

# PARLIAMENTARY DEBATES

HOUSE OF COMMONS  
OFFICIAL REPORT  
GENERAL COMMITTEES

## Public Bill Committee

### TERMINALLY ILL ADULTS (END OF LIFE) BILL

*Twentieth Sitting*

*Tuesday 11 March 2025*

*(Morning)*

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CLAUSE 8 agreed to, with amendments.

CLAUSE 9 under consideration when the Committee adjourned till this day at Two o'clock.

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**not later than**

**Saturday 15 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)                                 |
| † Kinnoek, Stephen ( <i>Minister for Care</i> )                       |   |
| † Kruger, Danny ( <i>East Wiltshire</i> ) (Con)                       | Lynn Gardner, Lucinda Maer, Jonathan Whiffing,<br><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)                          | † <b>attended the Committee</b>   |

## Public Bill Committee

Tuesday 11 March 2025

(Morning)

[SIR ROGER GALE *in the Chair*]

### Terminally Ill Adults (End of Life) Bill

9.25 am

**The Chair:** I have a few housekeeping announcements. Will everybody ensure that electronic devices are turned off or switched to silent. I remind hon. Members that tea and coffee are not allowed in the Committee Room.

We are due to continue line-by-line consideration. I am asked to remind Members that interventions should be short, and should raise points of clarification or ask questions; they should not be speeches in and of themselves. Members who do wish to give a speech should bob, please—we are not mind readers—and continue to do so throughout the debate in which they take part unless and until they are called.

When Members say “you”, they are referring to the Chair. “You” should not be used to refer to each other in any circumstances. Debate should be through the Chair.

Members may find it convenient to know that the Committee will be sit this afternoon and until 8 o’clock this evening. Please bear in mind that if there are Divisions on the Floor of the House and the sitting is not adjourned, then it will be suspended for the Division, which means that Members will have to come back even if the witching hour of 8 o’clock has passed. At that point, Members will sit again until the adjournment is moved formally. That can be done only when the floor is vacated, not in the middle of a speech.

Tomorrow morning, I shall be in the Chair; I shall also take the Chair at 5 o’clock tomorrow afternoon. Divisions in the House are expected tomorrow evening. There are six hours of protected business tomorrow evening, so those votes could again come up until and including 8 o’clock, or possibly even later if there is a statement or two. I have also indicated that I am willing, if necessary, to sit through the night. If the Committee chooses to sit very late, as a courtesy I expect to be notified in order that the people who really matter—the Clerks, the Doorkeepers and the *Hansard* writers—have a chance to be informed and organise their lives accordingly. I hope all that is clear.

We will now continue our debate on amendment 301 in the name of Rachael Maskell.

#### Clause 8

SECOND DOCTOR’S ASSESSMENT (INDEPENDENT DOCTOR)

*Amendment proposed (5 March):* 301, in clause 8, page 4, line 39, leave out “7” and insert “14”.—(*Naz Shah.*)

*This amendment would increase the period of reflection to 14 days.*

*Question again proposed,* That the amendment be made.

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

Amendment 317, in clause 13, page 9, line 12, leave out “14” and insert “28”.

*This amendment would provide 28 days for the second period of reflection instead of 14.*

Amendment 314, in clause 13, page 9, line 17, leave out

“48 hours beginning with that day”

and insert

“7 days beginning with that day and the person must be referred immediately for urgent specialist palliative care.”

*This amendment would increase the second period of reflection in cases where the coordinating doctor reasonably believes the person will die within a month from 48 hours to seven days.*

Amendment 315, in clause 13, page 9, line 17, leave out “48 hours” and insert “7 days”.

*This amendment would increase the second period of reflection in cases where the coordinating doctor reasonably believes the person will die within a month from 48 hours to seven days.*

**Danny Kruger (East Wiltshire) (Con):** It is a pleasure to serve under your chairmanship once again, Sir Roger. I am looking forward to this week’s debating.

I want to draw the Committee’s attention to further evidence that has come in since the debate got under way. Since we started the Committee, we have had more than 400 pieces of evidence, so I apologise for not having got to this earlier, but it is relevant. I do not want people who have submitted evidence to us to feel that their submissions have fallen into a black hole and are not being considered, and I think this is significant evidence. We are talking about the necessity of a proper period of reflection, which is acknowledged in the Bill—it is understood that it is inappropriate for people to be able to request and receive an assisted death in very short order. The debate is about the extent of that reflection period. I am supporting amendments that suggest that we need slightly longer in some cases.

I want to refer to two pieces of the evidence that has come in. One is from six palliative care doctors who wrote that

“our experience is that many patients experience a period of adjustment to ‘bad news’ and may say that they cannot live under these conditions. However, after a period of reflection and adjustment, the majority come to find peace and value in their altered life circumstance, in a way they would not have believed possible. This may often take many weeks and sometimes short months. It is our profound concern that the two ‘periods of reflection’...would not allow time for this adjustment. This is even more so the case where these periods of reflection are reduced for patients predicted to have an even shorter prognosis. It is thus a reality that patients and their families may miss out on a period of life they would have valued by seeking to end their lives prematurely, and these days, weeks and perhaps even months will never be regained.”

The other piece of evidence is from Tom Pembroke and Clea Atkinson, who are experts in hepatology and palliative care in Cardiff. They raised the problems of the seven-day reflection period where there is alcohol misuse. I do not think this topic came up in last week’s debate, but it is worth acknowledging because liver disease is the most common cause of death for people in middle age. It is also worth noting that liver disease disproportionately affects the people who are most disadvantaged in our society. These experts say:

“Prognostication in advanced liver disease is challenging as management of the underlying causes, including abstinence from alcohol, potentially reverses advanced liver failure...The neurocognitive

and depressive effects of alcohol misuse disorder frequently requires more than seven days to resolve following abstinence. Advanced liver disease frequently manifests with hepatic encephalopathy which can affect the ability to make informed decisions.”

Their concern is that

“A seven-day review period is not sufficient to ensure that there is an enduring wish to die which is not influenced by alcohol misuse.”

Considering the prevalence of alcohol misuse in our society, the extent to which so many people tragically die of it and the difficulties in prognostication, I suggest to the Committee that there is a particular argument to be made for extending that short period at the end for the expedited process that is being considered. I beg the Committee to consider accepting the amendment.

**The Minister for Care (Stephen Kinnock):** It is a pleasure to serve under your chairship again, Sir Roger.

Amendment 301 would prolong the first period of reflection, after which point the independent doctor can conduct the second assessment. In the original draft of the Bill, the first period of reflection is seven days, but the amendment would extend that period to 14 days. That means 14 days would have to pass between the time that the co-ordinating doctor has made their statement following the first assessment, and the independent doctor carrying out the second assessment.

Amendment 317 would increase the duration of the period of reflection before a person may make a second declaration from 14 days to 28 days. It relates to cases where a person’s death is not reasonably expected within one month of the date of the court’s declaration.

Amendments 314 and 315 would increase the duration of the second period of reflection before a person may make a second declaration, in cases where a person’s death is reasonably expected within one month of the date of the court’s declaration, from 48 hours to seven days. They would also introduce a requirement for a mandatory immediate referral for urgent specialist palliative care. The requirement would be introduced into the definition of the second period of reflection. It is unclear what impact it would have on the duration of the period of reflection. The amendments do not say who should be responsible for making the referral or where it should be recorded. The drafting is also ambiguous as to what happens if a person does not consent to such a referral or care.

I hope these observations are helpful to the Committee in considering the Bill and the amendments put forward by various Members. Whether these amendments should form part of the Bill is a matter for the Committee to decide.

**Kim Leadbeater (Spenn Valley) (Lab):** I have nothing to add on this group of amendments. I am confident that the Bill as drafted already includes significant periods of reflection. Bearing in mind that we are putting dying people through a very lengthy process already, I remain confident that the periods of reflection are adequate as set out in the Bill.

**Naz Shah (Bradford West) (Lab):** I have a couple of additional comments. We talked last week about the reflection periods. I referred to the fact that when even someone buys something from a shop, they have 28 days to return it; when they are deciding on whether to have an assisted death, there is a great deal more at stake.

During that debate, someone asked, “What if someone had a prognosis of just one month?”, but clause 13 has an option for a fast-track process in that situation—the person would be able to access the service in 48 hours.

I beg to differ with my hon. Friend the Member for Spenn Valley, the Bill’s promoter, who said that we have enough reflection periods in the Bill. Yes, there are reflection periods, but they come after the panel’s decision. The reality is that the NHS is under so much duress, with patients waiting weeks to see their GP for anything other than urgent treatment, that getting an appointment with another GP in seven days is unlikely; it is unlikely to happen given how uncommon that is at the moment. It is right that doctors are able to triage their patients to prioritise those who require medical intervention to keep them well, to prevent hospital admission, or to stop them deteriorating or even dying.

The Government are trying to protect the NHS, and the best way of achieving that is to ensure that medical interventions are provided at the earliest opportunity before a patient deteriorates. In some cases, a medical appointment may need to take priority over an appointment for an assisted death. If someone who is dying has longer—even just a further week—in which to reflect, it removes the pressure from GPs and consultants, and enables them to prioritise properly their patients. It does not build up false expectation in patients that they have a right to a rapid consultation process. Likewise, we know that it can currently take a few weeks for patients to see another consultant, if not months or even over a year. It is therefore more helpful for the patient to have a more realistic period of reflection before moving to the next stage of their assessment.

Issues of such intensity as someone planning to take their own life should not be rushed. We know from all the work that has been undertaken on suicide that other interventions and conversations can help with reflection and reconsideration. It is important that people are given this opportunity. In their first raising the matter with a doctor, the doctor would have provided a lot of information about alternatives to the patient, such as what treatment options would be available. Perhaps they would have had a discussion with a palliative medicine consultant to review their options. There needs to be time for a patient to really reflect on all this new information. If the patient does want to explore assisted dying, there will also be all the conversations about drugs and their impact, which we will come to when we discuss later clauses.

Amendment 317 to clause 13 seeks to increase the reflection period from 14 days to 28 days. I gently suggest that we should have the reflection period before the decision, whether it be by the judge or a panel, to give people the right amount of time to consider; currently, the reflection period is afterwards. This is such a monumental decision that people should be able to contemplate all other options available. As it is, the process is rushed, and a patient could be caught up in the moment of concentrating on getting through the stages. I appreciate that others have suggested that once we have got past that stage, with the paperwork and all those things out of the way, then there is time to reflect. During the process, however, the patient has not had time to consider the options in making their decision. I am not convinced that there is enough reflection during, as opposed to after, the process.

[Naz Shah]

Amendment 314 seeks to increase the reflection period from 48 hours to seven days for patients who have been given a month to live. In that case, seven days is quite adequate time to reflect on the information they have received to make informed choices. If this is about autonomy, which my hon. Friend the Member for Spenn Valley has talked about many a time, it is important for people to have choices. To have that autonomy is surely to have the options in front of us and be able to consider them in detail.

In considering whether to sit on this Bill Committee, I slept on the decision. I can usually make instantaneous decisions, but knowing the amount of work, knowing that I was new to the subject, and knowing the things that I knew then—not the things that I know now—it was a big decision for me. I was even thinking about how I would manage the workload. We are talking about something that is not at all comparable. We are talking about somebody who will be taking a decision to potentially exercise the right—if the Bill becomes law—to an assisted death. That is really important for me.

I beg to ask leave to withdraw the amendment.

*Amendment, by leave, withdrawn.*

*Amendments made:* 195, in clause 8, page 4, line 40, leave out “statement” and insert “report”.

*This amendment is consequential on Amendment 420.*

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);
- subsection (2)(a)
- (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.”—  
(*Kim Leadbeater.*)

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

**Danny Kruger:** I beg to move amendment 348, in clause 8, page 5, line 10, at end insert—

“(c) inform the person’s usual or treating doctor and, where relevant, the doctor who referred the person to the independent doctor, of the outcome of the assessment.”

*This amendment would ensure that the independent doctor communicates the outcome of their assessment to the referring doctor as well as the usual or treating doctor.*

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

Amendment 303, in clause 8, page 5, line 12, at end insert—

“(aa) has confirmed that no other practitioner has undertaken a second assessment for the same person.”

*This amendment would prevent a patient from seeking multiple assessments from different doctors.*

Amendment 458, in clause 10, page 6, line 45, after “declaration” insert “and if there has been a material change of circumstances,”

Amendment 459, in clause 10, page 7, line 3, at end insert—

- “(2A) (a) Where a referral is made to a registered medical practitioner under subsection (1), the coordinating doctor must provide that new registered medical practitioner with the report by the independent doctor setting out their reasons for refusal.
- (b) If the new registered medical practitioner reaches a different conclusion from the original independent doctor, they must produce a report setting out why they disagree.
- (c) Those two reports must be made available to any subsequent decision maker under this Act and to the Commissioner.”

Amendment 460, in clause 10, page 7, line 9, leave out “particular”.

**Danny Kruger:** This is a key group of amendments. I shall specifically speak to amendment 303, which would prevent a person from seeking multiple assessments from alternative doctors if a second assessment had already been undertaken. I am not sure that I will press that amendment to a vote, but it is important to explore this issue. I will take the view of the Committee on it.

Last week, my right hon. Friend the Member for North West Hampshire said that it was important to avoid doctor-shopping. He made that point in reference to the suggestion that there would be a list of professionals that would administer the procedure. I respect that view; I think it is absolutely right. It needs to be clear in law that we avoid doctor-shopping. For that reason, it is important that the independent doctor should seek to establish whether the patient has previously had a second assessment. That could be very material.

Clause 10 states:

“In consequence of a particular first declaration made by a person, the coordinating doctor may make only one referral for a second opinion under subsection (1).”

This only limits the number of times that a person can seek another medical assessment. Amendment 303 to clause 8, in the name of the hon. Member for York Central (Rachael Maskell), would further strengthen the current safeguards against doctor-shopping, by placing a duty on the doctor to confirm that there had not been previous assessments.

Doctor shopping is not a hypothetical concern. We have seen it take place in other jurisdictions. An understanding develops that some doctors are more likely to grant an application for an assisted death. That is totally natural. Professor Preston said in oral evidence to us:

“People go doctor shopping—they are going to multiple doctors until they get the right answer.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 30 January 2025; c. 245, Q315.]

According to an official report in 2021, one Oregon doctor wrote one eighth of all the prescriptions for assisted death. I met a doctor in Canada who had performed hundreds of assisted suicides. It was her whole practice; that was what she did, and people knew to go to her.

Doctors who are reluctant to grant an application may instead refer a person to doctors they know are more likely to grant the person’s application for an assisted death, so those practitioners become the go-to when other doctors deny applications. Over time, the safeguards can become weakened and circumvented by a system of doctors who apply the criteria quite loosely, as was found in Ontario. The Ontario review committee found evidence of patients doctor shopping for approval. Some 8% of non-terminally ill people who died by assisted dying had made previous requests. People do try again, naturally enough, if they do not get the answer they wanted.

9.45 am

In 2023, a memo was sent out to practitioners in Quebec affirming that administrators needed to be careful to respect the criterion concerning the diagnosis of serious illness and incurable disease as agreed in Quebec, and that shopping for a favourable second opinion was not an acceptable practice. Clearly, there had been a problem there with non-compliant administration of the efforts to prevent that. As I say, we found such evidence in Oregon too.

The fact is that there is nothing in the Bill to prevent a person who has failed in their attempt with one co-ordinating doctor to receive approval to die from continuing to search for different co-ordinating doctors to receive a different answer, and thereby start the whole process again. I recognise that if someone was judged ineligible but their circumstances have changed, they understandably might want to try again, and it may be appropriate for them to do so; however, there is no requirement in the Bill for a new application to be made on the basis of new circumstances regarding a person’s condition or capacity. Amendment 458, tabled by the hon. Member for Richmond Park, would address that by requiring that new applications be made, appropriately, on the basis of a change in circumstances, but even were that amendment accepted, as I hope it will be, it would simply mean that the applicant would have to cite some potentially quite minor change in their circumstances or symptoms to justify a new application.

Let us be clear what we are doing: if the first doctor declines an application, a person can shop around until they find a doctor who will approve it, and there is nothing to stop private practices springing up that would be happy to accommodate that request. If the second independent doctor declines, the person can also shop around, although that is limited to a single second attempt, but in that case the person could just go back to the beginning and start again. If we want simply to allow anyone with a terminal diagnosis to have an assisted death, the Bill will do that. Let us not pretend that we have safeguards to stop people shopping around until they find a doctor willing to help them.

**Naz Shah:** Does the hon. Member share my concern that if a doctor refused somebody an assisted death because they thought there was some form of coercion, the door could be open for people to keep going back through this route?

**Danny Kruger:** The hon. Lady is absolutely right. We will address in later debates the point that insufficient attention will be given to the reasons why an application has been refused. If an application has been refused on the grounds of coercion, a future doctor will not necessarily know that that was the reason. As the hon. Lady says, in cases of coercive control there is a very real danger that if a person has been unduly influenced to seek an assisted death and the doctor declines their application, possibly because they detected coercive control, the patient can then be coerced, or influenced, into starting again with a new doctor. There is nothing to stop that in the Bill. We have a real problem, and I hope the Committee will consider the amendments.

**Sarah Olney (Richmond Park) (LD):** It is a pleasure to serve under your chairmanship, Sir Roger. I will speak to my amendments 458 to 460, which would tighten the process around seeking a determination from a second independent doctor if the first has refused to say that the criteria are met. The amendments relate to clause 10, which I will say more about when we come to it, but they have been selected for debate in this group.

The risks of abuse in seeking a second independent doctor’s opinion are well illustrated by the evidence we have received from Dr Sharon Quick, the president of the Physicians for Compassionate Care Education Foundation, who tells us about the experience of Dr Charles Bentz, who refused to provide a second opinion for a physician-assisted suicide for a patient he had referred to an oncologist for cancer treatment. The co-ordinating doctor persisted and clearly found a compliant second opinion, as two weeks later his patient was dead.

Dr Charles Bentz said in his testimony:

“I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone

[Sarah Olney]

who knew him, the medical oncologist called me and asked me to be the 'second opinion' for his suicide. She told me that barbiturate overdoses 'work very well' for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did not concur. I was very concerned about my patient's mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma. When I reviewed his chart, the radiation oncologist documented a clear diagnosis of depression.

My patient did not die from his cancer, but at the hands of a once-trusted colleague who failed to recognize and treat his depression. This experience has affected me, my practice, and my understanding of what it means to be a physician. What happened to this patient, who was weak and vulnerable, raises several questions that I have had to answer."

I appreciate that, under the Bill, Dr Bentz could not have been the independent doctor as he already knew the patient and was treating him, but in that case that contributed to enhanced safety. Dr Bentz's example illustrates the real risks of abuse in a person being able to seek the opinion of a second independent doctor. The starting point is that the task of the independent doctor is not that of a normal doctor. It is not to cure the patient or to provide advice about medical treatments: it is to check whether the eligibility requirements are met. It is a decision-making function, not a medical one—albeit, of course, a decision-making function that is informed by medical expertise.

In the light of that function, it is not appropriate for someone to seek another decision simply because they do not like the answer that has been given. The independent doctor is asked to apply an objective set of criteria against the evidence in front of them in order to make an assessment. It is not the case—or it should not be—that a different doctor would come to a different assessment based on the same criteria and the same evidence. If we are doing our job properly in the Committee, we should not expect that a second opinion could be arrived at.

I have no objection to provision being made for a person to see a second independent doctor if the first did not manage to finish the task. Nor do I object in respect of cases in which there is a change of circumstances—for example, if the patient's condition deteriorates to such a degree that although the first independent doctor thought the six-month prognosis test was not met, it becomes clear that it is met—which is the point of my amendment 458. In such circumstances, it would make sense to allow the patient to go to a second independent doctor. Although my preference in such a situation would be to go back to the original independent doctor and ask them to reconsider in the light of the change of circumstances, that may not always be possible. Amendment 458 is an attempt to find a middle ground.

Amendment 459 seeks to reduce the possibility of abuse by ensuring that the second independent doctor has available the reasons why the first independent doctor concluded that the person was not eligible. That would allow the second independent doctor to approach the assessment with open eyes. Such a report would be particularly useful when it comes to the detection of

coercion or pressure, as the first independent doctor might have spotted something that the second independent doctor might not easily see.

Let us consider the evidence of Dr Tim Howard, who has been deeply involved in end-of-life palliative care and assisted dying for many years. He has been a non-exec director of a health authority, a member of an ethics committee, a postgraduate teacher and, finally, chair of the General Medical Council fitness to practise tribunals, dealing with complex medico-legal principles and decisions in public. He also helped to set up the Medical Practitioners Tribunal Service, which separated medical standard setting and investigation from adjudication.

Dr Howard says:

"I remain uncomfortable that when either doctor, the assessing doctor or the independent doctor, declines to agree with a request for"

assisted dying,

"they take no further action. I feel that the reasons for their refusal should, as well as being given to the patient, be recorded in the patient's notes, and given to any 'second opinion' independent doctor. This is not an attempt to bias; it is a value judgement that criteria are not being met, and as such, is sharing an early warning to be extra careful."

The Committee should note that he has, in his own words,

"been a strong proponent of medical assistance in dying...and a member of Dignity in Dying for many years."

**Danny Kruger:** It does seem an extraordinary gap in the Bill, but I am afraid it is not unique to this Bill. In countries where assisted dying in some form is legal, there are remarkable failures to insist on the proper recording of applications that are declined or about which there are concerns. This speaks to the general cloud of unknowing that we are operating in. Does the hon. Lady agree that were we to pass the Bill, it would be great if, at least in this country, we kept proper records?

**Sarah Olney:** The hon. Member is exactly right. An assessment of whether somebody should qualify for assisted dying needs to be based on objective criteria. If those are not met, the only way that a second independent doctor should have a role is if either the circumstances have changed or, for whatever reason, the first doctor is unable to reach a conclusion. There must not be a situation in which the first doctor has made one decision and a second doctor arrives at a different decision, because that would imply a variability in the way the objective assessments are made. Not tightening this loophole would imply that we are prepared to allow such a variability across the medical profession, and I do not think we should allow that.

My final amendment in this group is amendment 460. I am concerned that the word "particular" in clause 10(3) negates the subsection's purpose of ensuring that only one second opinion from the co-ordinating doctor can be sought, because a person could withdraw their first declaration, make a new one and start the process afresh; that declaration would then not be the "particular" first declaration. By removing "particular", the loophole would be closed, and the safeguard would be made more effective. This concern was brought out well in Disability Labour's written evidence:

“We are concerned that whilst 10(3) only allows for one second opinion to be sought, there appears to be nothing in the bill that stipulates a waiting period before a new application can be made. This risks applications being repeated until a supporting opinion can be obtained, thus negating the purpose of 10(3).”

I hope the Committee will accept my amendments.

**Dr Simon Opher** (Stroud) (Lab): I thank the hon. Member for Richmond Park for her considered amendments. I would like to go through all the amendments in the group.

Amendment 348 is about the doctor communicating the outcome of the assessment, but I understand that that is already covered in clause 8(5)(b), which states that, having carried out the second assessment, the independent doctor will

“provide each of the coordinating doctor and the person who was assessed with a copy of the statement.”

I therefore do not think the amendment is necessary—it would be doubling up.

**Rebecca Paul** (Reigate) (Con): I just point out that the amendment states that the independent doctor would “inform the person’s usual or treating doctor”, and that is not covered by the paragraph the hon. Gentleman just mentioned. I hope that is helpful.

**Dr Opher**: I do not see what that would add to the Bill. The co-ordinating doctor would have a result and the patient would have had the report back. I do not feel the amendment is necessary—it would over-complicate the Bill—but we can see what the Government’s legal position is on that.

Amendment 303, tabled by my hon. Friend the Member for York Central, suggests that the independent doctor should have to check that there has not already been a second opinion. We need to step back a bit and remember how the Bill will work. Basically, a doctor will refer to a co-ordinating doctor, who will make a full assessment of the patient. If, having carried out the first assessment, the co-ordinating doctor is satisfied that the requirements in the Bill are met, they will refer the person for the independent assessment. That doctor will therefore need to see a report, because he is the co-ordinating doctor. He cannot then get a second opinion from a different doctor; that would not be part of the process under the Bill. I do not feel the amendment would make the Bill any safer.

10 am

On the idea of doctor shopping, one of the provisions in the Bill is specifically concerned with that: it allows one, and only one, second opinion to the independent doctor. In medical practice, it is normal and fair that a patient has one second opinion on any assessment, so it is fair to the patient that they can go back to the co-ordinating doctor and get referred for a second opinion from another person.

**Sarah Olney**: Will the hon. Gentleman give way?

**Danny Kruger**: Will the hon. Gentleman give way?

**Dr Opher**: Actually no, I will not. I will go on, if that is okay.

Amendment 459 states that the second-opinion doctor “must produce a report” outlining their reasons for reaching a different opinion, but the whole nature of

this is that the doctor is independent. As we have heard, if it is suggested that someone either is or is not allowed to get an assisted death, that might affect the assessment of the independent doctor. It would not be good medical practice to have that assessment in front of the independent doctor—that would lead to poor assessments. We need a right to a second opinion and we should have a truly independent doctor.

Amendment 460, which is the last in the group, would allow a patient only one declaration in any part of their lives, even if circumstances change. Although there will be vanishingly few instances where that would be relevant, I do not feel that such a provision would make the Bill any fairer or safer.

Amendment 143, tabled by my hon. Friend the Member for Broxtowe, would allow a second and a third opinion. It is my opinion, and the opinion of many of us, that we do not want doctor shopping. We want to allow one second opinion from an independent doctor, but not more than that.

**Juliet Campbell** (Broxtowe) (Lab): Amendment 143 has been withdrawn.

**Dr Opher**: Has it? Okay. I thank my hon. Friend.

The amendments in this group all come from a good place, and I understand where hon. Members are coming from, but I do not feel that anything in them would make the Bill any safer or fairer for patients.

**Lewis Atkinson** (Sunderland Central) (Lab): It is a pleasure to serve under your chairship, Sir Roger.

I rise to speak to a couple of the amendments. Amendment 348 is likely unnecessary. I would have been minded to support it had it referred to a registered GP, but the language of “usual or treating doctor” is unconvincing. I am not sure what those terms refer to. The registered GP absolutely should be informed, and both normal practice and the provisions in the Bill about entering information into medical records would mean that that is the case. For me, “usual doctor” is not the right terminology; it does not achieve what I think some of its proponents want. With reluctance, I will vote against that amendment because it does not refer to a registered general practitioner.

On amendments 303 and 458, I believe there must be provision for a second opinion. However, I am persuaded by the points made by the hon. Member for Richmond Park about amendment 459. I slightly disagree with my hon. Friend the Member for Stroud: although the independence of the second opinion is important on matters such as the terminal prognosis, when it comes to the detection of coercion, the more information, the better. It is one thing to be independent in a medical assessment, but the amendment speaks to a psychosocial assessment. We are trying to detect coercion, so it is important that every decision maker gets further information as the process progresses.

The provision for five different touchpoints of assessment is one of the strengths of the Bill. Each assessment should be done in a way that can be progressed with more information. It is not just five different independent points of information; because of the Bill’s record-keeping provisions, the assessment should become increasingly informed throughout the process. I certainly think that the panel, or whatever we get to, should have sight of

[*Lewis Atkinson*]

any negative assessment from an independent doctor, as well as any positive one. The panel will then be able to do its job of scrutinising the two decisions, potentially weighing them up, and calling the different doctors who have given different decisions. I am, then, persuaded by amendment 459.

**Jake Richards** (Rother Valley) (Lab): It came up in the debates last week that we heard some evidence from medical practitioners on how decisions and assessments were better made when done collaboratively. That means that we need to keep them independent but that, where possible, doctors should be working together in this process. Does my hon. Friend agree that amendment 459, tabled by the hon. Member for Richmond Park, may assist in that?

**Lewis Atkinson:** Yes, I do. I recognise the importance of independent assessment for prognosis and capacity. However, particularly with the issue of coercion, healthcare is a team sport, as anyone who has worked in healthcare knows. The more information and the more viewpoints we can get in those instances, the better. One of the strengths of the Bill is the team sense around it, which we will further in the amendments to clause 12 that we will come on to in due course.

I will finish briefly on amendment 460. I do not see the loophole that has been described. I think we would all want someone to be able to cancel their first declaration, and they are more likely to do so if they feel they have the option of going back and making a future first declaration. My worry with amendment 460 is that, by removing the word “particular”, it suggests that people are only able to make one first declaration in the course of their life. With the periods of reflection built into the Bill, which Members spoke about earlier, if someone changes their mind, they should cancel their first declaration. They are absolutely free to do so and the Bill, as currently drafted, makes good provision for that. To me, amendment 460 would remove the ability for that person to come back to that decision at a later point and go through the assessment process again. While I understand the motivations behind amendment 460, I am cautious about it for those reasons.

**Stephen Kinnock:** Amendment 348 seeks to add an additional requirement to clause 8(5). This would mean that, where the independent doctor is satisfied that the requirements under clause 8(2) have been met, they must “inform the person’s usual or treating doctor and, where relevant, the doctor who referred the person to the independent doctor, of the outcome of the assessment.”

Some elements of amendment 348 duplicate requirements that already appear in the Bill, such as the requirement in clause 8(5)(b) for the doctor to inform the co-ordinating doctor of the outcome, including providing a copy of the statement.

The amendment would also overlap with the requirements in clause 16 for the co-ordinating doctor to make entries in the person’s medical record that must include the original statement or declaration. Where the co-ordinating doctor is not with the person’s GP practice, they must also give notice to a registered medical practitioner with the person’s GP practice of the outcome of the assessments.

Amendment 303 seeks to prevent a person from seeking multiple second assessments from different independent doctors. It places a requirement on the independent doctor to confirm

“that no other practitioner has undertaken a second assessment for the same person.”

This amendment creates the risk of a medical practitioner inadvertently committing an offence if there is no centralised record-keeping. It may also have the impact of preventing the person seeking assistance from obtaining a second opinion, as provided for in clause 10. Under the amendment, as drafted, it is unclear how this is intended to interact with the possibility of an independent doctor’s becoming unable or unwilling to continue to act as the independent doctor following the second assessment, when an alternative independent doctor may therefore be required.

On amendment 458, as the Bill stands, clause 10 provides that if, following the second assessment, the independent doctor refuses to make the statement confirming that they are satisfied that matters in clause 8(2)(a) to (e) are met, the co-ordinating doctor may refer the person to a different registered medical practitioner who meets the requirements of clause 8(6), and is able and willing to carry out an assessment mentioning clause 8(2). The effect of the amendment is to restrict the circumstances in which the co-ordinating doctor can make a referral under clause 10(1) to a different registered medical practitioner to only when there has been a material change of circumstances. It is not clear from the amendment who is required to establish that there has been a material change in circumstances and/or how that will be proved. That may cause some uncertainty for the co-ordinating doctor.

I now turn to amendment 459. Clause 10 provides that if, following the second assessment, the independent doctor refuses to make the statement that they are satisfied that the person meets the criteria in clause 8(2)(a) to 8(2)(e) when conducting the second assessment, the co-ordinating doctor may, if requested to do so by the person who made the first declaration, refer that person to a different registered medical practitioner who meets the requirements of clause 8(6) and is able and willing to carry out an assessment of the kind mentioned in clause 8(2).

The effect of the amendment is that, where such a referral is made to the registered medical practitioner under clause 10(1), the co-ordinating doctor is required to provide them with the report by the independent doctor setting out their reasons for refusal. If the new registered medical practitioner reaches a different conclusion from the original independent doctor, they must produce a report setting out why they disagree. The two reports must be made available to any subsequent decision maker under the Bill, and to the commissioner. This additional requirement for reports on the reasons for refusal or differences in opinion may make the process of seeking assistance longer and add to capacity demands on co-ordinating and independent doctors.

Turning to amendment 460, clause 10(3) provides that if, following the second assessment, the independent doctor refuses to make the statement mentioned in clause 8(5), the co-ordinating doctor may make one referral for a second opinion. The effect of the amendment is to remove the word “particular” from clause 10(3), which says that only one second opinion may be sought

“In consequence of a particular first declaration made by a person.”

The amendment is unclear and could have several possible effects in practice. For example, it could have the effect of limiting the circumstances in which a referral can be made under clause 10(1) to the first time a person makes a first declaration.

I hope that these observations were helpful to the Committee.

**Kim Leadbeater:** I associate myself with the Minister's comments regarding the other amendments in the group; however, I listened carefully to the debate on amendment 459 and the points made by the hon. Member for Richmond Park, my hon. Friend the Member for Stroud and the Minister. My view on that amendment has changed: I do think independence is really important in the doctor's opinions during the normal process that the Bill sets out. However, it is a really fair point to make that if the independent doctor refuses the patient, there needs to be transparency about that, and it is important that everybody involved in the process can see how that decision has been made. That is a really valid point. It is a good example of how this Bill Committee is operating, and should be operating, in that we have been listening to different views and opinions.

I take on board the Minister's point on capacity. We need to be aware of that. We will hopefully debate the third layer later today. That layer may be a panel of experts who are there to oversee the full picture of the patient journey. For them to see what has happened with the doctors that they have interacted with is very important. Therefore, I am minded to support amendment 459.

**Danny Kruger:** I want to respond to a point made by the hon. Member for Stroud. It is relevant to the whole debate about whether we are talking about a medical treatment at all. He made the point, in respect of the question of a second or subsequent referral to an independent doctor, that it is appropriate in medicine to have second opinions; he said that that is normal in medicine, and he is absolutely right. Indeed, there is nothing to stop a patient seeking a third, fourth or any number of opinions if they want to do that and can get a doctor to consider them. The fact is that what we are discussing here is not a medical diagnosis—that is not what is being asked for when someone goes to see the second doctor, or indeed the first. What they are asking for is permission to proceed with the process.

10.15 am

The job of the doctor is not primarily one of diagnosis or advice to a patient, as is appropriate in medicine and is exactly what a second, third or fourth opinion is for. The doctors are giving permission, or otherwise, to proceed. It is a decision that is being made, not a diagnosis. That is very important, because in no other area of law or civil life is the decision by an authority able to be second-guessed with another opinion. People cannot just say, "I don't agree with this decision; I am going to go and get another one," unless circumstances change, which is why the amendment 458, tabled by the hon. Member for Richmond Park, is so important.

What is being asked for in these situations is not a second opinion in the medical sense, but a decision. On that basis, it is important that we recognise that the decision has to be final. If the decision is made not to proceed, people cannot shop around until they find someone who will disagree with that first doctor.

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 2, Noes 20.

**Division No. 39]**

**AYES**

Kruger, Danny Paul, Rebecca

**NOES**

Abbott, Jack	Leadbeater, Kim
Atkinson, Lewis	Malthouse, rh Kit
Campbell, Juliet	Olney, Sarah
Charalambous, Bambos	Opher, Dr Simon
Francis, Daniel	Richards, Jake
Gordon, Tom	Sackman, Sarah
Green, Sarah	Saville Roberts, rh Liz
Hopkins, Rachel	Shah, Naz
Joseph, Sojan	Shastri-Hurst, Dr Neil
Kinnock, Stephen	Woodcock, Sean

*Question accordingly negated.*

*Amendment proposed:* 303, Clause 8, page 5, line 12, at end insert—

“(aa) has confirmed that no other practitioner has undertaken a second assessment for the same person.”—(*Danny Kruger.*)

*This amendment would prevent a patient from seeking multiple assessments from different doctors.*

*The Committee divided:* Ayes 2, Noes 20.

**Division No. 40]**

**AYES**

Kruger, Danny Paul, Rebecca

**NOES**

Abbott, Jack	Leadbeater, Kim
Atkinson, Lewis	Malthouse, rh Kit
Campbell, Juliet	Olney, Sarah
Charalambous, Bambos	Opher, Dr Simon
Francis, Daniel	Richards, Jake
Gordon, Tom	Sackman, Sarah
Green, Sarah	Saville Roberts, rh Liz
Hopkins, Rachel	Shah, Naz
Joseph, Sojan	Shastri-Hurst, Dr Neil
Kinnock, Stephen	Woodcock, Sean

*Question accordingly negated.*

*Amendment proposed:* 1, in clause 8, page 5, line 13, at beginning insert

“is a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council and”—(*Sojan Joseph.*)

*This amendment would require that the independent doctor is a registered psychiatrist.*

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 7, Noes 15.

**Division No. 41]**

**AYES**

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

## NOES

Abbott, Jack	Malthouse, rh Kit
Atkinson, Lewis	Opher, Dr Simon
Charalambous, Bambos	Paul, Rebecca
Gordon, Tom	Richards, Jake
Green, Sarah	Sackman, Sarah
Hopkins, Rachel	Saville Roberts, rh Liz
Kinnock, Stephen	Shastri-Hurst, Dr Neil
Leadbeater, Kim	

*Question accordingly negated.*

*Amendments made:* 197, in clause 8, page 5, line 13, leave out paragraph (a) and insert—

“(a) meets the requirements specified in regulations under subsection (6A).”

*This amendment and Amendment 198 impose a duty on the Secretary of State to make regulations about the training, qualifications and experience required in order to act as the independent doctor.*

Amendment 198, in clause 8, page 5, line 25, at end insert—

“(6A) The Secretary of State must by regulations make provision about the training, qualifications and experience that a registered medical practitioner must have in order to carry out the functions of the independent doctor.

(6B) The regulations must include training about—

- (a) assessing capacity;
- (b) assessing whether a person has been coerced or pressured by any other person.

(6C) Subject to that, the regulations may in particular provide that the required training, qualifications or experience is to be determined by a person specified in the regulations.”

*See the statement for Amendment 197.*

Amendment 199, in clause 8, page 5, line 28, leave out subsection (8).

*See the statement for Amendment 187.*

Amendment 21, in clause 8, page 5, line 29, at end insert—

“(8A) Regulations under subsection (6)(a) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory.”

*This amendment would require the registered medical practitioner acting as the independent doctor to have undertaken training on domestic abuse, including coercive control and financial abuse.*

Amendment 200, in clause 8, page 5, line 30, leave out subsection (9).—(*Kim Leadbeater.*)

*See the statement for Amendment 188.*

**The Chair:** I am satisfied that the items contained within the clause have been adequately debate. I do not therefore propose to permit a clause stand part debate.

*Clause 8, as amended, ordered to stand part of the Bill.*

## Clause 9

## DOCTORS' ASSESSMENTS: FURTHER PROVISION

**Kim Leadbeater:** I beg to move amendment 201, in clause 9, page 5, line 36, leave out “and their medical records” and insert

“, examine such of their medical records as appear to the assessing doctor to be relevant.”

*This amendment provides that the duty on an assessing doctor to examine a person's medical records is limited to records appearing to the doctor to be relevant.*

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

Amendment 422, in clause 9, page 5, line 36, after “records” insert

“make such enquiries of professionals who are providing or have recently provided health or social care to the person as the assessing doctor considers appropriate.”

*This amendment requires an assessing doctor to make such enquiries of professionals who are providing, or have recently provided, health or social care to the person as the assessing doctor considers appropriate.*

Amendment 468, in clause 9, page 5, line 37, at end insert—

“(aa) ask the person why they are seeking an assisted death.”

Amendment 423, in clause 9, page 6, line 20, at end insert—

“(2A) To inform their assessment, the assessing doctor must—

(a) consider whether they should consult a health professional or social care professional with qualifications in, or experience of, a matter relevant to the person being assessed;

(b) consult such a professional if they consider that there is a need to do so.

(2B) Where an assessing doctor consults a professional under subsection (2A)(b), the assessing doctor must give a written record of the consultation to the other assessing doctor.”

*This amendment requires the assessing doctor to consider whether they should consult specialist health or social care professionals, and to consult them if they consider there is a need to do so. A record of any consultation must be shared with the other assessing doctor.*

**Kim Leadbeater:** Amendment 201 provides that the duty on an assessing doctor to examine a person's medical records is limited to records appearing to the doctor to be relevant, which makes sense. Amendment 422 requires an assessing doctor to make such inquiries of professionals who are providing, or have recently provided, health or social care to the person as the assessing doctor considers appropriate. Amendment 423 requires the assessing doctor to consider whether they should consult health or social care professionals, and to consult them if they consider there is a need to do so. A record of any consultation must be shared with the other assessing doctor.

The amendments seek to emphasise the importance of taking a holistic and multidisciplinary approach to the assessments by both doctors. The Bill as drafted provides that the assessing doctor must

“make such other enquiries as the assessing doctor considers appropriate”

when making the first and second assessments. With the amendments, I have sought to strengthen that language, by being much more explicit and making specific reference to consulting health and social care professionals. I have done so in response to the evidence we have received from professionals such as nurses and social workers, who often spend a significant amount of time with terminally ill adults.

It is clearly right that the assessing doctors should have access to all relevant details of a person's medical records. If the records show that the person has recently been receiving health or social care, that may impact their application, so the doctors have to consult the providers of that care. As is the case at all stages in the process, records should be kept of any and all such discussions, and reports should be shared where appropriate.

Taken together, the amendments would ensure that the doctors' assessments are thorough and comprehensive, and have taken into consideration the views and opinions of any wider health and social care team that may be working with a patient.

**Danny Kruger:** I will speak briefly to each of the amendments in this group. I will allow my hon. Friend the Member for Reigate to speak to the amendment in her name, but I state clearly that I very much support it. In my view, it is very important that the doctor asks the simple question of the patient, "Why do you want an assisted death?" The question is not being asked at the moment.

I respect the points that the hon. Member for Spen Valley has just made about amendment 201, and that the amendment may be intended to focus assessments on the information that is relevant. Nevertheless, it would introduce subjectivity into what is deemed relevant, and by narrowing the scope of the review of patient records, it could unintentionally allow for incomplete assessments, thereby undermining the safeguards that we all want to see. The risk is that potentially crucial medical history, including past mental health concerns, poor coercion indicators or undisclosed diagnoses, might be overlooked.

I call the Committee's attention to the evidence from the British Geriatrics Society, which raised concerns that the definition of terminal illness in the Bill is often vague and risks misclassification, especially for older patients. Limiting the review of medical records could exacerbate that issue, as doctors may not have a full picture of the patient's long-term prognosis and their mental health history. The General Medical Council has called for strong regulatory oversight to ensure that eligibility assessments are thorough.

Allowing doctors to determine which records are relevant, without standardised criteria for that judgment in the Bill, risks inconsistency and potential misdiagnosis. The criteria should include diagnosis and prognosis, treatment history, consultation, second opinions and mental health history. Consideration should also be given to disclosures of domestic violence and abuse, or patterns in medical records that might indicate domestic abuse without explicit disclosure, such as frequent visits for unexplained pain, chronic pain complaints, mental health concerns such as anxiety and depression, inconsistent explanations for injuries, and multiple visits to different healthcare providers. All of that should be properly considered by the assessing doctor.

I draw the Committee's attention to the fact that in the Netherlands, 1% to 2% of assessments annually—a significant number when we consider the volumes we are talking about—are deemed "not careful" under the law. Other countries do not have adequate ability to look into the data, but that is significant, and it is often due to inadequate consultation or documentation. I also draw attention to the fact that in our country, I am afraid to say, the cause of death listed by doctors is too frequently inaccurate. Analysis of postmortems suggests that one in 20 deaths have been wrongly recorded. Clearly, mistakes are made in medical records, and therefore it is particularly appropriate to require doctors to give complete consideration to the full medical history of the patient.

I recognise very much that we are trying to create a Bill that works in practice; nevertheless, I think we can emphasise streamlining and efficiency at the expense of patient safety, and we are doing that here. If we tell doctors that they are only required to sift through records that appear relevant to them—a quick skim of recent notes, a glance at the obvious items in a medical history—that may sound efficient, streamlined and practical, but it is likely to leave the vulnerable exposed, in particular when social workers and psychiatrists are not involved at this early stage, as they plainly should be. No multidisciplinary team is looking at the patient at this stage.

10.30 am

Medical records in England and Wales are not an easy read, which is perhaps why concerns have been expressed about the requirement that doctors address the entirety of a patient's medical history. That is a problem. There is a sprawling and fragmented archive of information. I have been discussing that with doctors to try to understand what they have to do. A patient's story spills across GP files on EMIS or TPP, hospital notes from separate NHS trusts and scraps of paper from decades past. The NHS app gives a snapshot, but not the full picture.

Great care is needed from a doctor reviewing an assisted dying request, not only when it comes to diagnosis and prognosis—as we have discussed at length—but to gain a complete picture of the patient. Mental health history is where vulnerability screams the loudest. I have discussed this with doctors who have raised their concerns with me. A recent record might say, "Anxiety: sertraline prescribed", which would appear relevant, but what if a psychiatry file siloed in another trust states: "Severe depression, 2023: suicidal ideation"? What if a GP note from five years back states: "Patient tearful, family pressure"? Those are not flashing neon signs, but they are there. The complex and difficult cases that we have spoken about again and again are the ones that are missed when a doctor skips the deep dive—when they look just for what they regard as relevant information, providing the necessary legal cover for any criticism after the event.

Let us think about abuse. Coercion does not advertise itself. A patient's "yes" to assisted dying in last month's consultation might look voluntary, leading us to close the case, but a safeguarding log saying, "Concerns raised about son's influence, 2022" or "A&E visit: bruising unexplained" might sit untouched in files that might be dismissed as irrelevant. We know that these things are already missed too often.

This is not hypothetical. Buckinghamshire Disability Service informed me that disabled people are so used to finding that their NHS records are incomplete or inaccurate that Citizens Advice and other advice agencies recommend to them that they get their local record—their summary health record—personal independence payment-ready before they apply for disability benefits. People extremely commonly find diagnoses and treatments missing, wrong dates and inaccurate statements—the wrong leg listed as amputated; allergies or medication intolerance wrongly cited; major health incidents, including heart attacks, not listed; long-term conditions such as diabetes wrongly listed or not included. Mental health conditions are particularly likely to be missed off health summaries. This is not about bureaucracy or drowning doctors in paperwork.

**Lewis Atkinson:** Does the hon. Member share my concern that the wording in medical records has no duration over a person's lifetime? For example, consulting all the medical records of someone in their 70s or 80s at the end of their life would surely include the records from when they were a child—childhood vaccinations, the removal of tonsils and so on—and that would clearly be impractical. Does he not agree that amendment 201 would clarify that element?

**Danny Kruger:** What the amendment clarifies is that the doctor does not have to look at any records at all unless he or she considers them relevant. It gives total discretion to the doctor to disregard huge swathes of the patient's history. Yes, I do expect the doctor to review the entirety of a patient's record—obviously, the record of a childhood broken leg can be skipped over quickly. What I do not want to do, as the Bill currently does, is allow the doctor to say, "Oh, I missed this evidence of a mental health condition" or "this indication of coercion from five or 10 years ago, because I didn't consider that aspect of their records to be relevant." It places a significant obligation on the doctor, but that is, I am afraid, what we are doing in the Bill. We are placing huge obligations on doctors and we should do it properly.

**Dr Opher:** As the amendment states, it is about examining medical records for things that are relevant. If we are talking about coercion or capacity, these sorts of items will be relevant. I do not know if Members have ever seen medical records. Some people have extremely large medical records, and we have summaries for that, but if a part of that summary indicated something that we were suspicious of, we would look into it. As my hon. Friend the Member for Sunderland Central has just said, the complexities of childhood tonsillitis do not really need to be examined in this case. We have to, and we always do, specify what we look into doctors.

**Danny Kruger:** As I have said in my many exchanges with the hon. Gentleman, I want to see the good practice that he claims—absolutely accurately, I am sure—to perform is applied across the system. He says that if doctors see in the summary some indication of concerns, they will look more closely into it. Well, I jolly well hope they would. The problem is that the summary might not be complete. I suppose the distillation of my point is that we should say, "Don't rely on the summary. Proceed with a proper analysis. Take responsibility for making sure that you have reviewed the entirety of the patient's record."

We have to address throughout our consideration of the Bill the workload that we are placing on busy professionals. Nevertheless, if we consider that this matters—and it is a question about knock-on effects on the NHS, which we could discuss in due course—it is appropriate to expect proper time to be taken. A specialist with two hours and a full record in front of them might spot the misdiagnoses, question the prognosis, flag the depression and catch the abuse. If given half the time and a licence to skim the record, as the amendment would give them, they could very easily miss something, so I think the word "relevant" is a great gamble.

**Lewis Atkinson:** The hon. Member is discussing amendment 201, but there is also amendment 422, which indicates that the professional should make inquiries

of other healthcare professionals who have been involved in treatment recently. Does he not agree that that would mitigate against the sort of scenario he describes?

**Danny Kruger:** I will come on to that. I agree with him: amendment 422 is a very helpful amendment, and I support that. It is a very good suggestion that wider consultation should be made, and it is a point that we have been trying to make with amendments throughout. I recognise that that would enhance the safeguards in the Bill—I am grateful to the hon. Gentleman.

Amendment 422 seeks to introduce an additional requirement that the assessing doctor must consider whether to consult health or social care practitioners who are providing, or have recently provided, care to the patient. The amendment is presented as addressing previously expressed concerns, but I regret to say that I feel it is excessively weak. It is a positive step in recognising the issue, but it does not ensure a broader and more informed assessment of a patient's condition and external influences.

Patients with terminal illnesses often receive care from palliative care teams, social workers or community nurses who might have crucial insights into their wellbeing and the potential external pressures on them. The British Psychological Society has highlighted that mental health and social pressures are often overlooked in assisted dying requests in other countries. Social workers and allied health professionals play a key role in assessing whether a patient feels pressurised due to financial, social or familial burdens. As I have repeatedly said and we will debate further in due course, in my view it is very important that that assessment comes earlier in the process.

We have evidence from doctors—I will not cite it at length—pointing out that independent doctors who refuse assisted dying requests are often ignored, and patients are simply referred to another doctor willing to approve the request, as we have discussed. Consultation with health and social care professionals could act as an additional safeguard against that practice. Although the amendment introduces an obligation to consult other professionals, it leaves it to the discretion of the assessing doctor. It relies on the doctor's subjective judgment

"if they consider that there is a need".

I think that is too weak for assisted dying, where consistency is so critical. One doctor might consult a palliative care specialist to explore pain relief options, while another might not, assuming that they understand the patient's suffering sufficiently. The variability in the Bill—this discretion—undermines fairness and safeguarding.

There is also a lack of accountability in what is a very sensitive process. There is no requirement to document the consideration process, which weakens oversight in a context where errors could be fatal. I respect the point made by my right hon. Friend the Member for North West Hampshire that we must not police conversations and that being prescriptive may encourage a tick-box approach. I am afraid that we risk that tick-box approach if this amendment is all that we do on this subject. We can imagine a scenario in which a doctor simply makes a note in the record with little underpinning substance.

There is also no obligation to act on the specialist input, so the duty ends at the consultation. There is no requirement to integrate the findings of the additional

input that the doctor has received, which is a glaring flaw in what is an irreversible procedure that is being authorised. Finally, there is insufficient rigour for the ethical stakes. This discretionary duty is too weak to catch the difficult cases.

**Kim Leadbeater:** On the hon. Member's point about recording those consultations, amendment 423 states in its proposed new subsection (2B):

"Where an assessing doctor consults a professional...the assessing doctor must give a written record of the consultation to the other assessing doctor." So the consultation is recorded.

**Danny Kruger:** The hon. Lady is absolutely right, and that is very welcome. My concern is that there is no obligation to do anything about it. There is no obligation for the doctor to integrate the conclusions of the additional professionals that they have consulted into their treatment. I recognise that that provision is valuable and I welcome the amendments, but I suggest that they do not go far enough.

Let me use a hypothetical example to bring my point home to the Committee. Imagine a woman with terminal lung cancer asking to end her life. Her assessing doctor considers consulting a palliative care specialist for symptom control or a social worker to check on her home life, but decides, "My notes are enough. There's no need for that." What if the patient's pain could be eased with a new approach that the doctor does not know about? What if her family's pushing her to spare them the burden of her care goes unnoticed without a social worker's input? The lady might die needlessly or be denied treatment unfairly.

The discretionary duty that the amendment would introduce essentially collapses because it does not force the broader scrutiny that patients deserve. The amendment sees the problem, but it is too feeble: it is too discretionary, too vague and too unenforceable for a choice as profound as assisted dying. While I will support it, I do not think it goes far enough.

Amendment 423 builds on amendment 422 by requiring that if the assessing doctor consults a specialist, a written record of that consultation must be shared, as the hon. Member for Spen Valley just mentioned. It is critical for transparency, consistency and accountability in decision making. In high-stakes cases, such as assisted dying requests, paper trails matter. Without a formal record, one assessing doctor might dismiss concerns raised by another professional without accountability—a point made by the hon. Member for Richmond Park.

As I pointed out in an intervention on the hon. Member for Richmond Park, it is remarkable how few jurisdictions around the world have such safeguards. The American model in Oregon, Washington and California does not track how many doctors a patient consults before finding one willing to approve an assisted dying request, so we do not know the extent of doctor shopping abroad. Canada's system does not require refusals to be formally documented, making it difficult to assess the patterns of approval. Ensuring that records are available to both assessing doctors would add an extra layer of scrutiny and help to prevent doctor shopping.

However, while the amendment is a step in the right direction, it does not require an independent review of the records. Sir James Munby, the former president of the family division of the High Court, has criticised the lack of procedural rigour in oversight mechanisms,

warning that assisted dying laws risk becoming a rubber-stamp exercise if refusals and approvals are not documented with transparency. The Royal College of General Practitioners has called for independent oversight of the entire process, not just a reliance on individual doctors. These amendments would partially address that, but would not fully resolve it.

Amendments 422 and 423 are welcome but otiose: they would simply give doctors permission to do what they should be doing anyway. If they are conscientious, they will do it anyway, and if not, they will not. It is slightly like an illegal gun amnesty: the good guys will not have illegal firearms in the first place, and the bad guys with guns are not going to hand them in voluntarily. I fear that we are requiring good behaviour of good people, and not requiring it of doctors who are not doing their job properly.

10.45 am

We are constantly told that the Bill is about patient autonomy, but in fact we are creating huge doctor autonomy, and in one direction only. Amendment 201 refers to

"appearing to the assessing doctor to be relevant",

amendment 422 to

"as the assessing doctor considers appropriate",

and amendment 423 to

"if they consider that there is a need to do so."

That is helpful in so far as it makes it clear they should pursue good practice, but there is a real concern that it will be seen as unnecessary to query the patient's wish, examine their records or consult previous medics or other specialists, because it will be regarded as bureaucracy.

It has been suggested in this Committee that we are creating unnecessary hoops for doctors and patients to jump through. I am afraid that leaving it to the doctor's discretion will compound the problem. Any discretionary inquiry to other doctors will be seen by the patient as unnecessary delay and will be potentially very stressful to them. My view is that inquiries should be routine and mandatory, but meaningful. They should be done properly. The only way to ensure that is by strengthening the Bill in the way we have suggested.

**Several hon. Members rose—**

**The Chair:** Order. Rebecca Paul has an amendment tabled in this group, so I shall call her next. I have had indications from Rachel Hopkins and Dr Opher that they wish to speak, and I see two others, of whom I shall make a note.

**Rebecca Paul:** It is a pleasure to serve under your chairmanship, Sir Roger. I rise to speak to my amendment 468 to clause 9, which would ensure that the assessing doctor must

"ask the person why they are seeking an assisted death."

We have heard a lot in this Committee about the importance of the patient-doctor relationship. My hon. Friend the Member for Solihull West and Shirley said that we should be

"trusting in the judgment of clinicians, who know their patients well"—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 26 February 2025; c. 634.]

He also said that patients

[Rebecca Paul]

“may want to speak to their GP because they have had a relationship with them over 30 or 40 years”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 25 February 2025; c. 481.]

It is therefore worth asking how the Bill shapes the patient-doctor relationship.

The Bill asks doctors to do many things to and for patients. It asks doctors to consider whether to raise the subject of assisted suicide; personally, I wish we had agreed to the amendment that would have ensured that it was the patient who brought the subject up first, but we are where we are. The Bill asks doctors to explain the patient’s diagnosis and prognosis and to lay out options for treatment and palliative care, if there is any available; if there is not, the doctor can only state that point and move on. Nevertheless, we are asking the doctor to look into the matter and lay out possibilities.

The Bill asks doctors to check for capacity and for coercion, to ascertain whether the patient has a clear, settled and informed wish to end their own life, to witness declarations and, eventually, to give the patient a substance and oversee the patient taking it. In other words, it makes doctors absolutely central to the process, as the facilitators of the process, as the people who accompany the patient and as the professionals with the biggest responsibility for ensuring that the safeguards are followed, yet it never asks doctors to make a simple but vital inquiry: why?

That is all that my amendment would add. It would simply require the assessing doctors to ask the person why they are seeking an assisted death. I hope that the Committee will agree that that would be a reasonable and not overly burdensome change. Some hon. Members have suggested that certain amendments embroider the Bill too much, but in this case, the patient-doctor conversation is already embroidered. The Bill makes some very specific demands of the doctor as to what the conversation should cover. Surely it is only natural, amid all the conversations, for the doctor to take a moment—perhaps more than a moment, but a moment at the very least—to help the patient to talk through their reasons. This is a very vulnerable moment in somebody’s life.

The simplest of questions can often unlock the most information. In some cases, for the small number who would benefit from the Bill, the answer would probably reassure the doctor, but for those others we worry about, the question would provide another important safeguard. It would be another opportunity to check that this really is in the best interests of the patient.

How would the conversation go? I do not think that we can generalise. It might be the briefest exchange or it might lead to a really searching discussion. Doctors know how to take their cue from the patients in these things. Crucially, the doctor’s role is not just to offer advice or information. Even if the doctor says nothing, it may make all the difference for the patient to be able to speak aloud their concerns, their confusion and their hopes and fears. I absolutely accept that many doctors, if not most doctors, would ask the question why anyway, but given its importance, I still urge the Committee to set that out in the Bill. In doing so, we would be affirming that this is more than a bureaucratic exercise; it is about a person and about getting to the truth of what they want and need.

I do not think we should not make the mistake of assuming that every doctor has the time, or will take the time, to have the in-depth conversations needed to really understand what is driving a patient’s request. It is up to us to make legislation that keeps standards high at all times. There is currently nothing in the Bill that will guarantee an in-depth conversation. I am afraid that not all doctors believe that that is even a likely outcome. In written evidence, the GP Edward Tulloch states:

“To conduct the required assessments outlined in 7.2 and 8.2 of the Bill within a standard GP appointment (lasting 10-15 minutes) is completely unrealistic. It will require multiple appointments to properly carry out such detailed discussions and complete the associated legal paperwork.”

We all know what pressure the NHS is currently under. Many of us cannot get a GP appointment. So, how certain are we that adequate time can be allocated to the assisted dying process to ensure the criteria are truly met?

By putting the “why” question on the face of the Bill, my amendment would bring us closer to the possibility of real, serious and honest conversations about a patient’s reason for seeking an assisted death. That would be especially helpful for those who have just received a terminal diagnosis. We have received some important written evidence from six palliative care doctors, who state that

“our experience is that many patients experience a period of adjustment to ‘bad news’ and may say that they cannot live under these conditions. However, after a period of reflection and adjustment, the majority come to find peace and value in their altered life circumstance, in a way they would not have believed possible.”

The consultant psychiatrist Jennifer Bryden provides an especially interesting perspective, as someone who has seen this from both sides:

“Having gone through several long episodes of illness, I now know that feeling entirely useless and a burden to everyone is a phase that will pass. For many people a terminal diagnosis will be their first time through the cycle and they will believe those thoughts represent reality. In coming to terms with a severe illness, depression is an expected phase and learning to accept all humans need each other takes time”.

Dr Bryden goes on to say that the current cooling-off period is not enough time for people to come to terms with such a diagnosis. Clearly, people may need all the help they can get to understand their new situation. Asking the patient for their reasons is only the beginning of that process, but one that may help them come to terms with their situation and validate, or not, their initial inclination.

Finally, asking why can identify those patients who are being coerced or pressured. Nobody should think that that is easy to spot. According to the charity SafeLives, which counters domestic abuse, it takes the average person who experiences violent abuse 2.3 years to access effective help. In the year before they finally get help, 85% of victims will have sought help of some kind from an average of five professionals. Often, sad to say, those who missed the signs will have been healthcare professionals. That is for physical abuse; psychological abuse will be far harder to spot. We cannot put in enough safeguards to ensure that doctors have all the tools they need and all the opportunities they can, to spot those signs.

**Jack Abbott** (Ipswich) (Lab/Co-op): For clarity, at what point in the conversation does the hon. Member expect the question to be raised? In reference to an assessing doctor, do I take it that the question must be asked twice, at different times, by both the co-ordinating and the independent doctor?

**Rebecca Paul:** I thank the hon. Member for his very good questions. I suggest that it be asked twice, because it makes a lot of sense to ensure that the patient is given the chance to really explain what is driving their decision. It is the simplest of questions, but it is amazing what can sometimes come out of the simplest question.

I return to the safeguard against coercion. In a sense, this is not a new safeguard; rather, it confirms and bolsters the other safeguards in the Bill, which are there to explore the reasons for assisted dying. Asking why will help doctors to better understand what is driving a patient's decision and to give that patient an opportunity to validate that they are truly eligible. It is the simplest of questions, driving the most significant conversation that a doctor and patient can have. I hope that hon. Members will support my amendment.

**Rachel Hopkins** (Luton South and South Bedfordshire) (Lab): It is a pleasure to serve under your chairship, Sir Roger. I rise to speak in support of amendments 201, 422 and 423, which stand in the name of my hon. Friend the Member for Spen Valley, and against amendment 468.

On amendment 201, a point was made earlier about the relevance of records. It was mentioned that it might well not be relevant to look at a childhood tonsillectomy. However, I wish to speak in slightly more specific terms, in support of women and their reproductive rights, and to highlight the risk of unconscious bias if all records are to be looked at.

If a woman had a termination in her teenage years, that will be highly irrelevant to her decision, many decades later, whether to choose an assisted death. Relevance is very important, because there will be a high level of record keeping in the process. It is not only the doctors working with the patient on the assessment who will read the records and reports; ultimately, it will also be the panel. I make the point again that so many parts of a patient's medical records are highly irrelevant to the diagnosis and prognosis of a terminal illness, and to the six months under the eligibility criteria. Indeed, there is a risk of unconscious bias in the judgment. It is about the professionalism of the doctor in respect of understanding the records that are relevant for the process.

**Danny Kruger:** Will the hon. Lady give way?

**Rachel Hopkins:** I will continue, if I may.

I turn to amendments 422 and 423. The importance of a rounded, holistic assessment and discussion with the patient has been pointed out in many of our discussions, as has the importance of the multidisciplinary team and the other health and care professionals who support the patient with health and social care. That would all have to be recorded—the conversations that have been had, and why the assessing doctors and other health and social care professionals were involved. In oral evidence, many doctors in other jurisdictions said that they worked

in multidisciplinary teams. The amendment would firm that up. It is about being clearer, because the clarity that the amendments provide would make for a stronger process.

On amendment 468, the hon. Member for Reigate pointed out that it asks a very simple question. However, I return to the point about the professionalism of the doctors involved in the process, who will be working within the legal requirement under the Bill that the individual have a clear, settled and informed wish. The doctors will have to check individuals' eligibility under the requirements, for example that they are over 18 and have a terminal illness with a six-month prognosis. The doctors will use their expertise and professionalism, and that of the multidisciplinary team, to make assessments about coercion. They have strong rules about assessing for capacity.

The requirement to ask why someone wants an assisted death is a requirement to police the conversation that the doctor has with their patient. Setting it out in primary legislation would lead to a tick-box exercise, with doctors saying, "You've told me a number of times already in our conversation that I've been having with you, but I'm sorry: I have to officially ask this question and tick the box." That could lead to an insensitive conversation and relationship between the relevant people in the process.

To a certain degree, the patient may think, "So what? Do I have to tell you why? It is none of your business why I want to pursue this legal course of action down the line." I appreciate where the hon. Member for Reigate is coming from, but with the best of intentions, her amendment would actually lessen the individual's autonomy and their right to choose what if the Bill passes will be a legal course of action. I am content that the stringent training that will be required for any of the assessing healthcare professionals will enable a good holistic conversation so that good judgments can be made. Adding this extra sentence would detract from that, so I cannot support the amendment.

11 am

**Sojan Joseph** (Ashford) (Lab): I support amendments 422, 468 and 423, which I think would strengthen and safeguard the Bill. However, as someone who worked in mental health for many years, I have grave concerns about amendment 201, which would restrict access to medical records. Health professionals work in environments with great confidentiality of records; I have no concern about health professionals or doctors having access to health records. Some Committee members have talked about doctors not needing to know whether a person had tonsillitis, but most medical records or GP summaries will note whether someone has had tonsillitis, along with details about vaccinations and infections. I do not think that those records will necessarily be relevant or that a doctor would look in detail at what medication they have had in that respect.

What is relevant, however, are records for people who have a mental health disorder or are vulnerable. For example, people with serious mental illnesses such as chronic treatment-resistant schizophrenia may be on treatments such as clozapine that, if stopped, will have an impact on their mental health. The treatment that they may undergo during terminal illness may have an interaction, and medication that they have been using

[Sojan Joseph]

for many years to treat their mental health condition may have to be stopped. Doctors need to know why the person wanted to choose that route, and whether it will have an impact on their mental health.

Restricting access to important medical records by the doctor who makes the decision will have an impact on very vulnerable people. As we have discussed before, people may be homeless or may not have any family members, and it will all have an impact on why they decide to seek the assisted dying route. People may feel that they are a burden to society and the system. If there is any documentation from six months or a year ago, it will be relevant for the doctor. Removing access to medical records for doctors will have an impact on people with mental disorders, intellectual disabilities and neurodevelopmental conditions, so I oppose amendment 201, although I support the other amendments.

**Naz Shah:** I will try to keep my remarks brief. I first speak to amendment 468, tabled by the hon. Member for Reigate, on the asking of the question why someone wants to have an assisted death. When I originally came to this debate, Dermot, a humanist who was also my election agent—a lovely guy—came to me and said, “Now that this Bill is going through Parliament, will you support it?” I said, “Explain it to me.” He never once mentioned the word “autonomy”. If I remember correctly, what he talked about was suffering, pain and horrible deaths, which many hon. Members have referred to. We have heard lots of examples during this Bill Committee.

My hon. Friend the Member for Luton South and South Bedfordshire said that the decision was none of a doctor’s business and that the issue was about autonomy. However, if a woman was being coerced into an assisted death, the idea that it was none of the doctor’s business would not quite wash with me. We talk about autonomy, but if someone does not have autonomy in their lives—if they are in an abusive relationship, are a victim of coercion or have a vulnerability—they might not have the choice.

When we ask a question, it is often about something else. I have experienced this myself. I am very passionate; when I am talking about things, somebody might just stop me and say, “Naz—what’s this actually about?” That is all it takes to make me stop, take a step back and a breather, and think for a deeper minute about whether the issue could actually be about something else. We do not always stop to think.

**Dr Opher:** The amendment is good practice; I do not in any way deny that. The hon. Member for Reigate is obviously coming from a really good place. However, the amendment is almost like specifying that when someone goes to see a doctor, the doctor has to say, “How can I help? What is wrong?” It is just unnecessary; that is my only feeling about it. If someone came in and said, “I would like to request an assisted death”, the doctor would not just say, “Okay”—they would ask how the patient was feeling. It is normal medical practice to ask what is going on in someone’s mind, so that does not need to be specified in the Bill.

**Naz Shah:** I thank my hon. Friend for his intervention. There is a medical model and a social model of intervention. If I walk into a GP surgery with a really bad headache,

I am prescribed paracetamol. If the headache gets worse, I am prescribed something stronger—maybe co-codamol or codeine. Doctors are really busy. We have had to add another 40,000 appointments just for people to get through systems, so we know how hard it is to get a GP appointment.

If the person who turns up at the GP’s with a headache is usually quite healthy, the doctor might not take a minute to ask about what has actually happened. If I say, “I have a headache because I am banging my head against the wall—I have that much stress”, that is a whole different conversation. Having that conversation with the patient—probing a little more—is, for me, very important from a holistic point of view.

**Rachel Hopkins:** I want to check that my hon. Friend was not implying that I had not thought deeply—for more than a minute—in the course of making my comments earlier.

**Naz Shah:** No, that was not my implication. When referring to my hon. Friend’s remarks, I was speaking about a patient perhaps saying “It is none of your business” or that my hon. Friend was talking just about autonomy.

**Rachel Hopkins:** I am grateful to my hon. Friend for reiterating those points. Does she accept that it is a patient’s right to say, “It’s none of your business” in the course of the conversation?

**Naz Shah:** I absolutely accept that it is the patient’s right to say, “It’s none of your business”, with the really clear caveat that they could well be a vulnerable patient. They might say that it was none of the doctor’s business, and that doctor might then not be able to explore the other things going on with that patient. That is why, for me, this does not wash.

The point that I am trying to make is that, in the course of a normal consultation, it is presumed that every doctor will know their patient and be able to have these conversations. In most cases, they probably will because we have amazing doctors; I have amazing relationships with my doctors. But does that mean that the doctors will ask that one question: “Why?” That is the crux of the whole Bill.

**Rebecca Paul:** The right to say, “It’s none of your business” might be fine when no one else is involved, but if someone seeks an assisted death, that involves multiple members of NHS staff. There is an impact on all those people, who need to be comfortable with what they are doing. Maybe the person needs to accept that they do need to provide some information so that the medical staff feel comfortable about the question of eligibility.

**Naz Shah:** That opens up a whole different debate for me. Some clinicians will not sign up to this process and some will. That is a whole different debate, but I take the point that there has to be a reason.

We talk about the option for referral to palliative care. I have previously moved amendments that would have meant a referral, without the option; however, when considering that option, a doctor needs to understand that if a patient says, “I do not have to explain myself—full stop”, or, “I do not want to talk about palliative care”,

that should raise alarm bells. If a doctor says, “You’ve got this terminal illness. These are the options—let me spell them out for you. You have the option of referral to palliative care and the option of these drugs, so why do you want to kill yourself?”, and the patient turns around and says, “It’s none of your business”—

**Rachel Hopkins:** Will my hon. Friend give way?

**Naz Shah:** Sorry, I will just finish my point.

From a common sense perspective—I am not medically qualified—that situation should make me, as a human being, want to understand more. As a human being, I would like to understand whether something else was going on, such as anger towards—

**Jake Richards:** Will my hon. Friend give way?

**Naz Shah:** Sorry, I will not give way until I have finished my point.

I would like those conversations to be at least explored, which is why I support the amendment.

**Rachel Hopkins:** The Bill already sets out a number of things that a doctor has to assure themselves of, with regard to coercion and capacity. They would do that having had a significant amount of training to establish, in the round, after consulting others, that one way or another the legal requirements have been met. The “Why?” question appears to me to bring in a judgmental element—

**Kit Malthouse** (North West Hampshire) (Con): Subjective.

**Rachel Hopkins:** Indeed: subjective, as the right hon. Gentleman said. That is the point that I am trying to get at. There is an objective assessment, which is wholly appropriate, but a subjective assessment would lead down a different route and muddy the objective assessment.

**Naz Shah:** I absolutely see where my hon. Friend is coming from and appreciate her concern, but we will have to agree to disagree as we have a difference of opinion. A subjective assessment might reveal that something else is going on for that patient.

I hate to put myself in this position, but imagine I have just received a diagnosis and I am going to die within six months. I could have a whole load of anger about that happening to me and I could say, “I don’t want this. I don’t want to talk about it. It’s none of your business. I’m angry—this is what I want.” At that point, does the doctor stop? In most cases, my hon. Friend the Member for Luton South and South Bedfordshire is absolutely right, but in some cases she might not be. I might want to shut the conversation down because I am angry or because other things are going on in my head and I do not want to explain. Amendment 468 would allow the doctor, from a compassionate point of view, to have another conversation with the patient.

11.15 am

**Jake Richards:** Does my hon. Friend agree that she is making a powerful case against amendment 468? A multitude of conversations and different circumstances will need to be taken into account; it is wholly inappropriate

to have a mandated question in primary legislation. We should go back to clause 1, which I think the Bill is actually about. It states that the person must have “a clear, settled and informed wish to end their own life”.

Does my hon. Friend agree that that is what is at the heart of the Bill, rather than decisions about what is in the person’s best interests?

**Naz Shah:** I respectfully disagree. I am making the case that there is a conversation to be had. Yes, there is informed choice but is my hon. Friend suggesting that the question should not be asked at all? I take the point that with an informed choice there would have been an exploratory conversation, but sometimes just calling something out, or stating the obvious, makes a huge difference.

**Rebecca Paul:** I wish to clarify that the amendment is about not an additional assessment but merely a simple question. Like many who have spoken, I hope that most good doctors would ask the question anyway and take the answer. It may inform them or it may not but sometimes, as the hon. Member for Bradford West has just discussed so powerfully, it is helpful to remind medical staff, who are under lots of time pressure, that sometimes it is worth stepping back and asking why.

**Naz Shah:** I agree. Sometimes it will be the simple thing of asking the question as a human being—among all the conversations that are happening, just stopping and asking why.

**Jack Abbott:** I appreciate that my hon. Friend has given way a number of times, but I gently suggest that we already know the crux of the Bill and what we are debating. The “why” is that people with a terminal diagnosis, with six months to live, would like a course of action to end their lives in a pain-free way and to have the autonomy to do so.

We are in danger of over-legislating for a range of different permutations that could potentially happen in conversations. I agree that these kinds of questions are absolutely crucial, but it may satisfy my hon. Friend that amendment 21, to which we agreed a few moments ago, requires medical practitioners to take training on “domestic abuse, including coercive control and financial abuse”. That sort of protection and safeguard has already been agreed to.

We will rely on highly specialised individuals to pick up on these issues. They may want to explore, through further questioning, why people are making these decisions but we cannot legislate for all the different sorts of conversations, and all the emotions that may be going through people’s minds. If someone comes back and says, as my hon. Friend put it, “Well, it’s none of your business,” or whatever the answer may be, we will rely on the specialised professionals to pick up on danger signs. However, that would not necessarily lead them in every single conversation to have a suspicion of the patient’s motives. Life and conversation do not work like that and we cannot legislate in that way.

**Naz Shah:** I absolutely agree that life does not work like that. Life is very complicated and that is why I want the conversation to happen. My hon. Friend referred to amendment 21, which we have just agreed to. I spoke

[Naz Shah]

extensively about why that is a brilliant amendment that moves us towards much more safeguarding, but I also think that it does not go far enough for women, marginalised communities and people from ethnic minority backgrounds. I genuinely do not feel that amendment 468 is about over-legislating. It is just stating an obvious fact: sometimes, even in normal life, we go around the houses to get to a conversation and get to the right point. That is what I want to get to.

**Jack Abbott:** To follow up on the example my hon. Friend gave earlier, if—to be glib—someone said, “None of your business”, she would want the doctor to keep probing. At what point does that end? If someone genuinely does not want to have that conversation and says, “I want to end my life because I have a terminal diagnosis. I live in fear of the pain that could await me and I don’t really want to go into much detail,” where does that end? Where does that conversation continue to?

**Naz Shah:** My hon. Friend makes my case for me. If that person says, “It’s none of your business, but I have so much pain,” at that point, automatically, as we naturally do as human beings—

**Jack Abbott:** But this is a pure example.

**Naz Shah:** That example is a good example that strengthens my position.

**Danny Kruger:** I completely agree with the hon. Lady’s point. The conversation goes on in the way the doctor would want it to, but they have at least asked the question. Is it not very simple? The Bill already requires doctors to look for signs of external coercion. As we have acknowledged, there is no way to determine internal coercion—the influence people have on themselves. There is no way in the Bill at the moment to identify whether somebody feels that they want an assisted death because they fear that they are a burden to others. This question is the only opportunity we have to tease out that answer: does she agree?

**Naz Shah:** I thank the hon. Member for that intervention and he makes an important point.

**Kit Malthouse:** What is an acceptable answer? Can we have a list?

**Naz Shah:** Does the right hon. Gentleman want to intervene?

**Kit Malthouse** *indicated dissent.*

**Naz Shah:** The hon. Member for East Wiltshire makes an important point. Where are the opportunities? When doctors are doing the assessment.

The other issue that speaks to me is the question of internalised bias. We will have professionals with subconscious bias or affirmed bias. They will be clinicians who have chosen or agreed to take part in the process; fundamentally, the majority of clinicians will not take

part in this process because of their beliefs. It changes the relationship between doctor and patient from a societal perspective.

I know that a number of times I have been stopped during a process and asked a different question, and at times that opportunity for reflection—even without the pressure of knowing I have only six months to live—is of benefit to me. I am sure that others would benefit from it, too, particularly because the decision is so momentous. For that reason, I will certainly support amendment 468.

I thank my hon. Friend the Member for Spen Valley for tabling amendment 201. I have mixed views on it. I appreciate what my hon. Friend the Member for Luton South and South Bedfordshire said about medical records, especially when it comes to women and their past, but I also appreciated what my hon. Friend the Member for Ashford said about his experience from a mental health perspective.

I am still thinking about the amendment and I am not sure whether I will support it or not, but further thought needs to be given to the subject. There are the issues of mental health and women’s rights, but another issue applies, too. If someone has experienced trauma in childhood but that trauma has come out much more recently, even though it does not necessarily affect the decision at hand—whether to choose an assisted death—is there some kind of historical post-traumatic stress disorder that would then need to be explored? I do not have the answer, but I look forward to hearing the comments of my hon. Friend the Member for Spen Valley on that point. I would value hearing whether she has thought about that and what her understanding of it is.

**Stephen Kinnock:** As I have mentioned before, the Government have worked closely with my hon. Friend the Member for Spen Valley on some mutually agreed amendments, including amendments 201, 422 and 433. The amendments that the Government support aim to ensure the legal robustness and operability of the legislation, should it pass, and I will offer a technical explanation for them.

Amendment 201 will clarify the wording in clause 9 on the doctor’s assessment. It provides that the duty on an assessing doctor to examine a person’s medical records applies only to records that appear relevant to the doctor. The effect of the amendment is to make clear as part of the assessment process that the assessing doctor is required only to review medical records that are considered by the doctor to be relevant to the person’s request to seek an assisted death.

Amendment 422 would add an additional requirement on an assessing doctor to make inquiries of professionals who are providing or who have recently provided health or social care to the person and make such other inquiries as the assessing doctor considers appropriate. This applies to—

**The Chair:** Order.

11.25 am

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

*Adjourned till this day at Two o’clock.*