendments, we have discussed how some patients could see doctors' language as a suggestion rather than an option. I make no apologies for the fact that I said that this could be the next Horizon scandal or the next infected blood scandal. I struggle with that.

A chap called Nick Wallis, who exposed the Horizon scandal, said something pertinent that I want to put on the record. He said that the difference is that there will not be anybody else left to campaign—

The Chair: Order. I am genuinely trying to provide as much latitude as possible, but the Question before the Committee is whether the clause stands part of the Bill.

Naz Shah: Thank you, Mr Dowd. I will not oppose clause 4 stand part, but I put on the record my disappointment that we did not go further by putting in the safeguards that we had the option to add.

The Chair: For Members' benefit, as we are coming towards the end of the debate, let me say that I want people to be able to express their opinions as widely as possible, but it is also my responsibility as the Chair to ensure that that is contained within the parameters of our rules of debate.

Daniel Francis: Thank you for letting me speak, Mr Dowd. I will be brief.

As we reach the end of our debate on clause 4, I regret some of the decisions that we have made. I welcome the fact that in due course we will discuss amendment 418, in the name of my hon. Friend the Member for Spen Valley, which also relates to the preliminary conversation. My concern remains that it is “a” preliminary conversation, not, in my determination, “the” preliminary conversation. My amendments would have meant that “the” preliminary conversation could not be held before someone is 18. As I read amendment 418, someone could have preliminary conversations before they are 18; it is just that it will be recorded that there was a preliminary conversation after they turned 18. I regret that, as clause 4 now stands, the paperwork and initial discussion must be completed after someone is 18, but that will not necessarily apply to a preliminary conversation.

Equally, I have some regrets in relation to learning disability issues. I welcome the commitment from my hon. Friend the Member for Penistone and Stocksbridge on the amendment that she aims to bring forward, but I am conscious that it is not on the amendment paper for everybody to see. Just as she committed to work with me, I will continue to work with her on bringing it forward.

We have debated clause 4 long and hard, but I do believe that we have a clause that has loopholes in relation to people under 18 and to people with learning disabilities and autism. I will not press it to a Division, but I regret the fact that we have reached this place.

Question put and agreed to.

Clause 4, as amended, accordingly ordered to stand part of the Bill.

Clause 5

INITIAL REQUEST FOR ASSISTANCE: FIRST DECLARATION

Sarah Olney (Richmond Park) (LD): I beg to move amendment 271, in clause 5, page 3, line 5, at end insert—

“(1A) A person may not sign a first declaration within six months of being diagnosed with a condition which meets the requirements of section (2)(1)(a) unless they have received a psychosocial intervention in relation to their diagnosis with that condition.

(1B) The Secretary of State may, by regulations, create exceptions to the provisions of subsection (1A).

(1C) Regulations under subsection (1B) are subject to the affirmative procedure.”

This amendment would create a requirement that the person must have received a psychosocial intervention if a terminal diagnosis was received less than six months ago. The Secretary of State would be given a delegated power to create exceptions to such a requirement with regulations subject to the affirmative procedure.

The Chair: With this it will be convenient to discuss amendment 272, in clause 30, page 18, line 32, at end insert—

“(f) the form of the psychosocial intervention required under section 5(1A).”

This amendment is consequential on amendment 271, and would allow the Secretary of State to issue a code of practice in connection with the requirement for a psychosocial intervention.

Sarah Olney: I will not take up a huge amount of time, because a lot of what I wanted to say has been said in previous sittings, but I return to the issue of people who may request an assisted death who may also be suffering from a mental health condition. Amendment 271 was tabled by the right hon. Member for South West Wiltshire (Dr Murrison), and specifically concerns people who have received their terminal illness diagnosis less than six months ago and whose prognosis is less than 6 months in the future. The amendment specifically addresses the fact that the risk of suicide for people who are suffering from a terminal illness increases when the diagnosis has been made less than six months before.

Professor Louis Appleby is a key academic in the area of suicide prevention and advises the Government on it. Research by him and Professor Sleeman found:

“Diagnosis of severe conditions was associated with an increased risk of dying by suicide”.

In particular, they found:

“The increase in risk was more pronounced in the first six months after diagnosis or first treatment.”

They concluded that:

“A diagnosis of severe physical illness is associated with higher suicide risk. The interaction of physical and mental illness emphasises the importance of collaborative physical and mental health care in these patients.”

We talked at length in an earlier sitting about the risk that bringing in an assisted dying law would undermine suicide prevention strategies and efforts to address the issue of suicide. It is important that we return to this issue, and that we look seriously at the amendment in the name of the right hon. Member for South West Wiltshire, because it addresses the specific concern around those people who have had their diagnosis of terminal illness for less than six months and are therefore at a heightened risk of suicide.

NICE guidelines say that if someone is at risk of self-harm or suicide, a clinician must ensure that a psychosocial assessment has been carried out either by a mental health specialist or by a trained person in primary care. That should cover the person’s living arrangements, relationships, social support network, mental health disorders, risk factors, safeguarding concerns and so on. Professor Allan House told the Committee in oral evidence that this should be part of the assessment for assisted dying. He said the current assessment only answers the question:

“‘Is this person able to make decisions?’...it does not cover the psychological and social assessment.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 29 January 2025; c. 165, Q210.]

We have discussed at length the lack of the psychosocial assessment in relation to everybody who makes a request for an assisted death, but the amendment seeks to identify those who are at heightened risk of suicide—those who have received their diagnosis of terminal illness within the last six months—and specifically requires psychosocial assessments for those people.

Depression is common among those with terminal illness. Dr Price from the Royal College of Psychiatrists told the Committee that among

“people nearing the end of life...depression is...at around 20%—much more common than in the general population. We know that depression is strongly associated with a wish to hasten death”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 275, Q359.]

and that that wish is significantly alleviated if depression is treated, which is an extremely important point for the Committee to consider.

The Pathfinders Neuromuscular Alliance, which is a user-led charity for those with muscle-weakening conditions such as muscular dystrophy, have stated in written evidence:

“Pathfinders members have outlined how important it is to ensure psychological assessments are part of the process in order to ensure that the individual is in a position to make an informed decision. One member outlined:

‘I’ve been there, I’ve wanted to die, and I’ve been in the position where I would take that option if it was given to me, but looking back I can see I was depressed and now I’m so glad that I didn’t take that option.’”

Currently, the Bill does not require anyone to explore any psychosocial factors in respect of someone’s situation. Although the person can be referred to a psychiatrist under clause 9(3), that only covers a capacity assessment. Again, it only answers the question of whether the person is able to make decisions, and addresses none of the other relevant factors. In Oregon, there is more room to explore those factors—the doctor may refer a patient for counselling if the patient may be suffering from a psychiatric or psychological disorder or depression, causing impaired judgment.

On addressing the risk of social pressure and internalised feelings of burden, the British Geriatrics Society warned in its written evidence:

“There is an established link between frailty and feeling a burden to others, meaning many older people with treatable clinical frailty may choose an assisted death to avoid burdening their family, which we view as unacceptable.”

The Committee has already discussed at length the issue of older people or people with a terminal illness wishing to choose an assisted death motivated by the wish to save their family money. Dr Jerram, Dr Wagland and Dr Davis found that attitudes towards assisted dying changed over time. Patients closest to death were least likely to want assisted dying, suggesting that fear of suffering was the driving cause and that it may lessen as end of life care improves.

Psychosocial care is fundamental to good end-of-life care. Committee members and witnesses from other jurisdictions have said that palliative care and assisted dying can complement each other, and that assessment should be part of the picture. Glyn Berry told the Committee about the importance of

“the psychosocial aspect of palliative and end-of-life care”.—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 53, Q58.]

In its written evidence, the British Association of Social Workers said that

“good health care is not just about clinical interventions”, but also about

“the wider social context in which a person lives their life...This is particularly pertinent with assisted dying.”

That needs to come before the first declaration, because once somebody has signed that declaration, they are

[Sarah Olney]

already on a pathway. The amendment would provide an opportunity for people's needs to be met at the first opportunity.

In conclusion, I emphasise the importance of a psychosocial intervention, which was stressed by a number of witnesses giving oral evidence to the Committee. We have discussed this issue at length. Earlier amendments have been voted down, but I stress the particular importance of the amendment 271 for that group of people who are in the first months of their diagnosis of a terminal illness and the raised level of risk of suicide that they present.

Sojan Joseph: As the hon. Member for Richmond Park says, we have repeatedly debated people's mental health and how, once somebody has had a diagnosis of a terminal illness, it can have an impact on their decision making. Amendment 425, which we discussed earlier, is about having access to a multidisciplinary team. That team could have on it a social worker or a psychiatrist who would make a comprehensive assessment, which would cover amendment 271.

The amendment is an opportunity for the Committee to look into this issue, to make the Bill stronger, and to bring in safeguards for vulnerable people who may feel suicidal, and may feel a burden to society or to the healthcare system, and may choose this way. Those people who are vulnerable would have a psychosocial and mental health assessment, which would make the Bill stronger and safer.

Lewis Atkinson: I rise to speak against the amendment; there are significant issues with it both in practice and in principle. In terms of practice, I draw Members' attention to the fact that the amendment does not mention a psychosocial assessment; it mentions mandating "a psychosocial intervention". As defined by the World Health Organisation, a psychosocial intervention can be as brief as five minutes. I know that it is a brief intervention: I used to manage services delivering psychosocial interventions. Nowhere in the amendment is the type of psychosocial intervention or its purpose specified. If Members hope that the amendment will lead to a psychosocial assessment—

Sarah Olney: For clarity, if the amendment specified a psychosocial assessment, would the hon. Gentleman be minded to support it?

Lewis Atkinson: The holistic assessment is already set out elsewhere in the Bill, so the amendment is not required. Amendment 275, which we made to clause 4, requires "all appropriate" psychological support to have been discussed with an individual in advance of the first declaration. I clearly supported that amendment, and I am very grateful that the Committee did.

From a practical point of view, amendment 271 talks about six months from the point of diagnosis, but if I had prostate cancer, I might have had prostate cancer for absolutely years—so is it six months from the point of being diagnosed with prostate cancer or six months from the point of being told that that is terminal? There

are a huge range of practical issues with the amendment as currently written, but there are also issues regarding the principle as well.

5 pm

Fundamentally the amendment starts with the assumption that there is something psychologically wrong with a person if they have received a terminal diagnosis, and that they need to be persuaded of the fact that exploring their options is not the right thing to do. That is fundamentally wrong. There are genuine issues and concerns around the tragedy of suicide in all cases where it occurs. But in the instance following terminal diagnosis, as the hon. Lady set out, a prevention strategy should not start by assuming that everyone requires a psychosocial intervention regardless of screening, risk factors or any assessment.

Sarah Olney: Would the hon. Gentleman not accept that a terminal illness in itself is a risk factor for an increased risk of suicide, and also that that risk is increased in the first six months following the diagnosis? That is the thinking behind the amendment.

Lewis Atkinson: I accept that that is a risk factor, but it is by no means determinative. Therefore, that risk factor has to be considered in the round with other risk factors such as levels of family and social support. As set out, the amendment does not distinguish between someone receiving a terminal diagnosis by themselves without any support network, and someone who expects to receive a terminal diagnosis at the end of a very long illness. As a point of principle I do not accept that we should mandate psychosocial interventions or that people must receive a level of healthcare in order for them to access other options related to their care—let alone the practicalities, which I have laid out, about when the provision would apply in relation to diagnosis and the fact that it is an intervention, which is in no way an assessment or any such thing.

Stephen Kinnock: I have made it clear throughout the debate that I am not offering a Government view on the merits of amendments. My remarks are focused much more on the legal and practical impacts of amendments, to assist Members in undertaking line-by-line scrutiny.

The amendments were tabled by the right hon. Member for South West Wiltshire. They would create a further eligibility requirement of the person seeking assistance under the Bill. Amendment 271 and 272 would limit those eligible to seek assistance to end their own life, in circumstances where their terminal diagnosis was received less than six months prior to the date on which the person signs the first declaration, to those who have received a psychosocial intervention. This would be subject to any exceptions provided for by the Secretary of State in regulations. Amendment 271 does not define what is meant by "received a psychosocial intervention" in relation to their diagnosis.

The term "intervention" is usually employed in the health service to mean the provision of support or treatment. This is different from, for example, an assessment that a clinician might undertake to assess whether an intervention may be required. While there is not a standard definition of psychosocial intervention, we understand it to mean psychosocial interventions such as cognitive behavioural therapy. The amendment could

create uncertainty as to what type of treatment a person will need to undergo to satisfy the requirement. If a person who would otherwise seek assistance to end their own life under the Bill is unable to, or does not wish to, receive a psychosocial intervention, unless an exemption applies, they may need to delay starting the assisted dying process until at least six months has elapsed from their terminal diagnosis. That could be challenging in circumstances where the terminal diagnosis has a prognosis of six months or less.

The amendment would also introduce a requirement for people in certain contexts to undergo an intervention that could undermine a person's autonomy in making their own treatment decisions. Were the amendment made, it would confer a regulation-making power on the Secretary of State to create exceptions to the proposed provisions on psychosocial intervention. Regulations made using this power would be subject to the affirmative procedure. It would also give the Secretary of State the power to issue a code of practice in connection with the form of the psychosocial intervention required.

If the Committee decides to accept the amendment, further consideration would be needed on Report to ensure that it is operationally deliverable, and my earlier comments about the definition of psychosocial intervention and other comments would have to be clarified. The Government would, of course, stand ready to assist were the amendment to pass.

As I said earlier, the Government have taken a neutral position on the substantive policy questions relevant to how the law in this area could be changed—as I have made clear, that is a matter for this Committee and for Parliament as a whole. However, I hope that these observations have been helpful, and thank the Committee for its attention.

Kim Leadbeater: I have nothing to add, other than to associate myself with the comments of my hon. Friend the Member for Sunderland Central and those of the Minister.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 16.

Division No. 29]

AYES

Campbell, Juliet	Kruger, Danny
Joseph, Sojan	Olney, Sarah

NOES

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Paul, Rebecca
Francis, Daniel	Saville Roberts, rh Liz
Green, Sarah	Shah, Naz
Hopkins, Rachel	Shastri-Hurst, Dr Neil
Kinnock, Stephen	Tidball, Dr Marie
Leadbeater, Kim	Woodcock, Sean

Question accordingly negated.

Kim Leadbeater: I beg to move amendment 184, in clause 5, page 3, line 7, leave out “Schedule 1” and insert “regulations made by the Secretary of State”.

This amendment provides that the form of a first declaration is to be set out in regulations (rather than in Schedule 1).

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

Amendment 289, in clause 5, page 3, line 11, leave out “another person” and insert “another registered clinician”.

This amendment ensures that the second witness is a registered clinician.

Amendment 418, in clause 5, page 3, line 12, at end insert—

“(2A) Regulations under subsection (2)(a) must provide that the first declaration contains—

- (a) the following information—
 - (i) the person's full name and address;
 - (ii) the person's NHS number;
 - (iii) contact details for the person's GP practice;
 - (b) the following further declarations by the person—
 - (i) a declaration that they meet the initial conditions for eligibility (see subsection (2B));
 - (ii) 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;
- section 4(4)(a)
- (iii) a declaration that they are content to be assessed, for the purposes of this Act, by medical practitioners;
 - (iv) a declaration that they are making the first declaration voluntarily and have not been coerced or pressured by any other person into making it;
 - (v) a declaration that they understand that they may cancel the first declaration at any time.

(2B) In subsection (2A)(b)(i) ‘the initial conditions for eligibility’ are that the person making the declaration—

- (a) is aged 18 or over,
- (b) is ordinarily resident in England and Wales and has been so resident for at least 12 months, and
- (c) is registered with a general medical practice in England or Wales.”

This amendment makes provision about the content of regulations under subsection (2)(a), which will set out the form of the first declaration.

Amendment 277, in clause 5, page 3, line 12, at end insert—

“(2A) A person may not make a first declaration under subsection (1) until 28 days have elapsed, beginning with the day they received a diagnosis of the terminal illness.”

This amendment would mean a person could not make the first declaration until 28 days from the day they received a diagnosis of the terminal illness.

Amendment 420, in clause 7, page 4, line 16, leave out subsection (3) and insert—

“(3) After carrying out the first assessment, the coordinating doctor must—

- (a) make a report about the assessment (which must meet the requirements of regulations under subsection (4));
- (b) give a copy of the report to—
 - (i) the person who was assessed (‘the assessed person’),
 - (ii) if the coordinating doctor is not a practitioner with the person's GP practice, a registered medical practitioner with that practice, and

- (iii) any other person specified in regulations made by the Secretary of State;
- (c) if satisfied as to all of the matters mentioned in subsection (2)(a) to (g), refer the assessed person to another registered medical practitioner who meets the requirements of section 8(6) and is able and willing to carry out the second assessment ('the independent doctor').
- (4) The Secretary of State must by regulations make provision about the content and form of the report.
- (5) The regulations must provide that the report must—
 - (a) contain a statement indicating whether the coordinating doctor is satisfied as to all of the matters mentioned in subsection (2)(a) to (g);
 - (b) contain an explanation of why the coordinating doctor is, or (as the case may be) is not, so satisfied;
 - (c) contain a statement indicating whether the coordinating doctor is satisfied as to the following—
 - (i) that a record of the preliminary discussion has been included in the person's medical records;
 - (ii) that the making of the first declaration has been recorded in the person's medical records;
 - (iii) that the first declaration has not been cancelled;
 - (d) be signed and dated by the coordinating doctor."

This amendment requires the coordinating doctor to make a report about the first assessment, and (if satisfied of the matters mentioned in subsection (2)) to refer the person to another practitioner for the second assessment.

Amendment 195, in clause 8, page 4, line 40, leave out "statement" and insert "report".

This amendment is consequential on Amendment 420.

Amendment 209, in clause 16, page 11, line 8, leave out paragraphs (b) and (c) and insert—

- "(b) a report about the first assessment of a person is made under section 7;
- (c) a report about the second assessment of a person is made under section 8;"

This amendment is consequential on Amendments 420 and 421.

Amendment 220, in clause 34, page 20, line 36, leave out paragraphs (a) and (b) and insert—

- "(a) a report about the first assessment of a person does not contain a statement indicating that the coordinating doctor is satisfied as to all of the matters mentioned in section 7(2)(a) to (g);
- (b) a report about the second assessment of a person does not contain a statement indicating that the independent doctor is satisfied as to all of the matters mentioned in section 8(2)(a) to (e);"

Amendment 421, in clause 8, page 5, line 4, leave out subsection (5) and insert—

- "(5) After carrying out the second assessment, the independent doctor must—
 - (a) make a report about the assessment (which must meet the requirements of regulations under subsection (5A)), and
 - (b) give a copy of the report to—
 - (i) the person who was assessed,
 - (ii) the coordinating doctor,
 - (iii) if neither the independent doctor nor the coordinating doctor is a practitioner with the person's GP practice, a registered medical practitioner with that practice, and
 - (iv) any other person specified in regulations made by the Secretary of State.

(5A) The Secretary of State must by regulations make provision about the content and form of the report.

(5B) The regulations must provide that the report must—

- (a) contain a statement indicating whether the independent doctor is satisfied as to all of the matters mentioned in subsection (2)(a) to (e);
- (b) contain an explanation of why the independent doctor is, or (as the case may be) is not, so satisfied;
- (c) contain a statement indicating whether the independent doctor is satisfied as to the following—
 - (i) that a record of the preliminary discussion has been included in the person's medical records;
 - (ii) that the person signed the first declaration;
 - (iii) that the making of the first declaration has been recorded in the person's medical records;
 - (iv) that the first declaration has not been cancelled;
- (d) be signed and dated by the independent doctor."

This amendment provides that the independent doctor must make a report about the second assessment, and makes provision about the report.

Amendment 203, in clause 10, page 6, line 42, at end insert—

- "(A1) This section applies where the independent doctor has—
 - (a) carried out the second assessment, and
 - (b) made a report stating that they are not satisfied as to all of the matters mentioned in section 8(2)(a) to (e)."

This amendment is consequential on Amendment 421.

Amendment 204, in clause 10, page 6, line 43, leave out from beginning to second "the" in line 44.

This amendment is consequential on Amendment 203.

Amendment 329, in clause 13, page 9, line 20, leave out paragraph (a).

This amendment removes the reference to Schedule 4 from the clause and is linked to Amendment 330.

Amendment 207, in clause 13, page 9, line 20, leave out "Schedule 4" and insert

"regulations made by the Secretary of State".

This amendment provides that the form of a second declaration is to be set out in regulations (rather than in Schedule 4).

Amendment 330, in clause 13, page 9, line 26, at end insert—

- "(3A) A second declaration must include the following information—
 - (a) the name and address of the person;
 - (b) the NHS number of the person;
 - (c) the contact details for the general medical practice at which the person is registered;
 - (d) a declaration by the person that they have made a first declaration under this Act;
 - (e) a declaration by the person that the assessing doctors have made the appropriate declarations under this Act together with the dates of those declarations;
 - (f) the details of the declaration made by the High Court or Court of Appeal;
 - (g) a declaration by the person they are eligible to end their life under this Act;
 - (h) a declaration by the person that they wish to be provided with assistance to end their own life under this Act;

- (i) a declaration by the person that they understand that they must make this second declaration under the Act and that they do so voluntarily and have not been coerced or pressured by any other person into making it.
- (j) a declaration that they understand that they can cancel their declaration at any time.
- (k) any other information or signed declarations as may be set out by the Secretary of State in regulations.

(3B) Any regulations made under subsection (3A) are subject to the negative procedure.”

This amendment sets out the requirements for the second declaration by the person and is linked to Amendment 329.

Amendment 331, in clause 13, page 9, line 38, leave out paragraph (a).

This amendment removes the reference to Schedule 5 from the Bill.

Amendment 208, in clause 13, page 9, line 38, leave out “Schedule 5” and insert

“regulations made by the Secretary of State”.

This amendment provides that the form of a statement by the coordinating doctor following the making of the second declaration is to be set out in regulations (rather than in Schedule 5).

Amendment 332, in clause 13, page 9, line 41, at end insert—

“(6A) A statement made under subsection (6) must include the following information—

- (a) a declaration by the coordinating doctor that the person is terminally ill within the meaning of this Act and the nature of the relevant illness, disease or medical condition,
- (b) details of any relevant declaration made by the High Court or Court of Appeal;
- (c) a declaration that the coordinating doctor is of the opinion that the person’s death is either likely or unlikely to occur before the end of the period of one month beginning with the day on which the declaration was made by the High Court or Court of Appeal under this Act;
- (d) a declaration that the coordinating doctor is satisfied that the requirements of this Act regarding any period of reflection has been met;
- (e) a declaration that the person requesting assistance under the Act has the capacity to do so, and that they have a clear, settled and informed wish to end their own life;
- (f) a declaration that neither the first or second declarations by the person have been cancelled;
- (g) any other information or signed declarations as may be set out by the Secretary of State in regulations.

(6B) Any regulations made under subsection (3A) are subject to the negative procedure.”

This amendment sets out the requirements for the second statement by the coordinating doctor and is linked to Amendment 331.

Amendment 333, in clause 21, page 14, line 9, leave out paragraph (a).

This amendment leaves out reference to Schedule 6 and is linked to Amendment 330.

Amendment 214, in clause 21, page 14, line 9, leave out “Schedule 6” and insert

“regulations made by the Secretary of State”.

This amendment provides that the form of a final statement is to be set out in regulations (rather than in Schedule 6).

Amendment 334, in clause 21, page 14, line 10, at end insert—

“(3A) The statement mentioned in subsection (2) must include—

- (a) the contact details of the coordinating doctor;
- (b) the name, NHS number and medical practice of the person given assistance under the Act;
- (c) a declaration that the person was provided with assistance to end their own life in accordance with this Act;
- (d) the date of any declarations made by the person under this Act;
- (e) the date of any statements made by assessing medical practitioners under this Act;
- (f) the details of the advanced and progressive condition the person had;
- (g) the approved substance provided;
- (h) the date and time of death;
- (i) the time between use of the approved substance and death;
- (j) any other information or signed declarations as may be set out by the Secretary of State in regulations.

(3B) Any regulations made under subsection (3A) are subject to the negative procedure.”

This amendment sets out the information that must be included in a final statement under this Act and is linked to Amendment 333.

Amendment 403, in schedule 1, page 25, line 25, at end insert—

“7. I have—

1. informed my family of my wish to be provided with assistance to end my life and taken their opinions into consideration
2. decided not to inform my family of my decision
3. no family to inform of my decision”.

Amendment 404, in schedule 4, page 29, line 7, at end insert—

“10. I have—

1. informed my family of my wish to be provided with assistance to end my life and taken their opinions into consideration
2. decided not to inform my family of my decision
3. no family to inform of my decision”.

Kim Leadbeater: I rise to support my amendments in this group, which seek to clarify the details that must be included, under regulations, in the first declaration, and the report that is consequent on that declaration. While I believe it was useful on Second Reading for MPs to be aware of the content of the form that the doctor should complete, the advice I have received—with which I agree—is that the details are more appropriately a matter for regulations. There is always a balance to be struck, but it would not be reasonable to expect the House to have to consider changes in primary legislation simply to alter the contents of a declaration, important though the details are.

The proposed changes go further in a way that I believe should greatly reassure the Committee. As we discussed this morning, they make it clear that a person must have been over the age of 18 when the first discussion under the Bill took place. They also require doctors not just to make formal declarations, but to produce reports covering the eligibility of the person to request assistance, the nature of the assessments they have made, their discussions with that person and,

[*Kim Leadbeater*]

crucially, the person's understanding of those discussions and of what the process entails. This will ensure that all the relevant discussions have been recorded and understood, and that an account of them has been recorded and will be available for future reference. For reporting purposes, if a person applying for assistance is found not to be eligible, that information will be recorded too. I hope the Committee will agree that further safeguards will be put in place as a result, without imposing additional stress or burdens on terminally ill patients during such a different period.

Kit Malthouse: I rise to speak in support of amendment 184 and to point out that I have now withdrawn amendments 329 to 334, so we will not vote on them later. Like the hon. Member for Spen Valley, I had thought that although it was sensible at Second Reading to have schedules to the Bill that laid out the forms, they were quite limited and strict in their form, so we needed more flexibility and the opportunity for the House, by regulation, to add content to the required forms in the future. I also wanted to insert a declaration by the person that they had had an initial conversation covering all the factors in the Bill and, critically, that they understood the information that had been presented to them. Amendment 184 would do exactly that.

For Members' reference, I tabled similar amendments that would have done the same with the other schedules. Following conversations with the hon. Member for Spen Valley, I have now withdrawn them all and amalgamated them into amendments that would do the same as those that she has tabled, along with some additional bits and pieces. Amendment 184 is relatively self-explanatory.

I want to speak against amendment 277, which would impose a time limit of 28 days between diagnosis and the first declaration of a terminal illness. In a lot of circumstances, that would be a very difficult time delay for people to face. As the hon. Member for Bradford West, who tabled the amendment, will know, there are already periods of reflection in the Bill, although it also contains provision for a compressed time limit for those who face imminent death. Particularly for those who are unfortunately diagnosed with certain diseases, adding 28 days will insert a delay at a time when people who are facing what they do not want to face—a horrible death—need as much time as they can to get through the process. For example, if we take together all the factors for people who are sadly diagnosed with pancreatic cancer, the median survival is six to 12 months.

I do not know if the hon. Lady knows this, but pancreatic cancer is a particularly unpleasant cancer, not least because it does not exhibit symptoms in its early stages—people do not know they have it until quite late in its development. Treatment for it is not well advanced, and many people diagnosed with pancreatic cancer sometimes have only weeks to live. The idea that we should make them wait 28 days before they can even start the process seems impractical and, I am sorry to say, cruel to them in many ways. It is worth remembering that this is not a six-month “bang, I go and do it.” Most people who have a terminal illness will begin the application process at six months. Once they have the ability to ask for this service, they will then wait until they decide that

their life has come to its end, at the time and place of their choosing. That might be at six months, or it might be at six days. The point of the Bill is to put the power to make that decision in their hands. Although the Bill has periods of reflection—it recognises that people need to sit and think about these things—imposing an absolute 28 days on everybody, without accounting for what stage they are at in their disease and how long they have to live, is not necessarily a sensible amendment, and I will oppose it from that point of view.

I understand the objective of my hon. Friend the Member for East Wiltshire in tabling amendments 403 and 404, which are about informing family. I would hope that those are the sorts of discussions that doctors would have—perhaps one of the doctors on the Committee can tell us. On whether we should put that on the face of the Bill, I have been persistent in trying to make sure that the conversation is not guarded. The amendments ask whether I have any family—I am not quite sure what “family” means. Does it mean my children? Maybe I do not want to tell my children. Does it mean my next of kin? I do not know. Is it distant relatives? Is it my whole family? There are problems with the definition of “family”.

While I will not support the amendment, I understand what my hon. Friend was trying to do. I would hope that those are the kinds of sensitive matters that a doctor would tease out of an individual as they look for the various items that we have put in the Bill to make sure that the person is making the decision on a sound basis as a settled view and has the capacity to do so.

5.15 pm

Danny Kruger: I am grateful for the points made by my right hon. Friend the Member for North West Hampshire. I will speak briefly to amendments 403 and 404, which would create an expectation that a patient at least addresses the question of whether their family is aware of the decision they are making. In an amendment that has not been selected for debate today, I proposed simply to make that expectation clear.

My personal view is that I do not accept that this is healthcare, and therefore that a doctor would have an obligation to ensure that the next of kin of somebody to whom they are proposing to give lethal drugs is informed. However, in the spirit of the Bill, which is all about autonomy, and in an attempt to be constructive and put forward amendments that might be accepted, I accept that this is a decision for the individual in the same way as a healthcare decision, and that there is therefore no obligation under rules of patient confidentiality and the expectations around healthcare that the family should be informed.

Nevertheless, creating a moment at which the first doctor the patient speaks to gently encourages them to consider telling their family before taking the enormous step of signing the first declaration is appropriate. The amendment would give the patient three options: first, to confirm that they have informed their family of their wish to be provided with assistance to end their life.

The Chair: Order. I understand that the hon. Gentleman wants to touch on that amendment, but it has not been chosen today. He is talking about the declaration that

the person has informed their family of their decision and taken their opinions into consideration. We are not dealing with that today.

Danny Kruger: Nevertheless, amendments 403 and 404 have been selected for debate, and it is those amendments that would effect that declaration in the Bill.

The Chair: I ask the hon. Gentleman to take the spirit of what I am saying into account.

Danny Kruger: I am grateful to you, Mr Dowd, but I want to explain why these amendments are appropriate to the Bill.

The patient would have the opportunity to declare clearly that they do not have a family. I take the point made by my right hon. Friend the Member for North West Hampshire; it is not always clear what a family is. Nevertheless, if the patient wants to specify that they have no family or do not want to inform their family, the amendments would give them that right. I want to emphasise the importance of this consideration. I recognise that clause 9, which will come later in the process, includes consideration of the family. It states that, in so far as the assessing doctor considers it appropriate, they may advise the patient to inform their family, so there is recognition of that question a little later. My suggestion is that it should come earlier because it needs to take place before the first declaration is signed.

Crucially, we need to consider the wider impact of not considering or involving the family, particularly when children or dependants are involved. The Bill accepts the scenario where a family can find out after the fact—not through any formal notification, they just discover—that their loved one has ended their life with the help of doctors and the state. Families can be badly impacted by an assisted suicide: clinical grief disorders, depression and post-traumatic stress disorder are all harms that can follow from a family member taking an assisted death. It is unethical and irresponsible not to factor that in as we discuss and design the new law.

A parent may choose to end their life under the Bill, but is not required in any way to consider notifying their family. I wonder if the sponsor could clarify what would happen if they were the sole carer of a minor—would there be an obligation for anyone to inform the child that this was happening? One hopes that that would be an extremely rare scenario; nevertheless, it is possible under the Bill.

I want to mention two more groups quickly. In written evidence, a group of anorexia nervosa sufferers and carers said:

“The Bill does not anticipate situations where someone seeks to end their life as a result of cognitive symptoms inherent to the illness, as is the case with AN. For these patients, families would often be needed to advocate for their loved ones and their potential to recover... Without family involvement, patients may make decisions in isolation, potentially influenced by cognitive distortions or feelings of hopelessness inherent to the illness.”

I hope that we do not want to allow that scenario.

Finally, Dr Jamilla Hussain, who we have heard from a few times, said in written evidence that in her “consultation with structurally disadvantaged ethnic minority groups”—

which include Pakistani, Roma and Black Caribbean community groups, they showed much concern about the exclusion of families. She said:

“it was emphasised that, traditionally, family and community members provide hope and strength when someone feels like life is too much. There is apprehension that such expressions of care and support could be reframed through a medical or legal lens as coercion.”

That is the saddest thing, which was hinted at quite strongly—in fact, stated explicitly—in some of the evidence sessions. It has been suggested that wanting a loved one to live is seen by doctors as a form of coercion that should be resisted; that trying to argue a loved one out of an assisted death is the coercion that we need to guard against and, on that basis, we should not be making any expectation that families are informed. What a tragic thing for us to say. To enable doctors to issue lethal drugs that kill people without their family knowing is an absolutely tragic thing. I beg the Committee to consider what on earth we are doing allowing that.

The Chair: I apologise to the Member, who was within his rights to speak to amendments 403 and 404.

Naz Shah: I rise to speak to my amendment 277, which would add a new subsection to clause 5. Like my amendment 276, it would alter the time that must elapse between a person receiving a diagnosis of severe illness and their discussion of assisted dying with a medical practitioner. To put the most important point first, the amendment aims to prevent people opting for assisted dying while they are suffering from the initial shock of having a serious illness diagnosed, by imposing a pause. There would have to be 28 days between when a person receives a diagnosis and prognosis of the illness that might end their life within six months, and when they could have their second consultation with a doctor about assisted dying.

The right hon. Member for North West Hampshire asked me whether I was aware of pancreatic cancer. A dear friend of mine, who was known as the “king of curry” in Bradford, told me only in June—the day I launched my election campaign, funnily enough—that he had been diagnosed with terminal cancer. In October, he was gone. I am overly familiar with pancreatic cancer and how fast he went down from being a healthy individual. He is greatly missed in Bradford.

The Committee has already rejected amendment 276. I ask all Members to think again and in particular to consider the evidence given to us by several distinguished doctors, including senior psychiatrists. What those doctors said to us, in both written and spoken evidence, was that immediately after someone receives a diagnosis of serious illness they often experience a major increase in depression and a desire to hasten death. For some patients, that desire to hasten death is what psychiatrists call an increase in suicidality; that is, the patient wants to actively do something to end their own life. For other patients, they do not have an active desire to carry out a physical act to end their life, but they do wish that their life would end sooner.

We can all empathise with people who have just received such a shocking diagnosis and prognosis. They have been told that they are likely to die soon. They may also either have been given information that makes them think their remaining months of life will be degrading

[Naz Shah]

and painful, or they may assume that they will be. That might well be how many of us would think if we had such devastating news. But the psychiatrists who gave evidence also said that depression and a desire for death are often not permanent conditions for people who have received such a diagnosis. When a patient gets treatment for their physical symptoms plus social care, and if necessary psychological treatment, the desire to hasten death will often fall.

Let me refer to the evidence of Dr Annabel Price, vice chair of the Royal College of Psychiatrists Liaison Faculty. I appreciate, Mr Dowd, that I am repeating some things I have mentioned previously, but when I spoke previously with reference to this evidence it was to other amendments. Hence, I am having to repeat it for the purpose of this amendment in particular. She said:

“There is a lot of research evidence around depression in people with palliative care needs and people nearing the end of life. We know that depression is common, and across a number of studies it is at around 20%—much more common than in the general population. We know that depression is strongly associated with a wish to hasten death, and that if depression is found and treated in that group of patients, there will be significant change in the wish to hasten death.”

She said that there were a number of factors besides depression that were associated with the wish to hasten death. In those who had received a diagnosis of serious illness, she told us:

“they include difficult symptom experience, poor functional status—needing a lot of help with things—and being socially isolated. Those are really key ones. They also include a sense of loss of dignity and feeling like a burden on others.”

For patients who have all those factors, she said:

“These things can all come together to make life feel very unbearable.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 275, Q359.]

Perhaps the most important part of Dr Price’s evidence was when she said what good medical and social care could do for people who felt their lives were unbearable. She said:

“The evidence that we have from research—this is in populations who would fulfil the criteria in terms of terminal illness—is that the prevalence of depression is around 20%. That is across a number of populations. It is associated with a wish to hasten death. Depression might impact upon that person’s decision making; I am not saying that it absolutely would, but it might. Also, treatment might change their view. We know that there is a strong association, for example, between pain and a wish to hasten death.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 281, Q369.]

Kit Malthouse: On a point of order, Mr Dowd. I am very sorry, but I just want your guidance. The hon. Lady is giving a speech which I am afraid we have covered before. We have had extensive debates on the impact of terminal diagnosis on people’s mental health and depression. I just want your guidance on what the Committee should do to resist the temptation to repeat debates that we have already had extensively, while we are considering these amendments.

The Chair: I thank the right hon. Gentleman for that point of order. I reiterate the point I have made on a number of occasions. I do not want to interrupt Members when they are making a point, because we are in a very

sensitive situation—of that there is no doubt. I exhort Members, when they are discussing these things, to bear in mind those factors and those issues.

Naz Shah: Thank you, Mr Dowd. Before I carry on, may I just add to that? I did refer to that and I appreciate the right hon. Gentleman’s point of order, but these things speak to this particular amendment on 28 days. While they speak to many other debates, the Committee will have no doubt that there are many issues in which one piece of evidence crosses over many amendments. I assure the Committee that my intention is just to draw attention to the evidence that is related to the particular amendment that I am speaking to. I appreciate there that there is huge repetition—for want of a better word—but I feel that it is necessary, unless advised otherwise. I would be happy to take your guidance, Mr Dowd.

5.30 pm

As I was saying, we know that there is a strong association between pain and a wish to hasten death. I am still quoting Dr Price, and I ask Committee members to listen very carefully to this next part. She said:

“Unresolved physical symptoms make people want to die, and when that pain is better, people no longer feel that way. That is borne out in my clinical practice. We will get urgent referrals to see somebody who wants to die and who they are very concerned about. Then the pain is under control: we see them that day or the next day and they say, “Do you know what? The pain’s better. I don’t feel like that any more.” When we think about symptoms, we need to think carefully about what is treatable and what is remediable. That may be about psychiatric interventions, but it is often about a biological, psychological and social approach.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 281, Q369.]

We need to consider those words from an experienced psychiatrist very carefully. She is telling us what psychiatrists as a profession have learned from rigorous large-scale studies of people who have been given diagnoses of serious illness. That is what she has seen in her own practice as a psychiatrist.

The Bill should give patients who have been diagnosed with serious illness and prognosed with six months to live the time to think about whether they want assisted dying. As Dr Price told us, it should give patients, doctors and the social care authorities enough time to put the right medical and care treatment in place. If we look in detail at the Bill, I am afraid that we have to conclude that it does not do that. That is why I am asking all Members to consider voting for my amendment.

When the Committee discussed amendment 276, prior to rejecting it, my hon. Friend the Member for Stroud rejected the need for a 28-day waiting period. To quote from *Hansard*, he said:

“With the panel also involved, there will be more than a month between the first time the patient sees a doctor and when they actually get a decision that they can end their life. I do think that that protects. I would support amendment 276, because it is important that people do not say, “Right—I would like my life to end now” and not to give due consideration, but due consideration is already written into the Bill.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 26 February 2025; c. 649.]

I thank my hon. Friend for those thoughtful and courteous words, but I want to explain why I disagree with his reasoning. As I understand it, if the Committee accepts

the amendments tabled by my hon. Friend the Member for Spen Valley that would create assisted death panels, there would be a total of 21 days in reflection periods between the first time that the patient sees a doctor and when they actually get a decision that they can end their life. There may also be time when the panel is deliberating. However, as the Bill is drafted, that is not clarified and there is no doubt that it will differ from patient to patient. Furthermore, and perhaps most importantly, those 21 days would not come as one pause for reflection. Rather, they would come seven or 14 days at a time, in between the stages of the process to apply for assisted dying. I will break this down for the Committee.

First, the Bill does not at any point state that there must be a time interval between a person receiving a diagnosis of serious illness and a prognosis of death being likely with six months, and that person having their initial discussion with a medical practitioner. Indeed, as the Bill is currently written, a doctor could give a patient a diagnosis of serious illness and a prognosis of likely death within six months, and then in that same room at that same time, while the patient was immensely shocked, that patient could talk to a doctor about assisted dying. This seems to have considerable risks. I note in passing that this is a matter covered by other amendments, whereby the doctor could: first, give the patient their diagnosis of serious illness; secondly, give a prognosis of six months to live; and thirdly, raise the option of assisted dying with them.

Secondly, the Bill states that there must be no pause between a declaration after a person's initial discussion with a registered medical practitioner and the action of the co-ordinating doctor. Clause 7(1) states:

“The coordinating doctor must, as soon as reasonably practicable after a first declaration is made by a person, carry out the first assessment.”

In other words, a patient shocked by their diagnosis and prognosis could have a first doctor's assessment of their desire for assisted dying as soon as the patient can make an appointment with a doctor willing to discuss the matter. Again, that seems to carry enormous risks. Some patients will have the immense strength of mind needed to weigh the facts that they have been given as rationally as possible. Others, understandably, will be in immense shock and might be looking for a rapid exit from what they may fear will be a horrible death.

The first period of reflection comes only after the end of the first doctor's assessment. There are serious concerns with that. That period of reflection comes after the patient has taken three steps on the path to assisted dying: the initial discussion, the initial statement and the first doctor's consultation. The period of reflection does not come after the patient receives their diagnosis and their six-month prognosis. We heard from the psychiatrists that that is when patients with such a diagnosis and prognosis most need two things: the time to reflect on the terrible news that they have just heard; and, even more importantly, their doctors and their social care authorities to arrange medical treatment, social care and psychiatric support for their new diagnosis. If they receive those things, their desire for a quick death would be likely to fall, but the Bill does not provide for that time.

Another serious concern and a problem with the Bill is that the first seven-day period of reflection is too short to get things done. A 28-day waiting period would

provide the doctors and social care authorities with much more time to arrange suitable treatment. Under the Bill as written, if two doctors both believed that the applicant were eligible for assisted dying, they would send the case to the High Court, although I understand that my hon. Friend the Member for Spen Valley wants to amend that process so that the case is scrutinised by a panel of three qualified professionals.

Once the case has been scrutinised, whether by the High Court or by a panel, there will be a second period of reflection. That one will last 14 days. Again, there are some things that are very seriously wrong with that. The period is too short. Fourteen days will not, in many cases, give doctors and social care authorities enough time to organise good treatment for a patient. It would make far more sense to give them 28 days to organise such care, and for the patient to consider whether they really did wish to opt for an assisted death.

Let us think about when the second period of reflection must take place. It must take place after the patient has had their initial discussion of assisted death. It must take place after the patient has made their declaration that they are seeking an assisted death. It must take place after the patient has had their first and second consultations with a doctor, and convinced both doctors that they wish to die. It must take place after the panel, which may—I stress, “may”—call the patient in to check that they do indeed wish an assisted death.

When does that second period of reflection come? It is after a process lasting weeks, in which a patient has had to convince doctors, and possibly also a three-member panel, that they wish to die. That is not the right way to do things. We should give patients who have had a shocking diagnosis and prognosis much more time to reflect before they have in effect reached the end of the application process. The Bill refers to a “period for reflection”, but it should not. I disagree with that term, and with the premise and assumption behind it. This is not a disagreement about language; it is much more important than that.

The 28-day pause in my amendment is not just about reflection. It is also about seeing whether we can improve medical and social care for patients who so desperately need it. When that care is in place, they may still wish to opt for assisted death, but they may not. We should not make this process too hasty. If we do, we will push many people down the path of seeking an assisted death when, if they were given the time to arrange better medical treatment and social care and the time to reflect, they might not go down that path.

I ask hon. Members to support amendment 277. It will give patients time to think. It will give them that time near the beginning of the assisted dying process, whereas the Bill as currently drafted gives them time almost at the end of the process. Most importantly, it will give patients what senior psychiatrists have asked for: simply put, the chance for people who have received a shocking diagnosis and prognosis to work with their doctors and social carers to put new treatment plans in place.

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): I rise to set out why—reluctantly—I cannot support amendments 403 and 404, which have been tabled by my hon. Friend the Member for East Wiltshire.

[*Dr Neil Shastri-Hurst*]

It is not because of the principle involved, because my hon. Friend was very clear in setting out the amendments. They would not provide for a prescriptive situation where an individual must tell their family. A range of options are set out, which I anticipate that any sensible and responsible doctor or clinician would take a patient through, encouraging them to involve their family in their decision making.

The issue that I have is around the legal clarity of the wording of the amendments, because under the English and Welsh legal system there is no statutory definition of “family”. There is a concept of family, but the concept of family to me may be very different from that of my neighbour, or from that of someone who lives in another city. For example, for some people stepbrothers, stepsisters and step-parents are very much part of their family; for others, they are not. For some people, unmarried couples with children are a family; for others, they are not. For some people, unmarried couples without children are a family; for others, they are not.

Danny Kruger: I take that point; families are difficult to define. Nevertheless, the Bill currently refers to the opportunity for a doctor, or the suggestion that a doctor, “in so far as the assessing doctor considers it appropriate, advise the person to consider discussing the request with their next of kin and other persons they are close to.”

That is more precise. Would my hon. Friend accept an amendment along the lines that I have proposed, prior to the first declaration, but using the language that is currently in the Bill about

“their next of kin and other persons they are close to”?

Dr Shastri-Hurst: That would satisfy me. The reason I say that is because at the moment the wording is too broad and ill-defined. The question is: is this about the closeness and proximity of a relationship? The suggested wording that my hon. Friend just put forward would be much closer to that and much clearer, and more akin with the language of medical registration. When someone turns up in A&E, they are asked to give the name of their next of kin. That defines the closeness, the proximity and the permanency of that relationship.

If my hon. Friend was perhaps to consider withdrawing this amendment and tabling it again in an alternative form, or rewording it, that would certainly be something that I would be open to supporting. I have outlined why, as the amendments currently stand, I cannot support them.

Stephen Kinnock: Although it is for Parliament to decide whether to progress the Bill, this Government remain committed to ensuring the legal robustness and workability of all legislation. For that reason, the Government have worked closely with my hon. Friend the Member for Spen Valley, and some amendments have been mutually agreed upon by her and the Government: in this group, those are amendments 184, 418, 420, 195, 209, 220, 421, 203, 204, 207, 208 and 214.

This group of amendments replaces the forms set out in the schedules to the Bill, with the requirement for the forms to be set out in regulations by the Secretary of

State. The amendments also make provision about the content and form of the first and second declarations, statements and reports.

Amendment 184 provides that the form of the first declaration must be set out in regulations made by the Secretary of State, as opposed to in schedule 1 as currently drafted. Operationally, using regulations will allow for consultation in relation to the form and content of the declaration. It will also provide flexibility to tailor or update the content of the declaration.

The effect of amendment 289 would be to limit those able to act as a second witness to a first declaration to registered clinicians, though that term is not defined in the amendment. In normal usage, “registered clinician” is broader than “registered medical practitioner”, so practically the amendment may lead to a wide range of registered healthcare professionals being able to act as a witness to a first declaration under the Bill.

5.45 pm

Turning to amendment 418, clause 5(2)(a) of the Bill sets out that a first declaration must be

“in the form set out in Schedule 1”.

Under the hon. Member for Spen Valley’s amendment 184, which we have just discussed, the form and content of the first declaration would instead be set out in regulations made by the Secretary of State. Amendment 418 makes provision for the content of the regulations that would be made under clause 5(2)(a), which would set out the form of the first declaration.

Amendment 277 states that a person would be unable to make a first declaration to be provided with assistance to end their own life until 28 days had elapsed after receiving a terminal diagnosis. The effect would be that those who are given a terminal diagnosis and are expected to—or go on to—live for less than 28 days may be precluded from accessing assisted dying under this legislation.

Let me turn to amendment 420. As the Bill is currently drafted, if, having carried out the first assessment, the co-ordinating doctor is satisfied that the patient has met all eligibility requirements, the co-ordinating doctor must make a statement to that effect in the form set out in schedule 2. This amendment seeks to replace the requirement for the co-ordinating doctor to complete the form in schedule 2 with a requirement to complete a report, with the information set out in clause 7(3). The amendment includes a regulation-making obligation, so that the Secretary of State is required to set out in regulations the form and content of the report, including the details specified on the face of the Bill. The co-ordinating doctor would be required to provide a copy of the report to the person seeking assistance, to a registered medical practitioner at the person’s GP practice—if the co-ordinating doctor is not at that practice—and to any other person specified in regulations.

Amendments 195, 209 and 220 are minor consequential amendments that flow from amendment 420. Two replace references to “the statement” in clauses 8 and 16 with references to “the report”, and the other updates the requirements for the chief medical officer’s report in clause 34.

Amendment 421 seeks to achieve a similar effect as amendment 420, whereby the co-ordinating doctor is required to complete a report following the second

assessment. It further makes provision for the content of that report in regulations. As with amendment 420, amendment 421 puts the requirement on the independent doctor, with regard to the second assessment; they must complete a report of the assessment and share it with the relevant people, as specified. The amendment makes provision for the content of the report to be set out in regulations, with particular details for which there must be provision in the regulations specified on the face of the Bill.

Amendments 203 and 204 are consequential to amendment 421, which provides that the independent doctor must make a report about the second assessment. The amendments amend the provision at the start of clause 10(1) referring to circumstances in which the independent doctor does not make a statement.

The purpose of amendments 329 and 330 is to remove schedule 4 to the Bill and set out the minimum requirements for what information the second declaration must contain. There is a regulation-making power to allow the Secretary of State to include other information or declarations for the second declaration. The information listed as required in amendment 330 are largely the same as those that currently appear in schedule 4, although there were some minor changes to the wording.

Amendment 207 provides that the form associated with the second declaration is to be set out in regulations, as opposed to in schedule 4 on the face of the Bill. This would have the effect of providing flexibility to update the content of the declaration if required later.

Amendments 331 and 332 would enable some flexibility on the form and content of a second statement by the co-ordinating doctor.

Kit Malthouse: Just to be clear, a number of the amendments the Minister mentioned are in my name; I have now withdrawn them, albeit they would not have been voted on until later stages. I have withdrawn them in favour of the amendments tabled by the hon. Member for Spen Valley, which broadly do the same thing.

Stephen Kinnock: I thank the right hon. Gentleman for that clarification, because I had heard he was withdrawing but I thought perhaps he meant he would not push him amendments to a vote.

Kit Malthouse: No, no. I formally withdrew those amendments earlier today.

The Chair: Order. As far as I am aware, they are still on the amendment paper, but let us not get too technical at this particular stage.

Stephen Kinnock: I will therefore speak to amendment 208, which provides

“that the form of a statement by the coordinating doctor following the making of the second declaration is to be set out in regulations” as opposed to the current position, where it is set out in schedule 5 of the Bill. This would have the effect of providing flexibility to update the content of the form of the statement if required later.

Amendment 214 provides

“that the form of a final statement is to be set out in regulations” as opposed to in schedule 6, on the face of the Bill. This would have the effect of providing flexibility to update the content of the form if required later.

Amendment 404 would mean that, following court approval, the person seeking assistance must confirm, in a second declaration on the form set out in schedule 4, whether or not they have informed their family of their wish to be provided with assistance to end their own life. From a practical perspective, the amendment does not specify how a family would be defined. This may create uncertainty as to who the person would need to inform or how to determine that they have no family. It requires the form of the first declaration, set out in schedule 1, to capture whether a person seeking assistance to end their life has: informed their family of their wish to be provided with assistance to end their life and taken their family’s opinion into consideration; or decided not to inform their family of their decision; or has no family to inform of their decision. It is not clear how the term “family” would be defined. It is also worth noting that the amendment would conflict with amendment 184, which removes schedule 1 to the Bill. I hope those observations have been helpful to the Committee, and I thank Members for their attention.

Amendment 184 agreed to.

Amendment made: 418, in clause 5, page 3, line 12, at end insert—

“(2A) Regulations under subsection (2)(a) must provide that the first declaration contains—

(a) the following information—

- (i) the person’s full name and address;
- (ii) the person’s NHS number;
- (iii) contact details for the person’s GP practice;

(b) the following further declarations by the person—

- (i) a declaration that they meet the initial conditions for eligibility (see subsection (2B));
- (ii) 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;
- (iii) a declaration that they are content to be assessed, for the purposes of this Act, by medical practitioners;

(iv) a declaration that they are making the first declaration voluntarily and have not been coerced or pressured by any other person into making it;

(v) a declaration that they understand that they may cancel the first declaration at any time.

(2B) In subsection (2A)(b)(i) ‘the initial conditions for eligibility’ are that the person making the declaration—

- (a) is aged 18 or over,
- (b) is ordinarily resident in England and Wales and has been so resident for at least 12 months, and
- (c) is registered with a general medical practice in England or Wales.” —(*Kim Leadbeater.*)

This amendment makes provision about the content of regulations under subsection (2)(a), which will set out the form of the first declaration.

Amendment proposed: 277, in clause 5, page 3, line 12, at end insert—

“(2A) A person may not make a first declaration under subsection (1) until 28 days have elapsed, beginning with the day they received a diagnosis of the terminal illness.” —(*Naz Shah.*)

This amendment would mean a person could not make the first declaration until 28 days from the day they received a diagnosis of the terminal illness.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 12.

Division No. 30]

AYES

Campbell, Juliet
Francis, Daniel
Kruger, Danny
Olney, Sarah

Paul, Rebecca
Shah, Naz
Woodcock, Sean

NOES

Abbott, Jack
Atkinson, Lewis

Charalambous, Bambos
Green, Sarah

Hopkins, Rachel
Kinnock, Stephen
Leadbeater, Kim
Malthouse, rh Kit

Opher, Dr Simon
Richards, Jake
Saville Roberts, rh Liz
Shastri-Hurst, Dr Neil

Question accordingly negatived.

Ordered, That further consideration be now adjourned.
—(Bambos Charalambous.)

5.55 pm

Adjourned till Wednesday 5 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

TIAB 408 Royal Pharmaceutical Society (further written evidence)

TIAB 409 Physicians for Compassionate Care Education Foundation (PCCEF)

TIAB 410 Dr Michelle Myall

TIAB 411 Disability Labour

TIAB 412 Jenny Carruthers

TIAB 413 Dr Sandra Lucas and Dr Rhona Winnington at University of the West of Scotland

TIAB 414 Professor Richard Huxtable, University of Bristol

