

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Nineteenth Sitting

Wednesday 5 March 2025

(Afternoon)

CONTENTS

CLAUSES 5 TO 7 agreed to, with amendments.

CLAUSE 8 under consideration when the Committee adjourned till Tuesday 11 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House.

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

not later than

Sunday 9 March 2025

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The Committee consisted of the following Members:

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

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

Public Bill Committee

Wednesday 5 March 2025

(Afternoon)

[CAROLYN HARRIS *in the Chair*]

Terminally Ill Adults (End of Life) Bill

2 pm

The Chair: I wish to notify the Committee that I have selected amendment (a) to amendment 420 for a separate decision. When amendment 420 is moved, I will invite Danny Kruger to move amendment (a) to amendment 420 formally.

Let me also say that I will not tolerate the word “you”, that I will not tolerate long interventions and that Members are to address the Chair, not other members of the Committee. If we stick to those rules, I am sure we will get along just fine.

Clause 5

INITIAL REQUEST FOR ASSISTANCE: FIRST DECLARATION

Amendment proposed (this day): 360, in clause 5, page 3, line 23, at end insert—

“(e) who, if receiving remuneration for the provision of services in connection with the provision of assistance to that person in accordance with this Act, makes publicly available an annual statement setting out total turnover from the provision of services under this Act and the number of patients assisted, and such other information as the Secretary of State may specify by regulations.”—
(*Danny Kruger.*)

This provides that if the coordinating doctor receives remuneration for providing assisted dying, they must then make a public annual statement about their operation.

Question again proposed, That the amendment be made.

The Chair: I remind the Committee that with this we are discussing amendment 361, in clause 5, page 3, line 28, at end insert—

“(7) Regulations under subsection (3)(e) are subject to the affirmative procedure.”

This is linked to Amendment 360.

Kim Leadbeater (Spen Valley) (Lab): I have nothing further to add in this debate.

Danny Kruger (East Wiltshire) (Con): In the light of the suggestion from the hon. Member for Spen Valley that there will be further amendments later, when we can discuss the shape of the provision and presumably any remuneration, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 186, in clause 5, page 3, line 23, at end insert—

“(3A) 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 act as the coordinating doctor.

(3B) The regulations must include training about—

(a) assessing capacity;

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

(3C) 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.”—(*Kim Leadbeater.*)

See the statement for Amendment 185.

Amendment made to amendment 186: (a), after

“(b) assessing whether a person has been coerced or pressured by any other person.”

insert

“(c) specific and up-to-date training on reasonable adjustments and safeguards for autistic people and people with a learning disability.”—(*Daniel Francis.*)

Amendment 186, as amended, agreed to.

Kim Leadbeater: I beg to move amendment 187, in clause 5, page 3, line 24, leave out subsection (4).

This amendment is consequential on NC8, which contains a single duty to consult before making regulations under various provisions of the Bill.

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

Amendment 188, in clause 5, page 3, line 28, leave out subsection (6).

This amendment is consequential on Amendment 233, which contains a single set of provisions about the procedure for regulations under the Bill.

Amendment 192, in clause 6, page 3, line 36, leave out subsection (4).

See the statement for Amendment 188.

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

See the statement for Amendment 187.

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

See the statement for Amendment 188.

Amendment 206, in clause 11, page 7, line 24, leave out subsection (3).

See the statement for Amendment 188.

Amendment 211, in clause 19, page 13, line 31, leave out subsection (5).

See the statement for Amendment 187.

Amendment 212, in clause 19, page 13, line 33, leave out subsection (6).

See the statement for Amendment 188.

Amendment 213, in clause 20, page 13, line 39, leave out subsection (3).

See the statement for Amendment 188.

Amendment 215, in clause 28, page 17, line 11, leave out subsection (3).

See the statement for Amendment 188.

Amendment 216, in clause 30, page 18, line 37, leave out subsection (4).

See the statement for Amendment 188.

Amendment 217, in clause 30, page 18, line 38, leave out “that procedure” and insert “section 39”.

See the statement for Amendment 188.

Amendment 218, in clause 32, page 19, line 31, leave out subsection (4).

See the statement for Amendment 188.

Amendment 219, in clause 33, page 20, line 24, leave out subsection (5).

See the statement for Amendment 188.

Amendment 222, in clause 38, page 23, line 1, leave out subsection (2).

See the statement for Amendment 188.

Amendment 233, in clause 39, page 23, line 6, leave out subsections (3) to (5) and insert—

“(5A) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under section 5(3A), 8(6A), 30(3) or 32 unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(5B) Any other statutory instrument made by the Secretary of State containing regulations under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.”

This amendment brings together the various provisions about the procedure for regulations and makes regulations under clauses 5 and 8 about training, qualifications and experience subject to the draft affirmative procedure.

Amendment 225, in clause 40, page 23, leave out line 23.

The amendment is consequential on Amendment 233.

Amendment 226, in clause 40, page 23, leave out line 37.

The amendment is consequential on Amendment 233.

New clause 8—*Duty to consult before making regulations*—

“(1) Before making regulations under section 5, 7, 8, 13, 19 or 21, the Secretary of State must consult—

- (a) the Commission for Equality and Human Rights, and
- (b) such other persons as the Secretary of State considers appropriate.

(2) The persons to be consulted under subsection (1)(b) must include—

- (a) persons appearing to the Secretary of State to have expertise in matters relating to whether persons have capacity, and
- (b) persons appearing to the Secretary of State to have expertise in matters relating to whether persons have been coerced,

unless the Secretary of State considers that, having regard to the subject-matter of the proposed regulations, it would not be appropriate to consult such persons.”

This new clause imposes a duty to consult before making regulations under various provisions of the Bill.

Kim Leadbeater: This group of amendments is consequential on new clause 8, which would create a single duty for the Secretary of State to consult before making regulations under various provisions of the Bill. It would consolidate the previous requirements to consult in relation to clauses 5, 8 and 19 and expand the duty to cover additional clauses. It would require the Secretary of State to consult the Equality and Human Rights Commission and such other persons as the Secretary of State considers appropriate. The persons to be consulted under subsection (1)(b) must include persons appearing to the Secretary of State to have expertise in matters relating to whether persons have capacity, and persons appearing to the Secretary of State to have expertise in matters relating to whether persons have been coerced.

This is an important strengthening of the Bill. It applies to multiple clauses: clauses 5, 7, 8, 13, 19 and 21. The duty to consult experts, particularly on issues around capacity and assessing for coercion, is an important change that reflects the detailed debate that the Committee has undertaken on those two important issues.

Amendment 233 brings together the various provisions about the procedure for regulations. It would make the regulations to be made under clauses 5 and 8, on training, qualifications and experience, subject to the draft affirmative procedure, so that Parliament has to debate and approve them first. Again, that would strengthen the Bill.

Danny Kruger: In a sense, this is a technical set of amendments that consolidate the provisions for secondary legislation. However, it reflects the seriousness of a concern that I and others have raised, which is that so much in this Bill will be left to the discretion of Ministers, often through the negative procedure.

It is important to reflect briefly on the questions that we are considering. The hon. Lady has mentioned quite a few of them, but we are talking about the training of doctors; the High Court procedure, if there is one; the substances that may be used in the administration of assisted death; the prescribing of those substances; the registration of deaths; the codes of practice to be introduced; provision through the NHS; notification to the chief medical officers; changing the schedules in the Bill, and so on.

Those are important matters. I recognise that many of them are complicated and technical, and that it is appropriate to leave them to a degree of professional and ministerial discretion. Nevertheless, my great concern, which relates to the parliamentary procedure—you may have a view on this, Mrs Harris—is that we are having this debate without the benefit of a delegated powers memorandum to explain why each power has been taken, the nature of it, the reason for taking the power and the procedure to be selected.

In a recent report on the Bill, the Hansard Society notes that under the Government’s “Guide To Making Legislation”, a delegated powers memorandum would normally be published prior to Second Reading for a private Member’s Bill on issues of conscience on which the Government are neutral. The report explains that a delegated powers memorandum gives

“details of each power in the bill, including its context, its scope, to whom the power is delegated, and the parliamentary scrutiny procedure...the reasons for taking the power; and...why.”

It points out that

“where the responsible department recommends that the Government should support the Private Member’s Bill or remain neutral then a DPM should be produced for consideration by the relevant Cabinet Committee—the Parliamentary Business and Legislation (PBL) Committee—alongside other key documents such as the explanatory notes, a legal issues memorandum, and an impact assessment”.

We have not yet had an impact assessment either.

The Chair: Order. I ask the hon. Member to speak to the amendments. You have gone out of scope.

Danny Kruger: I am sorry about that. I am trying to make the point that the amendments would all grant a large number of powers to Ministers through the statutory instrument procedure. That is why I am referring to the Hansard Society report.

The Chair: Please stick to the amendments.

Danny Kruger: I understand, but it would be interesting to know whether the Government have produced a delegated powers memorandum, and when it will be published.

[*Danny Kruger*]

I have four quick points to make about my concerns about the amendments and new clause 8. First, new clause 8 provides that when making the SIs, the Secretary of State must consult the Equality and Human Rights Commission. That is a very positive step, but the other provisions on who should be consulted are, on closer inspection, illusory. The Secretary of State must consult those with expertise on capacity and coercion—that is all great—unless he or she considers that

“it would not be appropriate”.

What the new clause gives with one hand, it takes with the other. It would be good to identify in the Bill who the groups are that the Secretary of State must consult for each power.

Secondly, the vast majority of the SIs made under the Bill, as amended by the amendments, are to be made by the negative procedure. The last time that an SI subject to the negative procedure was annulled by the House of Commons was 1979. The procedure gives only the outward appearance of involving Parliament again. The SIs take effect when signed by the Minister, subject only to a motion of either House to annul them. However, by strong convention the Lords will do no such thing, and the convention in the Commons is that the Government will make time to debate such a motion only if it is put forward by the Opposition Front Bench, and it is at the Government’s discretion.

This being a matter of conscience, it is unlikely that any Opposition Front Bench would be in a position to table such a motion, and no one else has any standing. In practice, that means that there will be no opportunity for parliamentary scrutiny on, which lethal substances may be approved, for example, or on what events should be notified to the chief medical officer. These are not mere details.

Thirdly, on some of the matters addressed in the amendments it is doubtful whether the use of delegated powers is even appropriate, because even if there is a debate and a vote in Parliament, debate on an SI is limited to 90 minutes only and an SI is not amendable. In fact, the House of Lords Delegated Powers and Regulatory Reform Committee considered it improper that the Assisted Dying Bill introduced by Baroness Meacher gave the power to the Secretary of State to decide which substances should be allowed to cause death, because it was an inappropriate question for an SI.

Finally, and perhaps most substantially, clause 32 will establish a vast Henry VIII power. It allows Ministers even to amend primary legislation, and those changes would be subject to a simple yes or no vote in the Commons, without the possibility of amendment. It has been suggested in the Hansard Society podcast with the drafter of the Bill that the power is there because provision on the NHS could be made only if section 1 of the National Health Service Act were modified, removing the duty of the Secretary of State to improve the “physical and mental health” of the public. I look forward to seeing whether the amendments that have been promised include that. However, they will not necessarily amend the National Health Service Act, because that could be done under the statutory instruments created in these amendments.

If such a foundational piece of legislation as the National Health Service Act needs to be modified to allow this law to pass, surely it would be better to do it on the face of the Bill. I want to know why a Henry VIII power is needed. I hope that the Government might bring forward the relevant amendments to the Bill so that a Henry VIII power is not needed. I see that the hon. Member for Spen Valley is nodding, which is encouraging.

I stress that the Committee must bear it in mind that this power would exist on the statute book forever, unless the statute is repealed, so any Government could use this power. The last time that a Parliament found its voice to reject an SI by the negative procedure was back in the 1970s. When we come to a decision on amendment 233 and new clause 8, I will seek to make further amendments.

Daniel Francis (Bexleyheath and Crayford) (Lab): It is a pleasure to serve under your chairship, Mrs Harris. It would be remiss of me not to comment briefly on new clause 8, given that throughout this process I have consistently raised issues around evidence given by the Equality and Human Rights Commission, and given that new clause 8 states that before making a recommendation the Secretary of State must consult the commission.

I remind hon. Members that the commission has told us that it strongly recommends that

“at the earliest opportunity, Parliament is provided with further information and assurance about the bill’s compatibility with equality and human rights.”

It went on to say that its concerns were that the Bill

“may also particularly impact disabled people. We recognise that this bill is focused on assisted dying for adults who are terminally ill, and does not propose access to assisted dying on the basis of disability or chronic conditions. However, there is not always a clear line between terminal illness and disability. Disabled people can also suffer from terminal illness, and illness may itself amount to a disability.”

It has also stated:

“A vital factor in determining how to manage access to assisted dying will be the concept of mental capacity...It will be important to ensure that all decision-makers involved in the process have a full and clear understanding of the law around mental capacity under the Mental Capacity Act 2005.”

I welcome new clause 8, which is in the name of my hon. Friend the Member for Spen Valley, as it would ensure that the Equality and Human Rights Commission is consulted. We await its comments, which hopefully we will have before Report, on whether the concerns that it raised, both in writing before Second Reading and in their oral evidence, have been allayed. However, I welcome this initial commitment, and we will see where that brings us on Report.

2.15 pm

The Minister for Care (Stephen Kinnock): It is a pleasure to serve under your chairship, Mrs Harris. The amendments have been tabled by my hon. Friend the Member for Spen Valley in consultation with the Government. This reflects the Government’s role in ensuring that the Bill is legally robust and workable. The amendments relate to the regulation-making powers and bring together various provisions about procedure and requirements for regulations and consultation.

I will address the amendments in two groups, starting with new clause 8 and its consequential amendments 187, 199 and 211. The new clause contains a duty to consult

before making regulations; it is intended to consolidate three subsections that contain duties to consult before making regulations, as set out in the original draft of the Bill under clauses 5, 8 and 19. In addition to retaining the existing duties to consult before making regulations in clauses 5, 8 and 19, the new clause requires the Secretary of State to consult before making regulations under clauses 7, 13 and 21, and brings together these requirements under a single duty.

The new clause would place an additional requirement on the Secretary of State to consult the Equality and Human Rights Commission, as well as such other persons that the Secretary of State considers appropriate. The latter group must include persons with expertise in matters relating to whether persons have capacity or have been coerced, unless it would not be appropriate to consult such persons.

I turn to amendments 233, 188, 192, 215 to 219, 222, 225, 226, 212, 213, 200 and 206. There are provisions throughout the Bill, as it is currently drafted, about the procedure for making regulations. All regulations, except for those made under clause 5(3)(a), clause 8(6)(a), clause 30(3) and clause 32, are required to be made under the negative procedure. Amendment 233 would bring together the various provisions about the procedure for making regulations into a single clause, clause 39, thereby removing repetition in the Bill. The amendment seeks to achieve that by replacing subsections (3) to (5) in clause 39 with the following:

“(5A) The Secretary of State may not make a statutory instrument containing (whether alone or with other provision) regulations under section 5(3A), 8(6A), 30(3) or 32 unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament.

(5B) Any other statutory instrument made by the Secretary of State containing regulations under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.”

The amendment would require that any regulations made under those provisions must be laid before, and approved by, a resolution of both Houses of Parliament. This procedure, the draft affirmative procedure, will apply to regulations setting the training, qualifications and experience of both the co-ordinating and the independent doctors, establishing a code of practice and securing arrangements for the provision of assisted dying under the Act. Any other statutory instrument made under powers within the Bill will remain subject to the negative procedure.

As I have said, the Government have taken a neutral position on the substantive policy questions. These comments relate to the legal and regulatory side of the Bill, and I hope that my observations are useful to the Committee.

Kim Leadbeater: I have nothing further to add.

Amendment 187 agreed to.

Amendment made: 20, in clause 5, page 3, line 25, at end insert—

“(4A) Regulations under subsection (3)(a) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory.”—
(*Daniel Francis.*)

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

Amendment made: 188, in clause 5, page 3, line 28, leave out subsection (6).—(*Kim Leadbeater.*)

This amendment is consequential on Amendment 233, which contains a single set of provisions about the procedure for regulations under the Bill.

Clause 5, as amended, ordered to stand part of the Bill.

Clause 6

REQUIREMENT FOR PROOF OF IDENTITY

Kim Leadbeater: I beg to move amendment 189, in clause 6, page 3, line 30, leave out

“where a person makes a first declaration”

and insert

“in relation to the making of a first declaration by a person”.

This amendment adjusts the wording so as not to suggest that a first declaration has been made before it is witnessed.

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

Amendment 190, in clause 6, page 3, line 31, leave out “at the same time as that declaration is made”

and insert “before signing that declaration”.

This amendment provides that the required two forms of proof of identity must be provided before the person signs the first declaration.

Amendment 291, in clause 6, page 3, line 33, at end insert—

“(2A) At least one of the forms of identity required under subsection (2) must contain photographic proof of identity.

(2B) The person must, at the same time as that declaration is made, provide proof that they have been resident in the UK for at least a year to the coordinating doctor and the witness mentioned in section 5(2)(c)(ii).”.

This would require a person to produce a form of photographic ID and proof they have been resident in the UK when making the first declaration.

Amendment 292, in clause 6, page 3, line 34, leave out “may” and insert “must”.

This places an obligation on the Secretary of State to make regulations on proof of identity.

Amendment 191, in clause 6, page 3, line 35, at end insert—

“(3A) The coordinating doctor may witness the first declaration only if satisfied that the requirements of subsection (2) have been met.”

This amendment provides that the coordinating doctor may witness the first declaration only if satisfied that the requirements of subsection (2) are met.

Amendment 419, in clause 6, page 3, line 35, at end insert—

“(3B) The coordinating doctor may witness the first declaration only if—

(a) the coordinating doctor has conducted a preliminary discussion with the person or is satisfied that another registered medical practitioner has conducted such a discussion, and

(b) the coordinating doctor has made or seen a written record of the preliminary discussion.”

This amendment provides that the coordinating doctor may witness the first declaration only if satisfied that a preliminary discussion of the kind mentioned in clause 4 has taken place and that a written record of it has been made.

Amendment 293, in clause 6, page 3, line 36, leave out “negative” and insert “affirmative”.

This will change the process to the affirmative procedure for statutory instruments specifying acceptable forms of ID for the first declaration.

Kim Leadbeater: Amendment 419 provides that the co-ordinating doctor may witness the first declaration only if satisfied that a preliminary discussion of the kind mentioned in clause 4 has taken place and that a written record of it has been made. The co-ordinating doctor must have made or seen a written record of the preliminary discussion. Amendment 189 adjusts the wording so as not to suggest that a first declaration has been made before it is witnessed to clarify that proof of identity must be provided before the declaration is signed and witnessed.

Amendment 190 provides that the required two forms of proof of identity must be provided before the person signs the first declaration. Amendment 191 provides that the co-ordinating doctor may witness the first declaration only if satisfied that the requirements of clause 6(2) are met; that is to say, that the patient has provided two forms of identity to the co-ordinating doctor. This is a relatively straightforward set of amendments to tidy up the requirements around proof of identity.

Naz Shah (Bradford West) (Lab): I rise to speak to amendments 291, 292 and 293, which were tabled by my hon. Friend the Member for York Central (Rachael Maskell). I do not intend to press them to a vote; they are probing amendments. They all relate to the amendments tabled by my hon. Friend the Member for Spennings Valley about the identification required of applicants for assisted dying. They do not change those requirements; they take a more logical and businesslike approach to proving that those requirements are met.

Amendment 291 would change the current requirements on identification and require applicants for assisted dying to produce a piece of photo ID and proof of residence in the UK for the previous year. As currently written, clause 6(2) states:

“The person must, at the same time as that declaration is made, provide two forms of proof of identity to the coordinating doctor and the witness mentioned in section 5(2)(c)(ii).”

Subsection (3) states:

“The Secretary of State may, by regulations, make provision about the forms of proof of identity that are acceptable for the purposes of subsection (2).”

Surely that is not tight enough.

In particular, the Bill as written does not specify that either form of proof of identity should be photo ID. That may be a major omission. For much less significant decisions, the law of England and Wales requires at least one form of photographic ID. For example, there is currently a requirement to have photo identity to work on the parliamentary estate, vote, or have a bus pass or railcard. None of those is as important as applying for an assisted death.

I remind hon. Members that assisted death is a process that would end in a person being issued with and then taking a mixture of lethal drugs. In a hospital setting where drugs are dispensed, rigorous processes are undertaken to verify the patient. Drug errors are not uncommon. The previous Health and Social Care Committee’s report into pharmacy witnessed how clinical practice was being improved to reduce drug errors. Given that a lethal dose is dispensed as part of this process, the identification mechanisms are weak and should be addressed in this preliminary stage through

the provisions set out in this amendment. It is possible that the wrong person could be prescribed the medication. That would be an extreme case, but we are talking about creating a wholly new power that would relate to life and death. We are talking about making assisted dying available to people who are, in many cases, extremely distressed. People in extreme circumstances will sometimes do extreme things. We should expect some extreme cases and seek to guard against them.

Amendment 291 would provide such a safeguard. The Bill says that to qualify for assisted dying, applicants must have been resident in the UK for at least a year, but it does not ask them to provide any proof of that residence. In such a serious matter, we surely cannot simply accept someone’s word that they live in the UK. Making that a requirement without a test to establish it de-values the importance of the criteria for qualifying.

Amendment 292 would change clause 6(3), which currently reads,

“The Secretary of State may, by regulations, make provision about the forms of proof of identity that are acceptable for the purposes of subsection (2).”

The amendment would change that “may” to a “must”, as the former treats the identification process with reduced seriousness. If the word “may” stays in legislation, there is no obligation to have rigour in the identification process. As drafted, the Bill is more open for abuse.

Amendment 293 seeks to place the regulations concerning identification under the affirmative procedure, which the hon. Member for East Wiltshire mentioned earlier. Assisted dying is so important that no regulations made under it should be drawn using the negative procedure. As Members will know, if a statutory instrument is made under the affirmative procedure, it must be approved by Parliament within a certain timeframe, which is usually 28 or 40 days. If that does not happen, the change to the law made by the statutory instrument will not take place. In the Bill as drafted, these regulations are covered by the negative procedure, which means that if and when the Secretary of State decides to change them, they could go through on the nod unless Members raised an objection. A statutory instrument laid through the negative procedure becomes law on the day the Minister signs it and automatically remains law unless a motion rejecting it is passed by either House within 40 sitting days.

Placing all changes to regulations under the affirmative procedure would ensure that we have scrutiny by Parliament. We should all approve this. Our responsibility for this legislation will not end when and if it becomes an Act of Parliament. These amendments speak to tighter safeguards and parliamentary scrutiny for all new regulations made by the Secretary of State in relation to identity and residence. All hon. Members should support them.

Danny Kruger: I will quickly echo the points well made by the hon. Member for Bradford West in support of the amendments in the name of the hon. Member for York Central. It is important to specify the form of identity that will be presented. The person presenting themselves for an assisted death needs to be who they say they are. At the moment, the power to specify the forms of proof of identity has no minimum requirements. As written, it does not require the Secretary of State to specify what is acceptable.

Two specific aspects we have to pay particular care to are age and residency. The process must be accessible only to over-18s. I am concerned that we rejected amendments yesterday that would have prevented people under 18 having the conversation. In light of that, it is even more important that we make it clear that people who access assisted death must be adults. We need to ensure that the forms of identity are specified and that Parliament can satisfy itself that they are robust.

Kim Leadbeater: We did not reject proposals for the preliminary discussion not to be taken by people under 18. We actually put a clause into the Bill that would ensure that the preliminary discussion was not taken with someone under 18.

Danny Kruger: That is right. The preliminary discussion will not, but there is nothing to stop the conversation beginning before the person is 18. I know they cannot formally begin the process of an assisted death, but the concern—although I will not revisit the debate—was that the topic should not be raised or discussed with children, and we did not succeed in that.

The proposal is to ensure that we have proper ID—a passport, driving licence or other combined photo ID and proof of age, so a birth certificate must be paired with something if it is to be robust. We think such questions should be reflected more clearly in the Bill. All sorts of ID would not be appropriate, such as student ID, a sworn statement with no underpinning official record and other such things, which we want to avoid.

2.30 pm

On residency, checks are important to prevent exploitation of the Bill and, frankly, tourism—probably not the right word, but we know what we mean. We need to stop those seeking to bypass stricter laws elsewhere perhaps coming to the UK to avail themselves of the assisted death law. In Switzerland, as I understand it, Dignitas sees non-resident cases, people from all over the world—obviously it does. My understanding is that here in the UK we want to avoid that. I hope that we can accept those amendments.

Lastly, I will speak to amendment 419. I mentioned this briefly earlier, but it is attached to this clause. The amendment in the name of the hon. Member for Spen Valley seeks to insert into a clause on the requirement for proof of identity that the co-ordinating doctor may witness the first declaration only if they have conducted a preliminary discussion with the person, or is satisfied that another registered medical practitioner has done so. As I have said, I welcome the introduction of the additional requirement that a preliminary discussion must be held before the first declaration is signed. As I also said earlier, however, I am unclear why it is being inserted here.

I would be grateful to know whether the promoter of the Bill received Government advice on the implications of a provision that is, frankly, in the wrong place in the legislation, divorced from the clauses dealing with the first declaration. This provision should sit in clause 5. I mention that because it creates genuine room for ambiguity or misinterpretation, which could communicate confusion to the courts about the intended scope or application, or its interaction with other clauses.

I will quote briefly from the official Government drafting guidance, which encourages drafters to take

“readers by the hand and lead them through the story you have to tell. Imagine that you are trying to explain something orally to interested listeners. Where would you start? What will they want to know first?... Finding a clear order in which to tell your story is fundamental. This goes for a story which is spread across a whole Bill... The material in your Bill should be set out in a logical order, so that later propositions build upon earlier ones”—

very good advice.

The Bill does that overall. It takes us clearly through a journey from the initial discussion to the final act. There is a chronology to the process, naturally enough, and the Bill reflects that. I am therefore unclear why we have this amendment 419, which I think is essential and important—I wish it were stronger, as I said earlier—but I am unclear why it is here. Why is it a subsection in a clause dealing with regulations for forms of identity? I am concerned about the amendment and why it is in the place it is. I will be grateful for clarification from Ministers or the promoter about why it is there.

Stephen Kinnock: This group of amendments refines the requirements related to the first declaration, clarifying the witnessing process, identity verification and regulatory obligations. I will take the amendments in turn.

In executing our duties to ensure that the legislation, if passed, is legally robust and workable, in this group the Government have worked with my hon. Friend the Member for Spen Valley on amendments 189 to 191 and 419. Amendment 189 would clarify the requirement for proof of identity when making a first declaration. It would adjust the wording to make it clear that proof of identity must be provided before a person signs a declaration, ensuring no ambiguity about when the requirement applies.

As with amendment 189, amendment 190 clarifies the requirement for proof of identity when making a first declaration. This amendment would make it clear that a person must provide two forms of proof of identity before signing the declaration, rather than simply at the same time. That ensures that both the co-ordinating doctor and the witness have received the necessary proof before the declaration is signed.

Amendment 191 ensures that the co-ordinating doctor can witness the first declaration only if they are satisfied that the person has provided two forms of proof of identity. The doctor must therefore first be satisfied that the required proof has been given to them and to the witness before proceeding with witnessing the signing of the declaration.

Amendment 419 requires that, before witnessing the first declaration, the co-ordinating doctor must be satisfied that a preliminary discussion has taken place, whether that was conducted by the co-ordinating doctor or another registered medical practitioner. The co-ordinating doctor must also have made or seen a written record of the preliminary discussion.

Amendment 291 adds to the requirement around proof of identity when making a first declaration. It requires that one of the forms of ID provided to the co-ordinating doctor and witness be photographic. The person must also provide proof of residence at this stage of the process. I note we would expect this type of issue to be considered by the Secretary of State when

[*Stephen Kinnock*]

making regulations about forms of proof of identity that are acceptable, as already provided for in clause 6(3). Requiring a person to provide proof that they have been resident in the UK for at least 12 months appears to impose a different residency requirement to other parts of the Bill. Specifically, “being resident” is a looser test than being “ordinarily resident”, in clause 1, and “in the UK” is broader than “in England and Wales”, also in clause 1. In consequence, our assessment is that this amendment may make the Bill less legally coherent.

Rebecca Paul (Reigate) (Con): I want to raise a question on photo ID. My apologies, I probably should have spoken sooner. Thinking this through as we have debated, I think photographic ID is important to avoid mistaken identity and fraud, and to make sure everything works as it should. With respect to this process, would the Minister normally expect photographic ID to be an acceptable or appropriate form of identification?

Stephen Kinnock: Yes, I believe so. Photographic ID would be the standard to which we would aspire. I do not know whether there was anything else under her question? I think the answer is yes.

Sojan Joseph (Ashford) (Lab): Could the Minister clarify whether the requirement for one year of residency in the UK means that a foreign citizen studying at a university here would be able to consider assisted dying?

Stephen Kinnock: I thank my hon. Friend for that intervention. We have the term “ordinarily resident” in the UK in clause 1. Obviously if the Committee sees fit to accept the amendment it would change to “resident”, which is a looser term. This matter would also be one for the Home Office, as the custodian of our rules and regulations on immigration, but my sense would be that if we stick with “ordinarily resident” then someone who is not ordinarily resident in the United Kingdom would not qualify for assisted dying.

As the Bill currently stands, the Secretary of State has the power but not the obligation to set these requirements in regulations. This amendment would remove this discretion and require the Secretary of State to specify what forms of ID must be provided.

Amendment 293 ensures that regulations on acceptable forms of proof of identify must be approved by both Houses of Parliament before coming into force, by requiring these regulations to follow the affirmative rather than the negative procedure. As I said earlier, the Government’s position is neutral, but I hope my observations—

Kim Leadbeater: This is a thought based on the comments by the hon. Member for Reigate. The issue of photographic ID is worth giving consideration. Photo ID is used in multiple settings for different reasons. My slight concern is that some of the people we are thinking about with this Bill would be older and I think of some of my own family members who no longer have driving licences, passports or potentially any form of photographic ID. I would be concerned this could be a barrier for terminally

ill people. Considering we are making this a robust process, which I totally agree with, I would be concerned that might present an issue.

The Chair: Order. I have asked for interventions to be short and not speeches.

Stephen Kinnock: I thank my hon. Friend for that intervention. She makes a very good point. It is definitely something that needs to be explored, to ensure that people are not being excluded for the reasons she set out. It is a different example, but when voter ID was introduced a special ID card was created by the Government to cater for exactly the situation she set out. We have to find a way of ensuring that people are not excluded because of that technicality. She makes a valid point.

Kit Malthouse (North West Hampshire) (Con): Scanning back through my experience of the health service, I do not remember ever having to show my ID, whatever the procedure or medical service. I do not remember showing ID to witness the birth of my children or my wife having to show her ID. I am not sure that is common in the health service. Why would we introduce it for this? I can go in and have a heart bypass and not be asked to show my ID. My assumption is that often people will have been—

The Chair: Order. I have asked for interventions to be short.

Stephen Kinnock: This section of the Bill covers the issue of ID and says that proof of ID is required. I am simply responding to the requirements of the Bill. I am more than happy to have a debate about ID cards and all sorts of other issues more broadly—

The Chair: On another day.

Stephen Kinnock: I look forward to having that debate on another day. Unless other colleagues want to intervene, I will now sit down, to the delight of the Chair.

The Chair: I call Kim Leadbeater, who now has the opportunity to say anything she likes.

Kim Leadbeater: You will be delighted, Chair, that I have nothing further to add.

Amendment 189 agreed to.

Amendments made: 190, in clause 6, page 3, line 31, leave out

“at the same time as that declaration is made”

and insert “before signing that declaration”.

This amendment provides that the required two forms of proof of identity must be provided before the person signs the first declaration.

Amendment 191, in clause 6, page 3, line 35, at end insert—

“(3A) The coordinating doctor may witness the first declaration only if satisfied that the requirements of subsection (2) have been met.”

This amendment provides that the coordinating doctor may witness the first declaration only if satisfied that the requirements of subsection (2) are met.

Amendment 419, in clause 6, page 3, line 35, at end insert—

“(3B) The coordinating doctor may witness the first declaration only if—

- (a) the coordinating doctor has conducted a preliminary discussion with the person or is satisfied that another registered medical practitioner has conducted such a discussion, and
- (b) the coordinating doctor has made or seen a written record of the preliminary discussion.”

This amendment provides that the coordinating doctor may witness the first declaration only if satisfied that a preliminary discussion of the kind mentioned in clause 4 has taken place and that a written record of it has been made.

Amendment 192, in clause 6, page 3, line 36, leave out subsection (4).—(*Kim Leadbeater.*)

See the statement for Amendment 188.

Clause 6, as amended, ordered to stand part of the Bill.

Clause 7

FIRST DOCTOR’S ASSESSMENT (COORDINATING DOCTOR)

Amendment proposed: 296, in clause 7, page 4, line 2, leave out from “must” to end of line 3, and insert

“after a first declaration is made by a person, arrange a time and which is convenient for both the medical practitioner and the person date that does not jeopardise the care of other patients, to carry out the first assessment.”—(*Naz Shah.*)

This amendment replaces the requirement that the coordinating doctor to arrange a first assessment as soon as practicable with a requirement to arrange it for a mutually convenient time which doesn’t jeopardise the care of other patients.

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

Amendment 127, in clause 7, page 4, line 2, leave out “as soon as reasonably practicable” and insert “within 10 working days”.

The amendment requires the coordinating doctor to carry out an assessment under the Act within ten working days.

Amendment 128, in clause 7, page 4, line 23, leave out “as soon as practicable” and insert “within 10 working days”.

This amendment would require the coordinating doctor to refer a person within 10 working days rather than as soon as practicable to another registered medical practitioner to carry out the second assessment.

Amendment 129, in clause 8, page 4, line 29, leave out “as soon as reasonably practicable,”

and insert “within 10 working days”.

This amendment would require the independent doctor to carry out the second assessment within 10 working days rather than as soon as practicable to another registered medical practitioner to carry out the second assessment.

Amendment 130, in clause 16, page 11, line 19, leave out “as soon as practicable,” and insert “within 10 working days”.

This amendment would require the coordinating doctor, where they are a practitioner with the person’s GP practice to record the making of the declaration or statement, or the refusal to make the declaration or statement, in the person’s medical records within 10 working days rather than as soon as practicable.

Amendment 131, in clause 16, page 11, line 23, leave out “as soon as practicable,” and insert “within 10 working days”.

This amendment would require the coordinating doctor, where they are not practitioner with the person’s GP practice, to give a registered medical practitioner from that practice notice of the making of the declaration or statement, or the refusal to make the declaration or statement, in the person’s medical records within 10 working days rather than as soon as practicable.

Amendment 132, in clause 16, page 11, line 27, leave out “as soon as practicable,” and insert “within 10 working days”.

This amendment would require the coordinating doctor, where they are not a practitioner with the person’s GP practice to record the making of the declaration or statement, or the refusal to make the declaration or statement, in the person’s medical records within 10 working days rather than as soon as practicable.

Amendment 133, in clause 17, page 11, line 38, leave out “as soon as practicable,” and insert “within 10 working days”.

This amendment would require the coordinating doctor, where they are not a practitioner with the person’s GP practice to record the making of the declaration or statement, or the refusal to make the declaration or statement, in the person’s medical records within 10 working days rather than as soon as practicable.

Amendment 134, in clause 17, page 12, line 2, leave out “as soon as practicable,” and insert “within 10 working days”.

This amendment would require the medical practitioner to whom notice or indication of the cancellation of declaration is given to notify a registered medical professional from the person’s GP practice within 10 working days rather than as soon as practicable.

Amendment 135, in clause 17, page 12, line 5, leave out “as soon as practicable,” and insert “within 10 working days”.

Amendment 136, in clause 21, page 14, line 12, leave out “as soon as practicable,” and insert “within 10 working days”.

Amendment 137, in clause 21, page 14, line 15, leave out “as soon as practicable,” and insert “within 10 working days”.

Amendment 138, in clause 21, page 14, line 18, leave out “as soon as practicable,” and insert “within 10 working days”.

Amendment 139, in clause 22, page 14, line 27, leave out “as soon as practicable,” and insert “within 10 working days”.

Amendment 140, in clause 22, page 14, line 30, leave out “as soon as practicable,” and insert “within 10 working days”.

Amendment 141, in clause 22, page 14, line 33, leave out “as soon as practicable,” and insert “within 10 working days”.

2.45 pm

Jake Richards (Rother Valley) (Lab): I was expecting someone else to have spoken in support of amendment 296, but I will be very brief. The tone of the debate so far has been respectful, and it should continue to be so. I hope that this will not be characterised as a personal attack on my hon. Friend the Member for York Central, who tabled the amendment, or anyone else who supports it, but this is a shocking amendment. It is shocking because I doubt that the motives behind it are to improve the Bill or make it safer. In fact, I fear that the motives are to build a political attack to support opposition to the Bill, rather than to be constructive in improving it.

I have come to that conclusion because there is no concept in any other piece of legislation, or in any healthcare guidance in operation, that would ever presuppose that a clinician would undertake a consultation, assessment or meeting that would ever put other patients in danger. I fear that this amendment has been tabled because some people are attempting to assert, perhaps not purposefully or wilfully, that the introduction of an assisted dying system would somehow force clinicians

[*Jake Richards*]

to put other patients at risk. If that is the assertion, that is wrong and—in my view—shocking. It is a shocking indictment on their view of our medical practitioners in the NHS.

Danny Kruger: The hon. Gentleman is impugning the motivation of his colleague, the hon. Member for York Central, who is herself an experienced practitioner in the NHS. To suggest that she has tabled this amendment improperly is a serious accusation, which I cannot believe that he really wants to make against his colleague. He said that the amendment's intention is to suggest that assisted dying would cause problems in the NHS, but the explicit terms of the amendment are to ensure that that does not happen. Of course, no practitioner would want to take choices that would prejudice other patients' care.

The Chair: Order. Mr Kruger, you are down to speak and you can make your point then. I want interventions to be short.

Jake Richards: I am grateful, Chair, and I can take further interventions on any further points from the hon. Gentleman, but I will deal with that one. This is not a personal criticism of my hon. Friend the Member for York Central. I do not doubt that she has good intentions. What I stated was that her opposition to the principle of the Bill is guiding some of the amendments that she has tabled, and this is one of them.

The Chair: Order. That is not a topic for this debate. Stick to the amendment.

Jake Richards: Not only do I question the motives behind amendment 296 but its necessity is—to put it politely—mind-boggling. We have attempted to navigate a balance between ensuring that, when clinicians are dealing with this process, they do so safely, and not mandating them to undertake such conversations, assessments and procedures in a straitjacket. Put simply, this amendment attempts to manage diaries. Primary legislation should not do that. We cannot use primary legislation to manage clinicians' busy diaries, as this amendment attempts to do. It is not only unnecessary but challenges the integrity of our clinicians and what they do every day. Therefore, I will be voting against it, if it is pressed to a vote.

The Chair: I call Danny Kruger.

Danny Kruger: I was not intending to speak on this amendment, but since you have called me, Mrs Harris, I will quickly respond to the comments of the hon. Member for Rother Valley. I sincerely think that he should withdraw the suggestion that the amendment was made in bad faith and his remarks about the motivation of the hon. Member for York Central. She clearly tabled it only to make the Bill safer, which is the purpose of all the amendments, even if there might be very good reasons to disagree with them, so I regret that attack on her integrity.

On the point that we should simply rely on the integrity of clinicians—although the hon. Member for Rother Valley has not done so in respect of the hon. Member for York Central, who is herself a clinician—of course we do that. Nevertheless, the laws we make and the

guidance we introduce send strong signals about priorities. The purpose of the amendment is to ensure that doctors do not feel that the obligations created by the Bill impose a duty on them to prioritise the assisted death procedure over other priorities. In fact, it would give clinicians genuine autonomy and freedom to make their own decisions—obviously, in consultation with colleagues and patients—about the appropriate prioritisation of the treatments and services they are offering.

The hon. Member for Rother Valley made the point that there is, in a sense, an attempt to suggest that the Bill should not become law because of the pressures it could impose on the NHS. I think that such pressures are a valid concern. When we create new laws, we should consider what new burdens they will place on existing services. We should consider whether the new service will be introduced and implemented safely, and its knock-on implications for the wider system.

Jake Richards: The point is that the amendment is not about the wider system; it is about a clinician's individual decision making. Does the hon. Gentleman agree that that is a very different prospect?

Danny Kruger: Well, that concern for the individual clinician is in the context of their wider obligation to treat their patients well and to manage a resource—their own time—in a way that is equitable to all the patients they have to see. As often in these debates, we are really considering the extent to which we should be putting into the Bill an obligation on doctors to do the job that we hope that they are doing anyway. We do have such rules in the system to clarify what we expect of clinicians, however, and I think they would be appropriate in this case, given the resource requirements—which are unknowable, but with common sense one can see that they will be quite significant—that this new service would entail for many clinicians in the NHS.

Jake Richards: If the Government were to introduce legislation to expand the NHS's role in how it undertakes operations in a certain area, would the hon. Member suggest that similar amendments should be added to that legislation, or it is just about this issue?

Danny Kruger: There is no rule that can be applied universally in the abstract. All rules take their value from how they are introduced. On the hon. Gentleman's hypothesis, I do not in principle suggest that every new treatment and every new obligation that is created in the NHS should require laws determining how clinicians prioritise them. In the case of a new service—I am trying not to use the word “treatment”, because I do not accept it as such, but it sounds like it will be treated as an NHS treatment—that is very significant and whose resource implications are unknown, it strikes me as appropriate that, as far as possible, we should be clear that doctors should manage the resource demands placed on them by the Bill in the context of their other obligations to patients.

Kit Malthouse: Can my hon. Friend not see that, as the hon. Member for Rother Valley said, the amendment is based on what could be construed as an offensive assumption: that doctors otherwise might or would? Effectively, it is the legislative equivalent of the “When did you stop beating your wife?” question.

Danny Kruger: I am afraid to say that we do impose obligations on doctors to do the things that we expect them to do. If that is offensive to doctors, so is all the guidance from the General Medical Council. It might well be argued that the amendment is otiose, because of course we would expect doctors to manage their resource requirements appropriately and to consider other patients. Nevertheless, the point that is being made in defence of the amendment, about which I feel strongly, is that we are creating a new service with unknowable resource implications, with strong parliamentary backing behind it, and with a whole set of guidance that will be created ex nihilo by the Secretary of State and that Parliament will have little control over.

Because we have not seen the amendments on the design of the service, we do not even know what the service will involve and how much work it will take. It is therefore appropriate to specify explicitly that doctors have an obligation to consider the potential impact on other patients.

Kit Malthouse: I understand where my hon. Friend is coming from. To give us fair warning, if the Committee votes the amendment down, how will he portray that publicly? Will he say to the public that the Committee has voted for doctors to harm other patients?

The Chair: Order. That is not a relevant question, Mr Malthouse.

Danny Kruger: I am grateful for your ruling, Mrs Harris, but I hope you will not mind if I do respond to the question.

The Chair: Order. I do mind.

Danny Kruger: Okay. I might address the question at a future point, because the issue of how we reflect on these proceedings outside this place has come up privately.

Kim Leadbeater: I do not consider for one second that there is any ill intent behind the amendment, but I am slightly concerned about the language, which is what I think my hon. Friend the Member for Rother Valley meant. The issue is the suggestion that a doctor would, in any circumstances, jeopardise the care of other patients. We are talking about doctors a lot, and we have the utmost respect for medical practitioners, but I imagine that that would be a worrying concept to have in writing from their perspective.

Danny Kruger: I respect that point, and it is a fair charge: that doctors would not do this. Nevertheless, as I have been stressing, we are in uncharted territory, and there is a genuine concern about the resource implications of the Bill.

The Bill clarifies and emphasises things in lots of other places—“for the avoidance of doubt” and so on—and the amendment would clarify that the procedure under the Bill would not take precedence in a clinician’s time over other matters that they also consider to be pressing and urgent. That is an appropriate safeguard for doctors.

Jack Abbott (Ipswich) (Lab/Co-op): The problem with the amendment, which has been mentioned before—I will not go as far as my hon. Friend the Member for Rother Valley and say that it would essentially nullify the Bill—is that it is entirely subjective. It is not guidance or a clear point of reference; it is entirely subjective to each individual doctor.

Danny Kruger: I am afraid that the English language is rather subjective. The service would rely on guidance or case law that had been built up, although one hopes that there would not have to be court cases in respect of it. The interpretation of the language of the Bill would be the duty of clinicians and, ultimately, NHS trusts and their lawyers.

Jack Abbott: A lot of the conversations we have had in Committee have been about eliminating the lottery that exists in our healthcare system. What the hon. Gentleman is suggesting will be exactly that: a lottery according to each individual clinician and doctor.

Danny Kruger: We cannot have it both ways. We cannot give doctors and clinicians autonomy, which the Committee has repeatedly seen as a ground to reject all sorts of obligations that I and others have proposed to ensure that doctors do the job in a specific way, and then suggest the opposite in this instance. I recognise what the hon. Gentleman says, and he may be right that that is inappropriate.

Naz Shah: Does the hon. Member agree that perhaps the amendment is not just about the context in which it has been referred to so far, but about protecting doctors in future? When mistakes happen, people would have a means to protect themselves.

Danny Kruger: The hon. Lady is absolutely right. We should not forget that doctors are indemnified against any civil claims under the Bill. Nevertheless, they will want to protect themselves against the accusation that they inappropriately prioritised one case over another. That is the purpose of the amendment, and I urge the Committee to support it.

I will finish with this point. I am ashamed to say it, because my party was responsible for the NHS for the 14 years until last year, but the fact is, as Labour Members said frequently when they were in opposition, that there are enormous resource constraints on the frontline in the NHS. I do not think that is inappropriate to consider, when we create a new service, how it might have an impact on existing treatments in the NHS. Leaving aside all the ethical questions, including on coercion and capacity and our concerns in that respect, what will this mean for hard-pressed GPs and clinicians of all sorts on the frontline? What protections can we offer them when they make difficult decisions about whether to support an assisted death application?

3 pm

The Chair: I remind Members that the running of the Committee will be much smoother if we do not have: long interventions; Members refusing to bob when they wish to speak and hoping that they will catch my eye; and conversations from a sedentary position. I will not tolerate any of those any longer.

Juliet Campbell (Broxtowe) (Lab): I will speak to amendment 127, which is a probing amendment. I will not press it to a vote, but the reason I tabled it is that I felt that the phrase “as soon as reasonably practicable” was a little vague. I was taking into consideration the fact that we often talk about people who have six months to live, who are eligible for the assisted death, but sometimes people learn later on and do not have six months. If people are thinking about having an assisted death, there might be some pace at which the doctors need to work together—the co-ordinating doctor and whoever else they speak to.

I put 10 days, because I needed to put something down, and that is why I am saying amendment 127 is probing, but I do think that we need to be a little tighter with the timeframe in which we enable doctors to speak to each other, so that the patient is aware of what is happening. Also, if the patient wants to change their mind and is speaking to another doctor, they would know what timeframe they have got. The amendment is probing, and I will not press it to a vote.

Rebecca Paul: I think most points have been covered, so I will be brief. The point of the amendment 296 is to recognise the challenges faced by medical practitioners in the NHS. It is really well intended. I suspect that there are different ways to do this, which we could discuss, but the amendment would recognise that medical practitioners will come under a lot of pressure.

The very nature of the assisted dying process means there is pressure to move quickly—for obvious reasons. If someone is in pain and an assisted death is what they have chosen to do, they are going to want to move forward at pace. It cannot be as usual, with however long it can take in the NHS—often for a normal procedure. The point of the amendment is simply to be cognisant of the fact that other patients, too, require healthcare. This comes back to the debate we have had many times about what is healthcare and what is not. It is one of the issues that comes up when we have assisted dying amalgamated with general healthcare in the NHS.

We are hearing concerns from doctors on the frontline. In written evidence, eight doctors, six of them GPs, say that the NHS lacks both the time and the capacity to create the new role of co-ordinating doctor with its grave responsibilities. The statistics bear out their concerns. In a 2024 survey by the Royal College of General Practitioners, over 40% of UK GPs who responded said that they were “unlikely” to be practising still in five years’ time; 40% feel stressed to the point of “not coping” at least once a week; and 79% are concerned about having fewer GPs at their practice and its impact on the quality of care that their practice can deliver. The reality of the matter is that we have to recognise that the introduction of assisted dying places another pressure on our health system, and to try to address that head on.

Kim Leadbeater: The hon. Lady is making some interesting points, but would she agree that we are talking about not new patients, but existing patients who are already in their last few months of life? It will not create a whole new pressure on the health service, because they are already receiving treatment.

Rebecca Paul: I thank the hon. Member for that point. There will absolutely be some occasions where that is the case, but assisted dying is a different pathway—and

we have a whole Bill on it, so there will be other formalities and safeguards. We are all here to make sure that rigour is applied to that pathway. With the best will in the world, there will always be more work and pressure, especially time pressure, on doctors. That time pressure will be critical.

Danny Kruger: I completely agree. The hon. Member for Spen Valley makes the important point that these patients are, indeed, being treated already; one would hope that the palliative care process would continue alongside their application. It is absolutely right that they are being treated, but as my hon. Friend the Member for Reigate says, there would be additional work being done for them. Does she agree that there is also an opposite threat—that the resource being expended on the patient might be less as a result of the assisted death that they get? I am afraid to say that that would introduce a terrible new incentive into the system, as happens elsewhere.

Rebecca Paul: This is a complex issue, and that is why I welcome the debate on this group. There are lots of things that need to be thought through to make sure that, if assisted dying is legalised, we manage it in the most effective way for patients.

Dr Simon Opher (Stroud) (Lab): I thank the hon. Lady for making this point, which is important, although probably not specifically relevant to what we are talking about in general with regard to making the Bill safe. Has the hon. Member for East Wiltshire not just completely contradicted the whole point of the amendment, however, by saying that we really do not know whether this process will cost more or less time for the NHS?

Rebecca Paul: Different situations will give a different result. It is a complex situation. We could have a patient who, if they did not have an assisted death, would be on a palliative care pathway, which might not involve as much time from their GP—the assessing doctor, in that instance. If they moved on to the assisted dying pathway, however, the assessment process would need to start, and it has to happen quickly for all the reasons that I have set out.

The Bill relies on doctors being highly conscientious and hard-working, but it also risks taking them for granted if it makes no allowance for the present realities that they face in our healthcare system. This amendment tries to reflect and recognise that.

In November, the hon. Member for Stroud said, “I have watched with horror as our NHS has gone from being the best health service in the world...to being a service on its knees.”—[*Official Report*, 6 November 2024; Vol. 756, c. 358.]

If the NHS is to get off its knees, surely we cannot afford for assisted suicide to jeopardise the care of patients who already struggle to get an appointment. We must recognise that there are people out there who cannot get an appointment to see their GP, and reflect that in the Bill.

Sojan Joseph: I rise to speak briefly to amendment 296. We all know how the NHS operates, how the appointment system works in the NHS and how long people have to wait to see a doctor. I do not think that my hon. Friend the Member for York Central tabled the amendment with any ill thought, but just to highlight the issue. I do

not think that the amendment will make the Bill any safer or stronger, or safeguard anything, but the Committee needs to acknowledge it.

I will quote the Royal College of Physicians, which represents 40,000 doctors who primarily work in hospitals, including on palliative care. The Royal College of Physicians took a neutral position on the Bill. In its written evidence, it highlighted,

“We recognise that the ultimate decision on assisted dying rests with society through Parliament, however any changes to the law will significantly affect clinical practice beyond palliative care...Should the law change, the RCP strongly argues that assisted dying must not divert resources from end of life and palliative care provision, which are not currently adequate.”

With amendment 296, my hon. Friend the Member for York Central is trying to get the Committee to acknowledge that some NHS departments work with vacancies of 50 medical professionals. A patient who has been waiting for six months should not have their appointment cancelled because the provision here is prioritised. I think that is what my hon. Friend meant with her amendment, and I commend her thought about wider NHS provision.

Danny Kruger: I appreciate the point that the hon. Gentleman is making, and that he will not be able to support the amendment, but does he acknowledge that its purpose is to clarify the triage process that needs to be done by doctors? It is a perfectly appropriate request to make of doctors.

Sojan Joseph: I agree. It highlights the point that the impact assessment will be very important here, to see from where the resources are being pulled to provide this. The Committee should acknowledge amendment 296.

Stephen Kinnock: These amendments introduce requirements on the timing within which the co-ordinating doctor must carry out a first assessment once the first declaration is made by a person. I will turn first to amendment 296. As currently drafted, clause 7(1) requires that the co-ordinating doctor must carry out a first assessment

“as soon as reasonably practicable”

after a person has made a first declaration. Amendment 296 would require that after the first declaration is made, the co-ordinating doctor must arrange a mutually convenient time and date for the first assessment to take place, but it removes the stipulation that the assessment must be carried out as soon as reasonably practicable. The amendment would also require the date and time agreed not to jeopardise the care of other patients. The effect of the amendment may be to lengthen the period between the first declaration and the first assessment, in some cases.

Amendments 127 to 141 seek to ensure that the assessments, declarations and statements made throughout the Bill are finalised and recorded within 10 working days of being started. The amendments achieve this by inserting the term “within 10 working days” in place of “as soon as reasonably practicable”

in clauses 7, 8, 16, 17, 21 and 22. This would put in place a time-bound limit that the medical practitioner must adhere to when carrying out the first and second assessments, when recording information in medical records at various stages, including the High Court declaration, and when recording other matters in medical records.

Our assessment suggests that in most circumstances, although it would depend on the facts of a particular case, the requirement to do an action as soon as practicable would generally amount to a requirement to do the action sooner than in 10 working days’ time. In terms of the operational effects, having a set timeline may give greater certainty to individuals seeking assistance. However, it may limit doctors’ discretion to set the timeline based around the patient’s wishes. These are matters for the Committee to weigh up and consider.

Kim Leadbeater: That has been a very useful discussion. I have nothing to add.

Naz Shah: I beg to ask leave to withdraw the amendment.
Amendment, by leave, withdrawn.

Daniel Francis: I beg to move amendment 347, in clause 7, page 4, line 4, leave out from “to” to the second “the” in line 5 and insert—

“ensure that steps have been taken to confirm that”.

This amendment would remove the emphasis on the role of the coordinating doctor in making these assessments.

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

Amendment 294, in clause 7, page 4, line 5, after “doctor” insert—

“based on provided evidence that”.

This amendment would require that the doctor bases their assessment on provided evidence.

Amendment 14, in clause 7, page 4, line 15, at end insert—

“(2A) The coordinating doctor must take the report required under subsection (2B) into account in making an assessment under paragraph (2)(b), (f) and (g).

(2B) One or more qualified persons must have conducted a separate interview with the person and made a report to the coordinating doctor on the matters specified in subsection (2C).

(2C) The matters that must be covered in the report required under subsection (2B) are—

(a) any evidence of duress or coercion affecting the person’s decision to end their life,

(b) any difficulties of communication with the person interviewed and an explanation of how those difficulties were overcome, and

(c) the capacity of the person interviewed to understand the information given to them under paragraph (9)(2), (b), (c) and (d).

(2D) A person shall be taken to be qualified to conduct an interview under subsection (2B) if that person—

(a) is a registered medical practitioner who—

(i) is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council, or

(ii) has such training, qualifications and experience as the Secretary of State may by regulations specify,

(b) has not provided treatment or care for the person being assessed in relation to that person’s terminal illness,

(c) is not a relative of the person being assessed,

(d) is not a partner or colleague in the same practice or clinical team as the coordinating doctor,

- (e) did not witness the first declaration made by the person being assessed, and
- (f) does not know or believe that they—
 - (i) are a beneficiary under a will of the person, or
 - (ii) may otherwise benefit financially or in any other material way from the death of the person.
- (2E) Before making regulations under subsection (2D)(a), the Secretary of State must consult such persons as they consider appropriate.
- (2F) Regulations under subsection (2D)(a) are subject to the negative procedure.”

This amendment, and its consequential and linked amendments (15, 16, 17, 18 and 19), would provide for an independent assessment, via an interview conducted by a specialist, of a person's capacity to make the decision to end their own life, their clear, settled and informed wish to do so, and that they have made the first declaration voluntarily and without coercion.

Amendment 15, in clause 8, page 4, line 38, at end insert—

“(2A) The independent doctor must take the report required under subsection 7(2B) into account in making an assessment under subsections (2)(b)(d) and (e).”

This amendment is linked to Amendment 14 and requires the independent doctor to take into account an assessment that would be required under that amendment.

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

“or conducted the interview under subsection (7) (2B)”.

This amendment is linked to Amendment 14 and ensures that the independent doctor cannot be the same person who undertakes the assessment that would be required under that amendment.

Amendment 284, in clause 9, page 6, line 27, leave out from beginning to “refer” in line 28 and insert “must”.

This amendment would require a referral for the purposes of assessing capacity for both assessments.

Amendment 17, in clause 9, page 6, line 27, leave out paragraph (b).

This amendment is consequential on Amendment 14.

Amendment 6, in clause 9, page 6, line 27, leave out “may” and insert “must”.

This amendment would require the assessing doctor to refer the person being assessed for a mental capacity assessment if the assessing doctor had doubt as to the person's capacity.

Amendment 280, in clause 9, page 6, line 27, after “assessed” insert—

“or,

(ii) the person has a mental health condition;”.

Amendment 370, in clause 9, page 6, line 29, leave out “registered in the specialism of psychiatry” and insert—

“a practising psychiatrist registered in one of the psychiatry specialisms”.

This is a drafting change.

Amendment 18, in clause 9, page 6, line 32, leave out “or (b)”.

This amendment is consequential on Amendment 14.

Amendment 19, in clause 9, page 6, line 34, leave out “or (b)”.

This amendment is consequential on Amendment 14.

3.15 pm

Daniel Francis: I will not press amendment 347 to a vote, but I will speak to it, and to this group of amendments.

First, I shall turn to amendments 14 to 19, tabled by my hon. Friend the Member for Hackney South and Shoreditch (Dame Meg Hillier), which would require a co-ordinating doctor to refer the patient to an independent psychiatrist, or someone else qualified, as decided by the Secretary of State. That practitioner would then produce a report that the co-ordinating doctor must take into account when assessing whether the person has capacity, has a clear, settled and informed wish to end their life, and has not been coerced or pressured.

These amendments would replicate the existing practice of assessment for living organ donors. If we use a psychiatrist's assessment for those who are donating an organ—a serious decision—how much more serious is this decision to end one's life, and how much more necessary is the psychiatric assessment? It feels illogical to offer psychiatric assessments to patients who may donate organs, but not to those who may end their life. The wording of these amendments mirrors the regulations that have been applied through the Human Tissue Act 2004 (Persons who Lack Capacity to Consent and Transplants) Regulations 2006.

For organ donation, there is a separate body—the Human Tissue Authority—which oversees the network of assessors. These amendments do not suggest a separate body for assessors in the context of assisted dying, instead suggesting that the assessor should be a registered psychiatrist or someone qualified, as decided by the Secretary of State. This ensures control over who can be an assessor while also being flexible.

My hon. Friend the Member for Spen Valley, the Bill's promoter, said in oral evidence that she had looked at the model of assessment for capacity and coercion that is used for living organ donation, so I will be interested, when we get to that point of the debate, to know why the Bill does not model its assessments on those that are already done for organ donation.

These amendments would strengthen the Bill by ensuring that patients are properly assessed as having capacity to make such a huge decision and would help to spot coercion. As it stands, the Bill has no mention of the doctors giving assessments having psychiatric specialisms. These amendments would ensure that a specialist meets the patient, which is vital. We have heard already how difficult it can be to spot coercion, especially repeat coercion.

Sean Woodcock (Banbury) (Lab): Given that this is a significantly more serious decision than organ donation, these amendments would seem a very appropriate change to consider.

Daniel Francis: I agree. An assessment by a specialist would protect patients and give another opportunity to spot coercion—something that we all want to safeguard against.

I welcome the acceptance of amendment 20, tabled by my hon. Friend the Member for Lowestoft (Jess Asato), ensuring that doctors will be better trained to spot these issues, but that is only the start. We need the same in-depth assessment that living organ donors would get. Patients must fully understand the decision they are taking, and doctors must be convinced that they are capable of making it.

For organ donation, the NHS recommends that potential donors meet a mental health professional at an early stage, particularly in cases where people have a history of mental illness. As we have already noted, those diagnosed with terminal illnesses are likely to also have mental health issues. Dr Sarah Cox, in her oral evidence, cited a study by Professor Louis Appleby, the Government's suicide prevention adviser. Dr Cox said:

"If we look at the evidence of suicide, we know that it is increased in people with serious illnesses."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 28 January 2025; c. 82, Q105.*]

Sojan Joseph: We have discussed this issue many times. Within the Bill there is a provision for clinicians to refer to a psychiatrist if in any doubt. Does the hon. Member think that having that conversation at an earlier stage would be beneficial, rather than at a later stage?

Daniel Francis: I agree with my hon. Friend about the number of amendments in this vein, but clearly the amendments suggested by my hon. Friend the Member for Hackney South and Shoreditch bring us into line with existing regulations. In her evidence, Dr Cox said:

"If we look at the evidence of suicide, we know that it is increased in people with serious illnesses, but it is actually increased in the first six months after diagnosis, not in the last six months of their lives, so it is about the trauma of the diagnosis."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee, 28 January 2025; c. 82, Q105.*]

It is likely, therefore, that those diagnosed with a terminal illness will experience mental distress that could affect their capacity to make a decision about an assisted death. In her written evidence, Dr Virginia Goncalves, a retired clinical psychiatrist with over 30 years of experience in the NHS, writes:

"In my consultant psychiatrist role, I have encountered many desperate and suicidal patients wanting to end their lives after struggling with longstanding mental distress, who could have easily sought the option of assisted suicide if it had been available to them! But however depressed and hopeless they felt, with a compassionate and hope filled approach from their care givers and the correct medical and psychological treatment, the vast majority recovered enough to be able to have a 'life worth living'. In so many cases, these patients have thanked me later for not giving up on them! Not once have I heard anyone say 'you should have let me die when I wanted to do it'."

A meeting with a psychiatrist or other psychological specialist will protect people who may otherwise not have chosen assisted dying. I emphasise again that we already ensure that patients who will donate an organ have this assessment, so why not those seeking an assisted death? We must protect vulnerable terminally ill people from being coerced into assisted death, and psychiatrists and other specialists are best placed to spot that. That is why the assessment is included for living organ donation.

Naz Shah: Does my hon. Friend agree that this is a safeguard that would actually strengthen this Bill, especially given the conversations we have had around repeated coercion?

Daniel Francis: Absolutely. This amendment, of course, is widely supported by Committee members for that very reason. As I was saying, we already use that assessment for organ donation, and Members supporting this amendment believe that should be the case for those that are seeking an assisted death.

I now move on to amendment 284, in the name of my hon. Friend the Member for York Central. This amendment would change clause 9(3). Currently, that subsection lays out, and I will quote the language of the Bill, that the assessing doctor,

"(b) may, if they have doubt as to the capacity of the person being assessed, refer the person for assessment by a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council or who otherwise holds qualifications in or has experience of the assessment of capability;"

This amendment would change the word "may" to "must". In other words, the assessing doctor would have a duty to refer the person being assessed to a consultant psychiatrist if they had any doubt about that person's capacity. I argue that this is a change that we both should make, and can easily make. If a doctor has doubts about the capacity of an applicant, it is good practice for them to refer that person to a doctor or a specialist in that field.

Dr Opher: Could I ask which amendment the hon. Member is talking about? Is it 284 or 6? Amendment 284 says that psychiatric assessment is mandatory in all cases, whereas amendment 6 says it is mandatory if capacity is in doubt. I just wondered which one he was talking about, because I support one and I do not support the other.

The Chair: Dr Opher, maybe you want to catch up on the papers and then intervene when you have a question to ask.

Daniel Francis: As my hon. Friend will know, my name is down as a supporter of amendment 6. I will get to that in due course. At the moment, I am speaking to amendment 284. I hear what my hon. Friend says—I am talking about the merits of amendment 284, but will get to amendment 6 in my closing comments.

On amendment 284, if a doctor has doubts about the capacity of an applicant, it is good practice to refer that person to a doctor with specialist expertise in that field. That would be true if the doctor was assessing the capacity of a patient to take any important decision, and is surely especially true when we are talking about a decision of this importance. I accept that people will have different views on amendment 6, when we get to it, from those they hold on amendment 284. Amendment 284 would put a duty on doctors to do something that is good practice. Most doctors in most circumstances would do it anyway, but in some cases, some may not. My hon. Friend the Member for York Central, who tabled this amendment, believes that we should write this law as tightly as possible so that doctors have that duty.

Amendment 294, which was tabled by my hon. Friend the Member for York Central, would require the doctor to base their assessment on provided evidence. Again, that is something that most doctors would do anyway in the extremely serious circumstances of a person's applying for assisted death.

Many laws that we consider in this House relate to things that we are familiar with and understand well; but as my hon. Friend the Member for Bradford West said last week, some laws, such as this one, concern new matters. They are about things to which we need to give due consideration, as we are doing in scrutinising the Bill, because we need to understand the issues that arise.

[*Daniel Francis*]

Those laws can introduce powers that could be dangerous if not properly safeguarded. This Bill, as has been accepted, needs strong safeguards. The aim of my hon. Friend the Member for York Central in tabling this amendment was to spell out that a doctor's assessment of someone seeking assisted dying should be based on evidence. That would make it much less likely that any doctor would not pay sufficient attention to evidence they were presented with.

Lastly, as my hon. Friend the Member for Spenn Valley knows, I am a long-standing supporter of amendment 6—I was in that base going into Second Reading. Alongside my concerns about clause 3, which she has heard at length, this matter was a key concern of mine going into Second Reading. I was therefore an early supporter of this amendment to change the wording around the referral from “may” to “must”. That was discussed on Second Reading. I do not want to speak for my hon. Friend, but I think she shares similar views to mine on the matter and suspect that the matter may be supported when we get to that debate.

Jake Richards: I will be brief. I will talk about my amendment 280, which I will not press to a vote. There remains an area that needs more exploring in this legislation—it has come up in debates already, but needs to be looked at further—namely, that a person may have capacity but have other mental health conditions that may impair their judgment. In those circumstances, a more thorough assessment than the two-doctor stage there is at the moment would be right. In reality, that is very likely to happen under the current structure of the Bill. My amendment simply attempts to make sure that it is mandatory. Having had discussions with my hon. Friend the Member for Spenn Valley, I know that she is sympathetic to that.

There are amendments in the next group that aim to do the same thing. They, along with my amendment, may not be quite right. I urge the Government to look at this issue and see how we can work together to come to a conclusion, because I think that all members of the Committee would want that. I also support amendment 6, as I think everyone does.

Dr Opher: I apologise, Mrs Harris—I have got slightly confused with all the amendments. I do not have a speech that has been prepared for me, or anything like that, but I would like to make some comments. I think this is about the role of psychiatry and capacity, and how we deal that in the Bill. All these amendments reflect that. I would like to concentrate on whether we should actually mandate referral for all patients to a consultant psychiatrist, or adopt amendment 6, which suggests that if one of the two assessing doctors has concerns about either capacity or mental health, they should refer the patient to a psychiatrist. Those are the two choices I think we have here.

3.30 pm

I have been a doctor for 37 years, and have never known a psychiatrist involved in palliative or terminal care. I have never come across that as a concept. I am not saying that that is not a good idea, but it is not common that psychiatrists get involved, because the primary doctors often treat the mental health issues.

For example, I have treated depression many times in people with a palliative or terminal diagnosis, because I recognised that they were depressed on top of that diagnosis. It is only in areas where we have doubt that we should be using a specialist service such as psychiatry to give us a reasonable opinion of that.

Danny Kruger: I appreciate the hon. Member's point, and it is very logical that it should only be in the case of doubt, but does he not recognise that in the case of organ donation, it is mandatory? If people have this proper assessment when they are giving an organ, why should they not be asked to have one if they propose to give their life?

Dr Opher: That is an interesting point, but we are not discussing organ donation, and we are dealing in a different environment here; the patients we are talking about are about to die, and all we are giving them is the right to control the moment and manner of that death. I acknowledge that using a psychiatrist in organ donation has its benefits, but in this service, getting every patient—who, for example, are frail and ill by definition, because they are about to die—to see a psychiatrist is frankly neither applicable nor appropriate.

Kim Leadbeater: My hon. Friend makes a powerful point. If we think about some of the people we have met—the families who have lost loved ones to terminal illness and the patients who are terminally ill—they are very clear in their decision. For me, it would be another barrier to those patients, who are dying people, to make them see a psychiatrist for every single case.

Dr Opher: I think it would create a barrier. We need to make sure that we deliver legislation that does what we are trying to do, which is to enable someone with a terminal illness, who has full capacity, to make a decision about the end of their life.

Danny Kruger: It is a very important point. Yes, we are talking about those people, but we are also talking about a different category of people who have a terminal diagnosis of six months or more, and may only be reasonably expected to die within six months. I am not just talking about people at the very end of their life, who are at death's door; we are talking about people who qualify for the Bill, which is a much larger category of people, so it is appropriate to require them to do this.

Dr Opher: I agree with all of this. I think psychological assessment is incredibly important in all patients, and I personally specialise in it from a primary care basis. But we are suggesting here that the two other doctors have no ability to do any sort of psychological assessment, and that is simply not true.

Naz Shah *rose*—

Dr Opher: I apologise to my hon. Friend; I will continue for a little bit. We use secondary care and psychiatrists when we have a doubt about our decisions. If we have a doubt, then it is entirely appropriate to use psychiatrists in that instance, and we must do so. That is why I approve of amendment 6.

Kit Malthouse: As I understand it, I do not think if someone is donating an organ that they do actually have to see a psychiatrist; they have to see somebody who is an appropriately trained assessor from the Human Tissue Authority. To me, that sounds equivalent to the second doctor in our process—someone who is appropriately trained to assess patients and what they need to do. This talk of it having to be a qualified registered psychiatrist, compared with an organ donation, is incorrect.

Dr Opher: I completely agree with the right hon. Gentleman. By amending clause 12 to include social workers, who specialise in spotting coercion, there would be a psychological component in that panel. I emphasise that the first two doctors are trained in psychological assessment—they have to be to become a doctor, and we must respect their knowledge and decision making. Psychiatrists will be incredibly useful in difficult cases of capacity, but using them in every case would not be using them in the best capacity.

Naz Shah: My hon. Friend is being generous with his time. I do not question the capability of those doctors, but how does that square with the concerns of the Royal College of Psychiatrists that if a doctor has never met the person before, they cannot make an assessment on coercion? That might impact on capacity.

Dr Opher: Sorry, could you make that point again? I did not quite understand it.

The Chair: No, I am afraid not.

Dr Opher: Fair enough. Thank you, Mrs Harris. I was warned yesterday not to take interventions and I should have followed that advice.

The Chair: Dr Opher, I remind you yet again that “you” is me, and I have not asked you any questions. It is “my hon. Friend”.

Dr Opher: I am grateful that you have not intervened as well, Mrs Harris. You did say that I am allowed to call you “you”.

I will finish on this serious point. Amendment 6 has much power, and we would all agree that if the first or second doctor has doubts, they must—not may—refer to a psychiatrist. Expecting every patient who requests assisted death to have a psychological or psychiatric assessment is simply not necessary, and it would not improve the safety of this Bill.

Stephen Kinnock *rose*—

Lewis Atkinson (Sunderland Central) (Lab) *rose*—

The Chair: I call Lewis Atkinson.

Lewis Atkinson: Thank you, Mrs Harris—you really are giving the Minister some exercise during these long sittings.

Amendment 14 likens assisted dying to organ donation. I understand that an organ donor, before the point of independent assessment, has had no other independent assessment, which is in stark contrast to this Bill. The idea that, by failing to support this amendment, we are somehow adopting a weaker framework than for organ donation is patently false.

As the Bill sets out, there are already at least two assessments by independent doctors. As per the amendments we have already agreed, those doctors must have training, as specified by the Secretary of State, on the assessment of capacity and coercion. The rationale behind this amendment is already met, and it is significantly more strenuous than the framework for independent assessment in the event of organ donation.

Danny Kruger: I am not sure that is right. The amendment insists that this referral and assessment should happen at the earliest stage possible, in the same way as for organ donation. One of the confusions of the Bill is that multiple different conversations could happen. The purpose is to ensure that this conversation with a psychologist or social worker, as per organ donation, happens at the very earliest opportunity.

Lewis Atkinson: I disagree with the hon. Gentleman’s reading. The amendment talks about the co-ordinating doctor, as in the first independent assessor, and that is the case in the provisions we have already adopted. Clearly, the co-ordinating doctor may consult—and must consult, as per the amendment we are about to get to—psychiatric or other expertise, if there is any doubt in their mind. Amendment 14 would not bring forward that assessment earlier than elsewhere. I urge hon. Members to bear in mind that the idea that this proposal is somehow weaker than the current human tissue regulations is absolutely false.

On the point made by my hon. Friend the Member for Bradford West, the amendment does nothing to address coercion by a medical professional who knew the person beforehand. Under the amendment, it is by definition an independent person who has no prior relationship with the person.

The Chair: I call the Minister.

Stephen Kinnock: Thank you so much, Mrs Harris—I will try again.

Although it is up to Parliament to pass or reject this Bill, the Government remain committed to ensuring its legal robustness and workability. For that reason, we have worked closely with my hon. Friend the Member for Spen Valley, and we have mutually agreed some amendments, including amendments 370 and 202. This group of amendments relates to the assessment process for determining a person’s ability to make a first declaration. I will take them in turn.

As the Bill stands, the co-ordinating doctor is responsible for ascertaining whether, in their opinion, a person applying for assistance to end their own life has met the eligibility criteria in clause 7(2), as part of the first doctor’s assessment. Amendment 347 would change the co-ordinating doctor’s role from ascertaining whether, in their opinion, the criteria in clause 7(2) are met to instead ensuring that steps have been taken to confirm that those criteria are met. Its practical effect would be that the co-ordinating doctor could rely on the assessment of other, non-specified, persons to confirm that the eligibility criteria have been met.

Amendment 294 provides that the co-ordinating doctor, in ascertaining whether, in their opinion, the criteria in clause 7(2) are met, would be required to base that assessment on evidence that has been provided. It does

[Stephen Kinlock]

not specify who would provide the evidence, what types of evidence would be considered acceptable or whether the co-ordinating doctor could disregard evidence if they consider it appropriate to do so. It could create uncertainty for the co-ordinating doctor in carrying out the first assessment.

Amendment 14 would require the co-ordinating doctor, when making the first assessment, to take into account an additional report. The report would be made by a qualified person and would cover duress and/or coercion, communication needs and capacity. It would be informed by an interview between the specialist and the person applying for assistance to end their own life. The specialist must have expertise in psychiatry or other qualifications set out in regulations. There are various exclusions aimed at avoiding conflicts of interest.

Amendment 15 would similarly require that the independent doctor, in making the second doctor's assessment, takes the report into account. Amendments 16 to 19 are consequential to amendment 14.

In practice, the amendments would represent a change at the medical assessment stage from requiring two professionals to requiring three. They also represent a departure from usual practice for professionals applying the Mental Capacity Act 2005. The requirement to interview the person and write a report that must, in all cases, address capacity may amount to an assessment of capacity in itself. That would undermine a core principle of the Mental Capacity Act, which is the presumption of capacity.

In addition, the test of capacity set out in the amendments is more limited than the test of capacity under the Mental Capacity Act. It covers only capacity to understand information, not capacity to retain, use or weigh it.

Amendment 284 would require the co-ordinating and independent doctors to, in all cases, refer the person seeking assisted dying to a psychiatrist for an assessment of their mental capacity. Although that is set out in the explanatory note from my hon. Friend the Member for York Central, the amendment does not specify the type of assessment that is required. Putting aside specification of the type of assessment, the overall intention of the amendment is that, in order to be eligible for assisted dying, a capacity assessment would always be required, irrespective of whether there is a proper reason to doubt that the person has capacity. That would differ from the Mental Capacity Act, under which capacity is presumed unless it is established that the person lacks it.

Amendment 6 would require the assessing doctor to refer all cases where there is doubt about mental capacity for an assessment by a doctor who is an expert in psychiatry. This is a power, as currently drafted, but the amendment would make it a duty. Requiring, rather than permitting, the assessing doctor to make a referral when capacity is in doubt would remove their discretion on whether to refer a person to a doctor who is an expert in psychiatry. Instead, it would be required in all cases where there is doubt about capacity.

3.45 pm

Amendment 280 seeks to ensure that individuals with a mental health condition can be assessed by a psychiatrist as part of the eligibility process for assisted dying. If the

assessing doctor identifies that the person has a mental health condition, they would have the power to refer the person for psychiatric assessment. The assessing doctor would then be required to take the psychiatrist's opinion into account. The amendment does not specify what type of assessment the psychiatrist would carry out, so this could be an assessment of mental disorder rather than capacity.

Additionally, the term "mental health condition" is not legally recognised and is not defined in the amendment. Its impact would therefore be unclear in some cases, such as where a person has a learning disability or a behavioural disorder.

On amendment 370, psychiatry is not a specialty in the GMC register. Rather, psychiatry is considered a family of specialisms. This amendment, stating that the registered medical practitioner must be registered in one of the psychiatry specialisms, will mean that the language of the Bill is more precise and technically accurate. The specialist register is a static record, which means that an entry does not guarantee that a doctor continues to practise in the specialty for which they are registered. Amending the wording of this clause to require that they are a practising psychiatrist will ensure that the clause captures only doctors currently practising in one of the psychiatry specialisms.

Amendment 202 will ensure that assessment of capacity is used by the assessing doctor, and it corrects a typographical error to ensure the assessment of capacity is applied consistently throughout the Bill.

I hope the Committee has found these observations useful.

Kim Leadbeater: I will do the easy bits first. As the Minister said, amendment 370 in my name is a drafting change to the definition of a psychiatrist, which is obviously very important. These useful amendments have enabled us to have this discussion, and they all come from a good place in trying to enhance safeguarding within the Bill.

On organ donation, my sister-in-law has had two kidney transplants. On neither occasion, to my understanding, did a psychiatrist speak to either her or the organ donor, who in one instance was her brother—my sister-in-law would be very upset that I have mentioned her in Parliament. My understanding of the law is that someone may be referred to a mental health specialist. I am happy to be corrected if that is not the case, but I do not think a consultation with a psychiatrist is compulsory.

As I said to my hon. Friend the Member for Stroud, it is absolutely right that we support amendment 6. From the start, I have been clear that we should move from "may" to "must" in referring to a psychiatrist where either doctor has any doubt. That is a sensible approach, and it covers most of today's discussion.

However, introducing a whole new system that would almost sit alongside the Bill, and that would change the process, is unnecessary. Those are my conclusions, based on what has been another very interesting discussion.

Daniel Francis: I will not come back on anything but, obviously, I will press some of these amendments in due course.

I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 294, in clause 7, page 4, line 5, after “doctor” insert

“based on provided evidence that”.—(*Daniel Francis.*)

This amendment would require that the doctor bases their assessment on provided evidence.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 34]

AYES

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

NOES

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

Question accordingly negated.

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

3.51 pm

Sitting suspended.

4.6 pm

On resuming—

Sarah Olney (Richmond Park) (LD): I beg to move amendment 363, in clause 7, page 4, line 7, at end insert—

“(ba) is not seeking assistance to end their own life because of an impairment of judgment arising from a mental disorder or other condition.”.

This amendment would require that the coordinating doctor is satisfied that a person is not seeking assistance to end their own life due to an impairment of judgement arising from a mental disorder or other condition. It is linked to Amendments 364, 365, 366 and 367.

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

Amendment 364, in clause 8, page 4, line 34, at end insert—

“(ba) is not seeking assistance to end their own life because of an impairment of judgment arising from a mental disorder or other condition.”.

This amendment would require that the independent doctor is satisfied that a person is not seeking assistance to end their own life due to an impairment of judgement arising from a mental disorder or other condition. It is linked to Amendments 363, 365, 366 and 367.

Amendment 365, in clause 9, page 6, line 31, at end insert—

“(ba) must, if they think a person may be seeking assistance to end their own life due to an impairment of judgment arising from a mental disorder or other condition, refer the person for assessment by a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council.”

This amendment would require that the assessing doctor to, if they think a person may be seeking assistance because of an impairment of judgment refer them for an assessment. It is linked to Amendments 363, 364, 366 and 367.

Amendment 366, in clause 9, page 6, line 32, after “(b)” insert “or (ba)”.

This is consequential on Amendment 365.

Amendment 367, in clause 12, page 8, line 2, at end insert—

“(ca) the person is not seeking assistance to end their own life due to an impairment of judgment arising from a mental disorder or other condition.”

This amendment would require that a court is satisfied that a person is not seeking assistance to end their own life due to an impairment of judgment. It is linked to Amendments 363, 364, 365 and 366.

Sarah Olney: Although this is not specified in any of the amendments—which are in the name of my good friend, my hon. Friend the Member for Bath (Wera Hobhouse)—they are very much informed by the work she has done over a number of years as the chair of the eating disorders all-party parliamentary group. This is a subject about which she has a great deal of knowledge, and that is what has prompted this group of amendments, which follow on from the debate we had just before the break.

It is important to remember that although amendment 6—in the name of another good friend, my hon. Friend the Member for St Albans (Daisy Cooper)—talked specifically about people’s capacity, this group of amendments very much returns to a topic I have spoken on at length in previous sittings: how a person’s capacity to request an assisted death might well be impacted if they are suffering from mental health difficulties.

Amendment 363 would require a mental health assessment if there is any indication that a person’s judgment may be impaired by a mental disorder or other conditions. We have debated this topic at length—*[Interruption.]* I see the right hon. Member for North West Hampshire nodding, but it is worth returning to the issue, because a principal concern of mine is that we have not yet dealt adequately with this risk in the Bill. We have talked about how the Mental Capacity Act might be applied and about psychosocial interventions, but I am keen to see amendment 363 agreed to, because it would deal with many of the objections raised in those other debates. It is an important safeguard that still needs to be included in the Bill.

The Bill has been described as having the strongest safeguards in the world, but it lacks this critical safeguard, which is seen in many similar laws around the world, including Oregon and California, which require that in addition to establishing mental capacity, doctors must ensure that a person’s judgment is not impaired by mental illness. In fact, in the American state of Hawaii, every patient who requests an assisted death is required to see a mental health professional, who can determine whether the patient is capable and appears not to be suffering from under-treatment or non-treatment of depression or other conditions that may interfere with their ability to make an informed decision.

It is provided for specifically and clearly in the legislation that governs assisted dying in other jurisdictions that assessments of the state of people’s mental health—and not just their capacity—must be made properly. The absence of any such safeguard in the Bill represents a clear risk. We know that mental health conditions can

[Sarah Olney]

impair decision making and lead to suicidal ideation, particularly when a person lacks adequate social support. Without this provision, individuals experiencing a treatable mental health crisis may be given life-ending medication instead of the care and treatment that could alleviate their suffering.

Professor Allan House made the importance of that clear in his written evidence. He wrote:

“Simply checking mental capacity and asking about coercion is not adequate.”

He emphasised that National Institute for Health and Care Excellence guidelines in other areas already require a comprehensive psychosocial assessment that explores “thoughts about life not being worth living”

and considers

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

Professor Louis Appleby, the Government’s adviser on suicide prevention—I have referenced him on many occasions in previous sittings—has also raised concerns that the Bill could undermine suicide prevention efforts. Speaking to *The Guardian*, he said:

“You have a number of potentially remediable risk factors like isolation, for example. Do something about isolation. Depression, treat depression. It should be the offer of supporting people through the remediable elements of a sense of despair.”

That highlights why a safeguard is necessary to ensure that individuals receive proper assessment and treatment, if needed, before making an irreversible decision. If a person qualifies for assisted dying but is also experiencing impaired judgment due to a psychiatric condition, how can we be confident that their decision is truly autonomous?

Amendment 363 would require the co-ordinating doctor to assess whether a person’s request for assisted dying is influenced by a mental health condition. If there is any concern that impaired judgment due to a mental disorder is a factor, the doctor must refer the individual for a psychiatric assessment. The amendment would explicitly protect individuals with mental health disorders, including eating disorders, from accessing assisted dying when their desire to die is a symptom of their illness rather than a rational decision deriving from a terminal illness.

Do not ask me how I know this, but eating disorders really scramble a person’s brain. They leave them entirely incapable of making any kind of rational decision. The lack of nutrition really affects the brain: it has a physical impact that means the brain simply cannot function as it is supposed to. That is a direct cause of a person not ingesting the nutrients they need. When that happens to somebody, their behaviour completely changes: they become anxious, fearful, irrational and aggressive. It is not just that they believe their life is not worth living; the entire span of their life has shrunk down entirely to the question of how they can avoid eating. What is the next meal? What is the next stage in their life when someone is going to try to get them to eat, and how can they avoid that? What tactics can they employ?

When a person is in the grip of that kind of eating disorder, if someone comes along and offers them the possibility of an assisted death, there is every chance that they will choose that as a way of avoiding eating. As I say, do not ask me how I know this, but I have seen

it, and for me it is beyond comprehension that we could possibly allow young people, and young women in particular, to put themselves in the position where they are being offered an assisted death and no one is taking those extra steps to treat their eating disorders—and eating disorders are always treatable. That is why I want to press the amendment.

Kim Leadbeater: The hon. Lady is making a powerful speech, and I understand that the amendments come from a very good place, and a very strong and experienced one, but she just made the point that eating disorders are treatable. That is the whole point: they would not fall under the criteria in the Bill.

Sarah Olney: That is why we need to ensure that people with eating disorders get the treatment they need, instead of being offered an assisted death. That is why we need the amendment.

Kim Leadbeater *rose*—

Sarah Olney: Let me just reply to the hon. Member’s original point. It is so important—and this is why we need the amendment in the Bill—that if there is any doubt at all that someone is suffering from a treatable mental health condition, they are not allowed to proceed with their request for an assisted death until all avenues of treatment for that condition have been explored. Eating disorders are treatable: people can recover and can, in the fullness of time, recover their zest for life. They can move beyond the stage where their decision whether to eat or not is their entire world. They can rediscover their friends, their employment and their education, and they can look forward to a full life again. But it is imperative that while they are in the grip of that eating disorder, they are not offered the option of an assisted death.

Kim Leadbeater: I agree with every word the hon. Lady said, and—possibly like her—I have experience of working with people with eating disorders. However, clause 2 defines terminal illness as “an inevitably progressive” illness or disease “which cannot be reversed by treatment”.

Eating disorders can be reversed by treatment, and therefore I am not willing to support the amendment.

4.15 pm

Sarah Olney: We need to consider the possibility that somebody is suffering from a terminal illness as a comorbidity with an eating disorder; they may be suffering from an eating disorder alongside something that can be considered a terminal illness—there are such cases. However, it is not unknown—and Chelsea Roff, an expert on eating disorders, who has given evidence to the Committee both orally and in writing, has uncovered a number of occasions in jurisdictions where assisted dying is already legal—for an eating disorder to be defined as a terminal illness. It is really important that we understand that there remains a risk that an eating disorder could be a terminal illness.

Danny Kruger: I am afraid that that is a risk in our own country too. Does the hon. Lady acknowledge that some young women have been put on palliative care pathways in the NHS? They have been diagnosed as having terminal anorexia.

Sarah Olney: The hon. Member is absolutely right. The Court of Protection has described eating disorders using language typically reserved for terminal illnesses. It has described an eating disorder as being in “the terminal stage”, talked of “all treatment options” having “been exhausted” and used words such as “incurable”. It is immensely regrettable, but nevertheless the case—even though eating disorders are always treatable—that if a person suffering from an eating disorder is deemed to have capacity and is refusing treatment, there may well be nothing that can be done to stop them choosing that path, which may ultimately lead to their death.

Naz Shah: Is the hon. Member aware that in nine of the 10 cases that went before the Court of Protection, the young ladies were deemed not to have capacity, but the judge still decided that it would not be in their best interests to feed them, and they were put on palliative care pathways?

Kit Malthouse: They did not have capacity.

Sarah Olney: I am grateful for that intervention and, dare I say it, for the one from the right hon. Gentleman. That is the whole point about eating disorders: there is a very fine line to be trod between people who have capacity, people who lack capacity and people who have capacity but who can still be allowed to make an unwise choice, which is obviously a huge risk for people with eating disorders. I find that risk very much magnified in the Bill as it is currently drafted, which is why it is of the utmost importance that it provides specifically for the possibility that somebody is suffering from any kind of mental health illness, and particularly from an eating disorder—but I do not see such a provision at the moment. I heard the arguments that were made when I raised this issue in earlier sittings, and I very much welcome amendment 6, but it deals only with capacity; it does not talk about mental illness.

To conclude, amendment 363 is a crucial safeguard that would prevent assisted dying from becoming an unintended route for people suffering from mental health conditions, such as eating disorders, to end their lives prematurely. It would ensure that requests for assisted death are based on genuine, rational decisions, rather than symptoms of a treatable disorder. By aligning with best practice from other jurisdictions and addressing a critical gap in the UK’s current approach, it would strengthen the ethical foundations of the assisted dying Bill and better protect vulnerable individuals.

Lewis Atkinson: I welcome the hon. Lady’s speech, which she made with her customary dignity and force. I feel we are repeating some of the discussions we had on earlier clauses regarding capacity, and it is for the reasons I articulated then that I believe we need to stand by the Mental Capacity Act—and not deviate from it by introducing language such as that proposed in the amendment—because that is where safety lies.

Sarah Olney: I believe I repeated several times in my speech that this is not about capacity; it is about mental illness.

Lewis Atkinson: I take the hon. Lady’s point, and I was about to come to that. The Mental Capacity Act already explicitly states that

“a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.”

The language around an impairment in respect of the mind or brain is already set out in that Act.

As has been acknowledged, the Court of Protection has repeatedly found that people lack capacity, and such people would therefore not be eligible under the Bill in some of the circumstances the hon. Lady set out. By introducing a new, undefined concept of “impaired judgment”, which as I understand it is not a term that exists anywhere else on the statute book, we would be clouding the Mental Capacity Act.

Sarah Olney: Does the hon. Gentleman assert that it is therefore impossible for anybody with a mental illness that might affect their ability to make a decision about an assisted death to be judged to have capacity?

Lewis Atkinson: As I am sure the hon. Lady knows, there are gradients of mental health issues, from low mood to suicidality and so on. We should not prevent anyone from accessing an option merely because of a mild element of, for example, depression, which they have lived with for their entire lives, if they have then been diagnosed with a terminal condition.

The key point, as my hon. Friend the Member for Spen Valley made out, is that the idea that eligibility will be conferred as a result of mental health illnesses is not correct. As we have discussed, the definition of “inevitably progressive” in clause 2, which is at the heart of the Bill, clearly protects against such instances. I also highlight the amendments we have made that help to clarify some of this. Members have pointed out the amendment from the hon. Member for East Wiltshire on removing medical conditions from the Bill, which was very helpful in this regard.

I do not want to fall foul of Standing Order No. 42 on repetition, but I feel like with this issue we are repeating some of our discussions on capacity. In particular, my hon. Friend the Member for Penistone and Stocksbridge highlighted significant elements of the relevant legal framework in her speech at that point. In my view, setting out a test that is separate to the Mental Capacity Act, particularly in respect of the impairment of judgment, which is not then defined in any way, would undermine that Act, which has to be the cornerstone of the Bill.

Kim Leadbeater: My hon. Friend is making an important speech. Is he, like me, reassured that it is not just about capacity, but about someone’s clear, settled and informed wish? If someone is suffering from a mental health condition, there is a very strong chance that they will not meet the criteria. Also, my amendment 423 will strengthen the fact that the assessing doctors must speak to somebody else in regard to the patient, including eating disorder specialists.

Lewis Atkinson: My hon. Friend is absolutely correct. There are clearly further safeguards in those provisions, and also in the training provisions that we have already discussed. When the Secretary of State makes provision on training and assessment in respect of capacity and related matters, it is clear to me that they will do so with reference to some of the mental health conditions that the hon. Member for Richmond Park and others have referred to. Yesterday we agreed to amendment 275—which I was honoured to move—to ensure that people have had discussed with them “all appropriate” care, including psychological support, which further covers capacity. I would be absolutely horrified if there was any suggestion that people with mental health conditions should not have full access to all the support that may be beneficial.

Sarah Olney: Will the hon. Gentleman address the point that the requirement to refer for specialist psychiatric support is a requirement in similar legislation in other parts of the world—in Oregon, in California, in the state of Victoria in Australia, and in other jurisdictions that we heard evidence from? It is written into their legislation and provides a crucial extra safeguard, which is separate from the judgment about capacity because it is deemed to be so important.

Lewis Atkinson: Indeed, and that is why I support amendment 6, which we have just debated, to mandate referral for psychiatric assessment in cases where there is any doubt whatever. I think we have incorporated those safeguards and more but, fundamentally, as Chris Whitty said in evidence, for this legislation to be as secure as possible, we have to base it on the Mental Capacity Act, which has been tried and tested through the courts for more than 20 years.

The insertion of language talking about impairments of judgment clearly deviates from that Act, where an impairment test is already set out. I do not feel that is appropriate. I absolutely applaud the sentiments behind the amendment, but I feel we have sufficiently strengthened the Bill elsewhere and that the MCA and other provisions give the safeguards and the reassurance that we need on these issues.

Naz Shah: Apologies, Mrs Harris: I was late returning to my seat earlier and missed the opening remarks from the hon. Member for Richmond Park on this amendment. I am happy to be corrected, but my understanding is that, as it is, if somebody has anorexia—we are not talking about capacity, which I referred to in the cases of the nine girls I spoke about—that is an accepted mental health condition and the amendment is trying to exclude those people from having an assisted death. In the nine cases I spoke of, the court found that those girls with anorexia had capacity and ruled that they had a terminal illness.

Kim Leadbeater: I apologise, but I thought my hon. Friend said that they did not have capacity.

Naz Shah: Sorry—they did not have capacity, but the Court of Protection still ruled that they would be taken down the route of palliative care. This is not just a matter of capacity; in this instance, when we talk about mental health—before we even get to the capacity

question—the issue is that anorexia is a recognised mental health condition. I beg to differ from my hon. Friend the Member for Sunderland Central on whether we have enough provision. We keep coming back to this issue time and again.

Kit Malthouse: I want to be clear, because the hon. Lady and I have exchanged views on this issue: my recollection from reading the briefing—I am happy to go back to it—is that, in those nine cases, the girls were found not to have capacity, but the judge then took the decision not to force-feed them because force-feeding them was likely to be threatening to their health and might precipitate their deaths. I do not think it is quite right to say that the judges put them on a palliative pathway. They declined to force-feed them on the basis that they thought it was in their best interests and that force-feeding them might actually precipitate their deaths.

Naz Shah: I thank the right hon. Gentleman for his intervention. When I came to this place, somebody said to me, “There’s the letter of the law and there’s the essence of the law.” As lawmakers, we make indications, and so do judges. By not opposing something, does that mean that by default we are supporting it? That is the question here for me. In those cases, those judges accepted—as he says—that those girls would inevitably die. Although the judges did not state that they put the girls on a palliative care pathway, by default, in my understanding, that was a palliative care pathway because it was accepted that those young girls were going to die by not being fed. It is just a matter of semantics for me.

I come back to the debate that we have just had. For me, the crux of the issue is that if someone has a mental health condition that then, by definition, becomes a terminal illness—regardless of the capacity conversation—this amendment surely strengthens the safeguard for them. By and large, this involves women who experience anorexia so this conversation is very gendered. I am happy to be corrected. That is all I have to say on the matter.

4.30 pm

Stephen Kinnoch: The purpose of these amendments is to prevent someone with an impairment of judgment arising from a mental disorder or other condition from being able to access assisted dying. Impairment of judgment is an uncertain legal concept that is far wider than the current test of capacity, which requires that the person must be unable to make a specific decision, and “impairment of judgment” is not defined in the amendment.

Under the Mental Capacity Act 2005, the inability to make a decision must be directly caused by “an impairment of, or a disturbance in the functioning of, the mind or brain.”

However, under the amendments, the requirement is merely that the inability to decide must arise from such an impairment or disturbance, making the threshold significantly broader. The meaning of other conditions outside of mental disorder is also unclear. For instance, it might include a physical condition, and it is unclear how this would interact with the Bill’s provisions on terminal illness. I hope those observations were helpful for the Committee.

Kim Leadbeater: As I said earlier, I have no doubt that these amendments are coming from a good place and from somebody with huge experience in this particular area. There is absolute consensus on the Committee that the last thing we want is for anybody with a mental health condition and terminal illness to end up going down a path that they did not want, and we have to put as many safeguards as possible in place to ensure that that does not happen.

However, I remain confident that the Bill, with the amendments that we have voted for in Committee and the safeguards that were already there, provides the highest level of safeguards to ensure that people with mental health conditions are protected. Let us look at the fact that there will be two doctors; we have talked at great length about not only their existing skills but the skills that they would gain from the robust training, particularly in assessing capacity, detecting coercion and the specific skills that we might say they would need for the purposes of the Bill.

We can also look at the fact that the doctors can make any referral to any other professional, as they want. Clause 9(2) currently says that they can “make such other enquiries as the assessing doctor considers appropriate”.

I have strengthened that further with amendment 423, which specifically talks about health and social care professionals, which is again another opportunity to have another professional involved.

Clearly, I would find it untenable for a doctor, presented with a terminally ill patient with an eating disorder, not automatically to speak to a professional involved in that field. That feeds into the broader point, with which I absolutely concur, that we need to do more to support people with eating disorders—that is a very important, separate piece of work. We then add amendment 6, which puts in place the compulsory referral to a psychiatrist. We have talked a lot about the psychiatrist’s role in assessing capacity, but we must remember that this would be a psychiatrist doing the assessment. As my hon. Friend the Member for Sunderland Central mentioned, mental health conditions are referred to in the Mental Capacity Act, and “impairment” is referred to in the Mental Capacity Act.

Many safeguards were there already, and we have added additional ones as a Committee. We also then come on to the multidisciplinary panel, which I hope the Committee will support. It would add extra layers of expertise, with social workers, psychiatrists and legal oversight. I remain confident that there are multiple levels of safeguarding at various stages in the Bill that would address the issues raised by the hon. Member for Bath. Equally, I am very happy to continue speaking to her and meeting her, as I did quite recently, to talk about this issue and look at whether we can do any other things to enhance the Bill going forward.

Question put, That amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 35]

AYES

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

NOES

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

Question accordingly negated.

Amendment made: 193, in clause 7, page 4, line 8, at end insert—

“(ca) is in England and Wales.”—(*Kim Leadbeater.*)

This amendment, which is consequential on Amendment 178, provides that the coordinating doctor must ascertain whether, in their opinion, the person who made the first declaration is in England and Wales.

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

“(ca) has relevant and available palliative care options.”—(*Danny Kruger.*)

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

Question put, That the amendment be made.

The Committee divided: Ayes 3, Noes 18.

Division No. 36]

AYES

Kruger, Danny	Paul, Rebecca
Olney, Sarah	

NOES

Abbott, Jack	Leadbeater, Kim
Atkinson, Lewis	Malthouse, rh Kit
Campbell, Juliet	Opher, Dr Simon
Charalambous, Bambos	Richards, Jake
Francis, Daniel	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.

Danny Kruger: I beg to move amendment 257, in clause 7, page 4, line 15, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) to (g) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

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

Amendment 258, in clause 8, page 4, line 38, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) to (e) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Amendment 259, in clause 12, page 8, line 14, at end insert—

“and that there is no real risk that the criteria in paragraphs (b) to (h) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Amendment 260, in clause 13, page 9, line 34, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) to (d) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Amendment 261, in clause 18, page 12, line 26, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) to (c) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Amendment 262, in schedule 2, page 27, line 12, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) and (b) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Amendment 263, in schedule 3, page 28, line 10, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) and (b) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Amendment 264, in schedule 5, page 30, line 22, at end insert—

“and that there is no real risk that the criteria in paragraphs (a) to (c) have not been met.”

This amendment provides that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

Danny Kruger: I was going to speak briefly to amendment 420(a), as per your ruling earlier, Mrs Harris.

The Chair: You can move it, but it cannot be debated.

Danny Kruger: I had misunderstood you; that is a shame. I have moved the amendment in the name of my hon. Friend the Member for West Worcestershire (Dame Harriett Baldwin), but I will not speak to it.

The Chair: Do you wish to speak to the amendment?

Danny Kruger: I do not, but other colleagues will, I am sure.

Rebecca Paul *rose*—

The Chair: I call Rebecca Paul.

Rebecca Paul: Thank you, Mrs Harris. I rise to speak in support of amendment 257 and the associated amendments in this group, tabled by my hon. Friend the Member for West Worcestershire. They require that the request for assisted dying will not go ahead if there is a real risk that the eligibility criteria are not met.

In reality, I would much prefer that the many amendments proposed to clause 1, to broaden coercion and pressure safeguards, to clause 2, to tighten the definition of terminal illness, and to clause 3, to raise the bar for capacity assessments, had been incorporated. In my view, that would have been the best way to improve the safeguards in the Bill. But we are where we are, so I am supporting this amendment, which puts in

place an additional safeguard at the point when the doctor has performed the first assessment and is about to make the statement.

If this Bill passes, we will be asking doctors to take a truly momentous decision: is the person standing in front of them, or whose documents they are reading through, going to be approved for an assisted death? The decision is momentous for them and even more for the applicant themselves, so it should be made on the firmest foundation possible. What is that foundation? The Bill sets out a number of criteria, which we have discussed in detail over the last few weeks, but it does not explain how sure the assessors need to be about some of them. There is no clear, consistent evidential standard, and many of the areas considered come down to estimation at the end of the day. A series of boxes, essentially, must be ticked by a trusted professional to determine whether someone is eligible for an assisted death.

Under the Bill currently, the schedules specify that the doctors must be satisfied that the patient has a clear, settled and informed wish to end their own life and has made the first declaration voluntarily and that, to the best of their knowledge, the patient has not been coerced or pressured. I note that amendments have been tabled to remove the schedules; if those are agreed to, that could have an impact on some of what I am saying.

Let us look at how easy it is for the component decisions, which appear innocuous in isolation, to add up to something monumental. A patient has been diagnosed with a terminal cancer that will undoubtedly end their life at some point. It is notoriously difficult to say, at this point, whether they have 18 months or just six months left to live. The margin of error can be significant, as we have heard previously in oral and written evidence. However, in this case, the doctor decides that six months is appropriate. The first checkbox is ticked.

When assessed for capacity, the patient is confused and inconsistent, anxious and depressed. However, there is no diagnosed disturbance or disorder of the mind or brain, so on the balance of probabilities—the “51% sure” test—the doctor, although he or she has reservations, has to assess the patient as capacitous. Sadly, that is undoubtedly the correct approach under clause 3 currently. A second checkbox is ticked.

The doctor needs to form a view as to whether the patient has a clear, settled and informed wish to end their own life. Without mind reading abilities, that is a difficult thing for a doctor to opine on—they will rely heavily on what the patient says, as that is all they can really go on. The patient is saying all the right things to reassure the doctor on this front. The doctor might have a niggle about something, but again, they have enough to check the box and to meet the threshold: to the best of their knowledge.

Finally, there is an even more difficult check. In the doctor’s opinion, has the patient been coerced or pressured? Again, the doctor does not necessarily know the patient very well or have a good understanding of the circumstances, and they are really busy, but they have not seen any overt signs of coercion. Everyone around the patient seems so lovely, so to the best of the doctor’s knowledge they should be comfortable and the checkbox gets ticked. At the end of this process, in which each criterion has been individually considered, the patient is clearly eligible. All the boxes are ticked.

Jake Richards: The hon. Lady has set out the process, but I believe she may have missed an important juncture in the Bill. If there are any doubts as to capacity, then the person would be referred to a psychiatrist for a full assessment.

Rebecca Paul: That is a “may” rather than a “must”. I hope that we would move to “must” in that event.

Dr Opher: This is just a point of accuracy: I think we are all going to support amendment 6, which would make it obligatory to refer to psychiatry if there were any doubts.

4.45 pm

Rebecca Paul: Obviously, I am speaking to the Bill as is. I do not want to presume the result of any vote. I assume none of us here knows how a vote may go.

All boxes checked, yet it is entirely possible that the margin of error could add up to the point where a doctor, when standing back and looking holistically at the situation, might feel there is sufficient risk to warrant not signing off. It is that niggle again—sometimes the sum of the parts is not the right answer. That is what amendment 257 seeks to do: to allow that the doctor that element of override discretion where there is a real risk that any of the eligibility requirements are not met.

My understanding is that the “real risk” test is taken from the jurisprudence of the European Court of Human Rights. That Court has held that states are under a duty to protect an individual from suicide if they are aware of a real and immediate risk of suicide. Doctors are already required under the Human Rights Act to assess of when there is a real risk of suicide, so it is a familiar legal test, I believe. Ensuring that it applies to the eligibility criteria, in particular those dealing with autonomy and voluntariness, may strengthen the Bill, make it safer and help ensure compliance.

I will welcome the Minister’s views, however, on whether the test is the right one legally given the spirit of what the amendment seeks to do. I appreciate that this is a technical legal point, and I am not a lawyer. I am also open to the argument that “real risk” might not be the appropriate test for every one of the eligibility criteria, so again a view from the Minister would be helpful. If the Government and the promoter of the Bill accept that this test should apply to the issues of capacity, clear and settled will, voluntariness, and absence of coercion or pressure, I will be happy for the Government to table a tidying amendment on Report to limit the test to those matters. My intention is to press the amendment to a vote and I hope that the Committee will join me in supporting it.

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): It is a pleasure to serve under your leadership, Mrs Harris.

I will speak to this octet of amendments and set out why I cannot support them. In my view, they are a classic example of legislative embroidery. If we wanted a better example, we could not find one. Sadly, they would achieve nothing but add a great deal of confusion to the situation.

Throughout the Bill, a clear set of criteria must be fulfilled in order to move from one stage of the process to another. To lay on, additionally, a frankly woolly and ill-defined legal test that has not been set out in in this legislation and that overrides those criteria, without any reasoning to underpin it or any sense of purpose behind it, is simply confusing. The test would make the Bill less operable in reality, and it undermines everything that comes before it—there is no purpose to having criteria that we have to move through if we are then to say, “Actually, that is null and void, because I have a sense that I am just not comfortable with it.” If one is not comfortable with one stage of the criteria, that is enough for it to fall or to be referred to someone else—for example, to a capacity assessment, as has been suggested. The amendment is legal nonsense. I see where it is coming from, but it is legal nonsense in how it is drafted, and it does not assist in making a more meaningful or operable Bill. Therefore, I cannot support it.

Stephen Kinnock: The amendments seek to ensure that an individual requesting assistance to die will not be able to do so if there is a real risk that the eligibility criteria have not been met.

The Bill provides in clauses 7, 8, 12, 13 and 18 that where the assessing doctor or court is satisfied that, in their opinion, the eligibility criteria that they are charged with assessing have been satisfied, they must complete the next relevant step required by the Bill. If, however, the assessing doctor or court are not satisfied that the eligibility criteria that they are charged with assessing have been met, they must not take the next steps set out under the Bill.

Our assessment is that, as drafted, this group of amendments could create uncertainty as to what the assessing doctors are required to assess. The amendment would add a separate, potentially overlapping requirement on the assessing doctors and the court to assess whether there were no real risk. That could create uncertainty for the assessing doctors as to what is additionally required. I hope those observations were helpful to the Committee.

Kim Leadbeater: I have nothing to add, Mrs Harris.

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

Amendment, by leave, withdrawn.

Amendment proposed: 14, in clause 7, page 4, line 15, at end insert—

“(2A) The coordinating doctor must take the report required under subsection (2B) into account in making an assessment under paragraph (2)(b), (f) and (g).

(2B) One or more qualified persons must have conducted a separate interview with the person and made a report to the coordinating doctor on the matters specified in subsection (2C).

(2C) The matters that must be covered in the report required under subsection (2B) are—

- (a) any evidence of duress or coercion affecting the person’s decision to end their life,
- (b) any difficulties of communication with the person interviewed and an explanation of how those difficulties were overcome, and

- (c) the capacity of the person interviewed to understand the information given to them under paragraph (9)(2), (b), (c) and (d).
- (2D) A person shall be taken to be qualified to conduct an interview under subsection (2B) if that person—
- (a) is a registered medical practitioner who—
- (i) is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council, or
- (ii) has such training, qualifications and experience as the Secretary of State may by regulations specify,
- (b) has not provided treatment or care for the person being assessed in relation to that person's terminal illness,
- (c) is not a relative of the person being assessed,
- (d) is not a partner or colleague in the same practice or clinical team as the coordinating doctor,
- (e) did not witness the first declaration made by the person being assessed, and
- (f) does not know or believe that they—
- (i) are a beneficiary under a will of the person, or
- (ii) may otherwise benefit financially or in any other material way from the death of the person.
- (2E) Before making regulations under subsection (2D)(a), the Secretary of State must consult such persons as they consider appropriate.
- (2F) Regulations under subsection (2D)(a) are subject to the negative procedure.—(*Daniel Francis.*)

This amendment, and its consequential and linked amendments (15, 16, 17, 18 and 19), would provide for an independent assessment, via an interview conducted by a specialist, of a person's capacity to make the decision to end their own life, their clear, settled and informed wish to do so, and that they have made the first declaration voluntarily and without coercion.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 14.

Division No. 37]

AYES

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

NOES

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

Question accordingly negated.

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

- “(3) After carrying out the first assessment, the coordinating doctor must—
- (a) make a report about the assessment (which must meet the requirements of regulations under subsection (4));
- (b) give a copy of the report to—
- (i) the person who was assessed (“the assessed person”),

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

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

Amendment proposed to amendment 420: (a), in subsection (3)(c), at end insert

“, unless they believe that there are particular circumstances which make it inappropriate for the person to be provided with assistance to end their own life.”—(*Danny Kruger.*)

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 15.

Division No. 38]

AYES

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

NOES

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

Question accordingly negated.

Amendment 420 agreed to.

The Chair: Amendments 54, 299, 265, 128, 295, 246 and 426 fall, as amendment 420 has been agreed to. We therefore come to the question that clause 7, as amended, should stand part of the Bill—

Danny Kruger: On a point of order, Mrs Harris. I defer to you, but my understanding is that amendments 346 and 348 and new clause 11, which are in group 6, have not fallen yet.

The Chair: They have fallen. If we are all satisfied, can we make progress?

Danny Kruger: You're the boss.

The Chair: I was beginning to wonder, Mr Kruger. *Clause 7, as amended, ordered to stand part of the Bill.*

Clause 8

SECOND DOCTOR'S ASSESSMENT (INDEPENDENT DOCTOR)

Danny Kruger: I rise to speak to amendment 55, in clause 71, page 4, line 33, leave out paragraph (a).

The amendment would ensure that the independent doctor has qualifications and experience in psychiatry or in assessing mental capacity. We have heard a lot in the debate about the importance of a holistic, multi-disciplinary approach to patient care at the end of life. We have also discussed the need for that to happen throughout the process and, in particular, during the crucial stages of the patient's assessment. In the oral evidence sessions, we heard from Dr Rachel Clarke about the need for teams to be involved with patients throughout the process. By requiring the input of a psychiatrically trained clinician in the assessment by the doctors, we would be making explicit the expectation that assisted dying should adhere to the best practice, which we already see in end of life care in our country. We would also be bringing our practice into line with jurisdictions such as Oregon, which require referral to a psychiatrist, as has been discussed.

Kit Malthouse: On a point of order, Mrs Harris. I do not think that the amendment is actually about qualifications or training. It is about the removal of certain assessments.

Danny Kruger: My right hon. Friend is absolutely right, I apologise. I am speaking to later amendments, so I apologise to the Chair and to the Committee.

The Chair: Do you actually want to move the amendment?

Danny Kruger: No. I am so sorry. The confusion of the last group has thrown me. I am very grateful to my right hon. Friend.

5 pm

I rise to speak to amendment 56, in clause 8, page 4, line 34, at end insert—

“(ba) would not, in the opinion of the independent doctor, be liable for detention under the Mental Health Act 1983.”

I do not know whether *Hansard* can simply copy and paste—I know the Committee do not want to hear this again. The point I was making was about the obligation, which we all recognise, for the clinicians performing the initial assessments to have the relevant expertise.

Kit Malthouse: On a point of order, Mrs Harris. I am sorry to raise this again, but I think my hon. Friend might not be on point. Amendment 56 is about detention under the Mental Health Act, not the training and standing of the doctors. He seems to be speaking to the qualification of the person, whereas the amendment is about the Mental Health Act.

The Chair: There are a lot of other amendments grouped with amendment 56. Does anyone want to move amendment 56 or shall we move on?

Sojan Joseph: I beg to move amendment 56, in clause 8, page 4, line 34, at end insert—

“(ba) would not, in the opinion of the independent doctor, be liable for detention under the Mental Health Act 1983.”

This amendment would require the independent doctor to assess whether, in their opinion, a person would be liable for detention under the Mental Health Act 1983.

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

Amendment 57, in clause 8, page 5, line 1, leave out subsection (4) and insert—

“(4) The independent doctor must, where possible, undertake the second assessment jointly with the coordinating doctor.

(4A) If the independent doctor is unable to undertake the second assessment jointly with the coordinating doctor under subsection (4), the independent doctor must confer with the coordinating doctor before completing that assessment.”

This amendment would require the independent doctor to undertake the second assessment jointly with the coordinating doctor, or, if they are unable to, to confer with that doctor before completing the assessment.

Amendment 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”.

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

Amendment 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 58, in clause 8, page 5, line 14, at end insert—

“(aa) is a practitioner approved as having special experience in the diagnosis or treatment of mental disorder for the purposes of subsection (2) of Section 12 (General provisions as to medical recommendations) of the Mental Health Act 1983,”.

This amendment, which is linked to Amendment 56 would require the independent doctor to have special experience in the diagnosis of mental disorder.

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

- “(6A) In Wales, all reasonable steps must be taken to ensure the practitioner under subsection (6) has fluent proficiency in the Welsh language if services or functions in the Act are to be provided to an individual in Welsh.”

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.

Sojan Joseph: I should like to speak to amendment 1—I am pleased that I was able to table my amendment first. We have already discussed safeguarding many times and how capacity is central to these measures. As we know, clause 1 lists the qualifying criteria that a terminally ill person must meet, which includes having the capacity to make such a decision. Indeed, the qualifying criteria might not be written in any order of importance, but the fact that that appears first underlines its significance.

In many days of sittings the most spoken words have been mental health, capacity, coercion and suicidal thoughts, rather than pain, cancer and suffering. The importance of capacity as a safeguard is again demonstrated when we turn to clauses 7 and 8, which in turn set out what both the co-ordinating doctor and the independent doctor must assess in order for a terminally ill adult to be allowed to end their own life.

In clause 7, the first assessing doctor with responsibility is the co-ordinating doctor. In clause 8, the second doctor is the independent doctor. The doctors are expected to assess mostly the same things. For example, the first doctor will assess whether the person is terminally ill, has capacity to make the decision to end their own life, is aged 18 or over, is ordinarily resident in England, and is registered as a patient with a general medical practice in England. The second doctor does exactly the same and assesses whether the person is terminally ill, has capacity to make the decision to end their own life, is aged 18 years or over and so on.

Before coming to the first assessing doctor, the patient has already been treated by a consultant and been diagnosed as terminally ill, so the three doctors are basically doing the same job. That is important and relevant to my amendment 1, which asks that one of the two assessing doctors should be a qualified psychiatrist or a specialist in psychiatry. As I said earlier, the issues that have been most discussed by Committee members in the last few sittings were capacity, mental health and suicide. In my view, there is a gap that needs to be addressed.

We talked earlier about unconscious bias. There is already a provision in the Bill to refer a patient to a psychiatrist if one of the doctors thinks that there is an issue with their mental health or capacity. We discussed a similar concept when we debated the patient having access to a palliative care consultant. Some of the comments were that needing another person makes it complex, and it should be simplified. Do Members think that if any of the doctors thinks that there is an issue with the patient’s mental health or capacity assessment, making a referral creates that same kind of complexity? Getting access to a psychiatrist could be simplified by having that second doctor be a specialist in mental health. It is to be strongly welcomed that both co-ordinating doctors and independent doctors have to make an assessment that the person wanting to ending their life has the necessary capacity to make such an important decision.

The question came up during the debate about whether, if somebody has mild depression or another mental health disorder, but they still think that they have capacity, they should be allowed to choose this route. We have seen that, in some other countries where this route is already practised, mental health was originally excluded from the criteria but was later added. Are we saying that even if someone has mental ill health, mild depression or some sort of mental illness, if they have capacity, we can allow them to choose assisted dying? Who will make that decision?

In my experience of working in mental health for many years, I have seen many terminally ill people being admitted to mental health wards because of their increasing suicidal thoughts. Many people who have a mental illness for many years, especially chronically mentally ill people, lead a normal life with the support of medication, but when they are diagnosed with a terminal illness, such as cancer, and start chemotherapy or taking medication for that, it can interact with the medication that they were already taking. That can have an impact on their mental health or decision making, so it is important that those patients have access to a psychiatrist.

I am not asking to make the process more complex or for us to draw any more resources from the NHS by adding a psychiatrist into the assessment. All my amendment asks is for one of the two doctors to be a psychiatrist, which in fact makes the process safer and more secure—some of the concerns that we have talked about.

Kim Leadbeater: I congratulate my hon. Friend on tabling amendment 1 on the amendment paper—a lot has happened since he tabled that amendment, it is fair to say. I get the impression from the Committee that we will all be voting in favour of making it compulsory to refer to a psychiatrist when one of the doctors feels there is a need to. Is my hon. Friend somewhat reassured by that?

Sojan Joseph: I thank my hon. Friend for her timely intervention. I was going to say that having tabled amendment 1 asking for a psychiatrist to be involved, and having now been through many Committee sittings, I wonder whether I influenced an unconscious bias among Members to table more amendments relating to mental health, capacity and suicide. I say to my hon. Friend that although there can be a psychiatry referral,

if we are talking about unconscious bias, as soon as the first and second doctor make the decision that the person has capacity, is terminally ill and is eligible for this process, the subsequent assessments can be influenced by the first assessment. That happens quite often in NHS healthcare, and especially mental health.

When the chief medical officer, Sir Chris Whitty, was before the Committee, I asked him about mental capacity assessments. He said:

“I would hope that most doctors are capable of identifying that someone has some degree...of mental health distress, or mental health illness”.

However, he went on to say:

“What not all doctors will feel comfortable doing is actually deciding whether that is sufficient to interfere with someone’s ability to make a decision with full capacity. That is where help from colleagues from psychiatry, and mental health more widely, is going to be useful.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 38, Q17.]

We have spoken about this many times, but in written evidence the Royal College of Psychiatrists said:

“A person’s capacity can change, and it is decision specific. While we are of the view that a person’s capacity to decide treatment can be reliably assessed, an assessment of a person’s mental capacity to decide to end their own life is an entirely different and more complex determination requiring a higher level of understanding.”

In a previous sitting, we discussed having a panel that is able to do a psychosocial assessment. I know that the new clauses are yet to be discussed, but the relevant new clause does not specify who the members of the panel will be and whether it should include a psychiatrist or a social worker. That is yet to be made clear, so I am not convinced about that.

Kim Leadbeater: To clarify, I think it is clear that the panel would include a psychiatrist and a social worker. I hope that reassures my hon. Friend.

Sojan Joseph: I thank my hon. Friend for confirming that. That is reassuring but, as I said earlier, I would like to know when the patient will have access to the panel. It is important that they access it early in the process, rather than later, because that is where unconscious bias comes in.

The purpose of my amendment is to save resources, because I know about the pressure on the NHS. Rather than having an additional psychiatrist on top of the two or three doctors, my amendment would simplify the process and save resources.

Although I acknowledge that the evidence I cited referred to the application of the Mental Capacity Act 2005 to the Bill—an issue on which the Committee has already decided—I would argue that it can equally be taken into consideration in this context. After all, in its written evidence, the Royal College of Psychiatrists said:

“Mental disorders, such as depression, are more common in people nearing the end of their life. Delirium is more common... Hopelessness is a common symptom of depression”,

and people’s capacity and consent can be affected when they are going through that condition. I can categorically confirm that I have seen that in my own practice. A person could be absolutely normal, but when they are diagnosed with a terminal illness, that can have an impact on their mental health. We have heard about

post-traumatic stress disorder and many other events that can have an impact on people’s mental health and, in turn, on their decision making and capacity.

If the Bill enters the statute book, we should ensure that at least one of the doctors assessing a terminally ill adult who wants to use the legal mechanism to end their life is properly qualified to carry out mental capacity assessments. I know from my own experience that psychiatrists deal with complex mental capacity assessments and other cases every day. For example, psychiatrists who work in accident and emergency departments regularly see people who are intent on ending their life—that is the bread and butter of their work.

5.15 pm

As a result of their expertise in critical cases, I am firmly of the view that psychiatrists are best placed to make capacity assessments. They can assess whether an individual wanting to end their life is doing so because of depression or their mental health, or because of their terminal physical illness. It is for that reason that I tabled amendment 1, which seeks to amend clause 8 by adding that the independent doctor

“is a registered medical practitioner who is registered in the specialism of psychiatry”.

At the moment, the clause states that the doctor should have

“such training, qualifications and experience as the Secretary of State may by regulations specify”.

Given the importance of assessing capacity and the amount of time the Committee has already spent debating it, by inserting the wording contained in amendment 1 we would add an extra protection in that regard into the legislation. We would also ensure that the independent doctor is appropriately qualified to conduct complex capacity assessments. I hope that Members will agree this amendment is a simple but necessary strengthening of the provisions in the Bill, and a way to protect resources within the NHS, and that they will feel able to support it. I am not expecting a complete change of mindset—the Minister may already have prepared the decision for this—but I would love Members to consider this issue in further discussions.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): For the record, amendment 428 is separate from amendment 427, which I discussed this morning. It is part of a progression, however, from amendment 413 to clause 4, which would have recognised a

“preferred language of Welsh or English”,

to amendment 427 to clause 5, which would have meant that “all reasonable steps” were taken to ensure that the co-ordinating doctor would have “fluent proficiency” in Welsh and English.

Amendment 428 would apply the same concept to clause 8 to ensure that “all reasonable steps” are taken for the independent doctor to have “fluent proficiency” in Welsh. As other colleagues and I are due to have further conversations with the Minister and the promoter of the Bill, I will not be moving this amendment, but it is important that the process and the rationale behind it are on the record.

Danny Kruger: I am sorry for having begun speaking to the wrong amendments earlier. I was trying to speak to amendment 58—I could not read my own notes—not amendments 55 or 56.

I do not want to reheat the previous arguments about the imperative—as I believe it is—to refer to a psychiatrist. I support the suggestion of the hon. Member for Ashford and the hon. Member for Runnymede and Weybridge (Dr Spencer) that the independent doctor should have relevant qualifications in psychiatry and experience in assessing mental capacity through their professional qualifications. The importance of having a holistic multidisciplinary team has been well argued and subsequent amendments to the Bill have attempted to deliver that.

I want to emphasise that if we adopted the amendment tabled by the hon. Member for Ashford, we would be acknowledging the reality that assisted dying is not like other medical decisions. By explicitly including psychiatrically trained clinicians, we would be giving special regard to the mental state of patients making an existential decision, not just a treatment decision. That is particularly appropriate for patients who are not expecting to significantly suffer bodily due to their terminal illness.

We have heard many stories of people who have died in painful or undignified ways, but that does not reflect the experience of the majority of those with a terminal illness—90% of cases, according to some studies—who are able to receive adequate or complete pain relief. For people who do not have an obvious motivation to have an assisted death, such as avoiding extreme pain, an investigation by a psychiatrist of their mental state would surely help to safeguard against those with depression or other ameliorable mental conditions that impair capacity accessing an assisted death.

I want to emphasise the evidence that we received from Professor Gareth Owen, who in 2021 conducted a large-scale survey of medical professionals in England and Wales. That found that non-psychiatric doctors—general practitioners and other doctors not trained in psychiatry—were less confident than other professionals in assessing capacity. It also found that 6.9%—less than 7%—of non-psychiatric doctors rated themselves as assessing capacity very well, which I think is significant. To place all the responsibility for assessing capacity and coercion, which are difficult to assess and contain complexities that psychiatrists are best placed to appreciate, in the hands of doctors who do not have specialist expertise is to be content with coercion being missed and capacity being poorly assessed. If we want to ensure that these tests are done well, the only way to do that is to involve psychiatrists, as the hon. Member for Ashford said.

Sean Woodcock: I will speak briefly on amendment 21, although I will commend my hon. Friend the Member for Ashford for his contribution to the debate. He speaks with clear expertise and experience, and a real love for his profession, and we all benefit greatly from his insights.

Over the last few weeks, I have found myself voting the opposite way from the promoter of the Bill on a number of occasions, but I am not opposed to assisted dying in principle. My issue is more about whether we can ever make it safe enough; the difference between us is marginal. One thing that has been apparent throughout

these debates is her passion for improving the training for those involved in palliative care, and in the wider NHS and social care generally.

That is why I want to speak to amendment 21. In the witness testimony, particularly from Rachel Clarke, there was a lot of concern about whether coercion and people being put under pressure to go for assisted dying would be picked up, and whether the NHS was geared up for that. I think that this amendment, tabled by my hon. Friend the Member for Lowestoft, goes some way to addressing that.

I do not think training is a silver bullet, hence my votes over previous weeks, but it would make a massive difference. That is true not only for the implementation of the Bill; it would have wider benefits for the NHS, social care and palliative care more generally. Even though those are not necessarily in scope of the Bill, I suggest that they are good things, which is why Committee members should get behind amendment 21.

Jake Richards: I want to speak to amendment 57. I do not intend to press it to a vote, but I will explore whether and how the Bill could be improved in terms of the relationship between the two doctors. There is a tension here. On one hand, we want to keep the two doctors separate, because the second one can then assess the person with a fresh perspective. We have had a debate about where there is a relationship between the doctors, which could cause problems as well. On the other hand, the evidence that we heard from some witnesses who gave evidence to the Committee was that decisions or assessments taken together can be more efficient and safer.

We may come back to this issue when we consider clause 9—next week, I presume, looking at the clock—but I wanted to raise it now. I have had conversations with the promoter of the Bill about it, but we also need to have conversations with Ministers about the best way to regulate the relationship between the two doctors to ensure that it is safe in the way that it keeps them separate but allows them to confer.

Naz Shah: I rise to speak to amendment 21, tabled by my hon. Friend the Member for Lowestoft, which is about the second, independent doctor. We debated amendment 20 earlier, and I am genuinely very pleased that the promoter of the Bill accepted that amendment. Some of what I would like to say now will be repetition, because it is a similar amendment, but I will try to keep my remarks contained and shorter.

I am not sure whether the promoter of the Bill is planning to accept amendment 21 as well as amendment 20—for both doctors. I will be happy to give way if she wants to clarify that now.

Kim Leadbeater: I am indeed happy to accept amendment 21 as well.

Naz Shah: Oh, perfect. I am really pleased that my hon. Friend will accept both amendments 20 and 21, tabled by my hon. Friend the Member for Lowestoft. Amendment 21 is about training. Although I welcome the amendments being accepted, my concern is that the amendment for training does not go far enough. We are talking about repeated coercion here, and my hon. Friend's intention with the amendment was for people to be

trained in picking up repeated coercive control. That is very different from domestic abuse, in terms of its manifestation and how it is picked up. From lots of evidence we have received, both written and oral, we know that coercive control is hard to detect. When it is repeated coercive control, it is even harder.

I want the Bill to be strengthened, especially when it comes to minoritised communities and older people. From a safeguarding perspective, the Bill's impact is very gendered. It is International Women's Day this week, and this is a very heightened issue. We celebrate women in this place because we do not have equality for women in our systems, across the globe and in this country. From the research and evidence we have had, we know that this Bill would impact more upon women, so it is important that we extend the training. As I suggested earlier, I would be happy to work with my hon. Friend the Member for Spen Valley to look at tabling another amendment and strengthening this safeguard, because I really want to get this one right.

Although I talked about this earlier, there are some statistics on suicide that I did not mention, which is why I want this training. Only this afternoon, I came across some research from the Kent and Medway NHS trust. In addition to research from last year, it has been found that women will kill themselves when they experience domestic abuse. For the first time, the number of women killing themselves as a result of domestic abuse has overtaken the number of women who are killed from domestic violence in intimate partner relationships. Bear with me—I will return to the research from the Kent and Medway trust in a moment, because I cannot seem to locate the statistics I wanted to point out. Either way, I want to support my hon. Friend the Member for Spen Valley to get this Bill right.

Sojan Joseph: We are talking about a very important issue in relation to training. Most training provided in the NHS, whether on the capacity assessment or domestic violence, is mandatory training that people are expected to retake yearly. Unfortunately, reports—especially the CQC reports—show that NHS trusts across the country are not fully compliant with this training, especially doctors, who are conducting this kind of training very poorly. Does my hon. Friend agree that just introducing training is not enough, and that we have to monitor compliance as well?

5.30 pm

Naz Shah: I thank my hon. Friend. I agree with his previous point, as well as the point made by the promoter of the Bill that the training that will be provided under this Bill should welcome that conversation with women, especially those who are victims of domestic abuse.

I have now found the research I wanted to share. Tim Woodhouse is a suicide prevention expert from Kent and Medway council, and he carried out research over five years until 2024. He estimated that about 30% of all suicides in that sample of people, largely women, experienced domestic abuse. Woodhouse estimates, in the UK as a whole, that

“over 1,800 lives are being lost in domestic abuse related suicides every year.”

He described that as

“a scandal, and national tragedy,”

and I completely agree with Tim's assertion. When it comes to women from ethnic minorities who have cultural differences, potentially including language barriers and different understandings of coercion, it is even harder to tease out their experience in any assessment from the first doctor or second doctor. I would therefore welcome any strengthening of the amendments.

The Chair: I call Steve Kinnock—sorry, I meant Minister Kinnock; he is Steve to his friends.

Stephen Kinnock: If I am still your friend by the end of this Committee, I will be absolutely amazed.

The Chair: Yes, we need to talk.

Stephen Kinnock: Under amendment 56, the second independent doctor would be required to assess whether the person seeking assisted dying would be liable for detention under the Mental Health Act 1983. If they are liable to be detained, the necessary statement cannot be made for the assisted dying process to continue. Assessment under the Mental Health Act requires consideration of someone's mental disorder and the risk of harm they present to themselves or others if they are not admitted and/or treated for their mental disorder.

Someone can be detained under the Mental Health Act both with and without capacity. Many people could be considered liable to be detained, but would not actually be detained if, for example, they could receive treatment for their mental disorder in the community. Members should be aware that the Mental Health Bill before Parliament, which will soon leave the Lords and come to this place, includes plans to strengthen and clarify the criteria for detention.

Amendment 57 would require the independent doctor to undertake the second assessment jointly with the co-ordinating doctor. If they are unable to, they would be required to confer before completing the assessment. In the Bill as currently drafted, the second assessment is intended to be conducted independently of the first.

I now turn to the famous amendment 1. As the Bill is currently drafted, the second doctor, known as the independent doctor, must be a “registered medical practitioner” who

“has such training, qualifications and experience as the Secretary of State may by regulations specify”.

The amendment intends to make it a requirement that the second assessment is conducted by

“a registered medical practitioner who is registered in the specialism of psychiatry”.

Operationally, focusing on one medical specialty may have workforce implications that the Government would need to work through, should this Bill pass with that amendment.

Amendment 197, along with amendment 198, place “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.”

The Government have worked with my hon. Friend the Member for Spen Valley on these amendments to ensure that the legislation is robust and workable. Amendment 198 specifies:

“The regulations must include training about... assessing capacity”

[Stephen Kinlock]

and

“assessing whether a person has been coerced or pressured by any other person.”

Under amendment 58, the second independent doctor would have to be an approved medical practitioner under section 12 of the Mental Health Act. A section 12-approved doctor is

“a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder”.

Their role is to make a medical recommendation, which is part of the process of determining whether someone is liable to be detained under the Act. Section 12-approved doctors are also eligible to carry out mental health assessments as part of the deprivation of liberty safeguards under the Mental Capacity Act. The objective of the mental health assessment is to ensure that the person is medically diagnosed as being “of unsound mind” and so comes within the scope of article 5 of the European convention on human rights, the right to liberty.

The purpose of amendment 428 is to impose an obligation to take all reasonable steps to ensure that the independent doctor is proficient in the Welsh language, if services or functions in the Bill are to be provided to an individual in Welsh in Wales. This mirrors amendment 427, which we have already debated. The amendment does not make clear who is obliged to ensure that these steps are taken or who will assess and enforce whether “fluent proficiency” is met. This may reduce the pool of registered medical practitioners able to carry out the function of an independent doctor under the Bill.

It may be helpful to note again that, regardless of this amendment, under the Welsh Language (Wales) Measure 2011, the NHS in Wales has a statutory duty to deliver its services to the public in both Welsh and English. That legislation gives the Welsh language official status in Wales, and it states that individuals in Wales

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

The Welsh Government’s active offer for health is intended to support all staff across NHS Wales to provide a service in Welsh for patients without them having to ask for it. Of course, I will add that we have agreed to have further discussions on these points with the right hon. Member for Dwyfor Meirionnydd, and I look forward to them.

Amendment 21 would require that a registered medical practitioner could act as an independent doctor only if they have undertaken training on identifying domestic abuse. Should this amendment be accepted, it would require setting up training mechanisms to equip registered medical practitioners who want to act as independent doctors with the knowledge and skills needed to identify domestic abuse, including coercive control and financial abuse. I hope those observations were helpful for the Committee.

Kim Leadbeater: I will not test the patience of the Committee by repeating the Minister’s comments on amendments 197 and 198, but he is absolutely right that they relate to the duty imposed on the Secretary of State to make regulations about the training, qualifications and experience required to act as the independent doctor. I hope that Committee members can support them.

Amendment 21 was tabled by my hon. Friend the Member for Lowestoft, and further to my comments this morning on the very similar amendment 20, I am very pleased to support amendment 21. We have spoken a lot about the training requirements for the provisions of the Bill, and I firmly believe that we have to set ourselves the very high standard of having the best training that we possibly can for medical practitioners involved in the processes set out in the legislation. It is vital because only those medical practitioners who have chosen to undergo such training would be allowed to play the role of assessing doctors.

We have already discussed many of the components that will be required in that training, but it must include assessing capacity and detecting coercion or pressure, which is in line with this amendment, so I am very pleased to support it in that regard. Doctors must have appropriate qualifications and experience to ensure that those seeking assistance under the legislation are in the best possible hands throughout.

I also welcome the comments made by my hon. Friend the Member for Banbury about the wider benefits of such training, which is a really important point to make. It feeds into the wider benefits that there would be for not just the health service but society as a whole. It also feeds into the work that is being done by the Home Office and my hon. Friend the Member for Birmingham Yardley (Jess Phillips), who is the Minister for Safeguarding and Violence Against Women and Girls—I just had to google the fancy title that she goes by nowadays. There is a broader conversation to be had about society and the role of training for coercive control, financial abuse and domestic abuse. I support amendment 21, along with my amendments 197 and 198.

Amendment 56 negatived.

Naz Shah: I beg to move amendment 301, in clause 8, page 4, line 39, leave out “7” and insert “14”.

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

The Chair: With this it will be convenient to discuss 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.

Naz Shah: These amendments were tabled by my hon. Friend the Member for York Central. Amendment 301 seeks to provide a time of reflection of 14 days, not seven. As somebody pointed out, the industry standard

for returning something bought in a shop far exceeds the cool-off period set out in the Bill. The reality is that the NHS is under such duress, with patients waiting weeks to see their GP for anything other than urgent treatment, that being able to get an appointment with a GP in seven days is something that we are unlikely to see.

It is right that doctors are able to triage their patients to ensure that those who require medical interventions to keep them well, prevent hospital admissions, or stop them deteriorating or even dying, are seen as a priority. This Government are trying to protect the NHS, and the best way of achieving that is to ensure that medical interventions are sought and provided at the earliest opportunity before a patient deteriorates. Giving someone who is dying within the terms of this legislation longer to reflect—just a further week—removes such pressure from GPs or consultants and enables them to properly prioritise their patients. It does not build a false expectation in patients that they have a right to rapidly have a consultation. Likewise, we know that it can currently take weeks, if not months or over a year, for patients to see another consultant, but the clause does not suggest that. It would therefore be helpful and better for the patient to have a more realistic period before moving to the next stage of their assessment.

Issues of intensity, such 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, conversations and reflections can help with reflection and reconsideration. It is important that people are given that opportunity. The first time a patient raises the matter with their doctor, the doctor would have provided them with lot of alternative information—for instance, on what treatment options are available. They might also have had a palliative medicine consultation to review their options. There needs to be time for the patient to really reflect on all that new information.

We know that when people are presented with information, it takes time for them to absorb and analyse it. Therefore, extending the period to two weeks—although that is arguably still too short a timescale—would be good practice. It would be in the interest of the person and of the carers, as we know from other jurisdictions that family often say that the process was too quick for them to be able to absorb. It could also enable a patient to make alternative choices. In medicine, practitioners want patients to make informed decisions and to have time to assure themselves of the choices they make. In the light of the Committee's vote to block the amendment that would have ensured that a palliative care specialist was involved in the counsel to support someone with decision making as they are dying, it is right that more time is given for patients' considerations.

Amendment 317 would provide 28 days, not 14, for second period of reflection. In line with good practice, extending the reflection period is important. I spoke about that at length when we debated my amendment 277. It is important for the patient to be able to fully explore their options and seek wider counsel before determining to take the route of assisted death. This part of the process is perhaps the most important. The period after a patient has completed their assessment and received court approval or that of the commission and panel—should the Committee choose to change this—will be the main period where they determine whether they want to go

through with ending their life. It is right to ensure that the legislation provides time. This is such a monumental decision, so that a patient has to be assured that they are making the right decision and have had time to really reflect on it and contemplate all other options available to them.

The process appears to be very rushed, and a patient could be caught up in the moment of getting through the stages. It will be intense. There will be lots of information. There may be new things for the patient to consider. Having a proper break clause would enable a patient proper time to reflect and consider in detail everything that has happened in the process to date, and then to contemplate their further options. We know that patients often need to hear information several times before they fully absorb what is being said and what is happening.

5.45 pm

Moving from one process to another without a break will lead to a person inevitably reaching for an assisted death. We must recognise that there is a heavy duty to enable patients to take an alternative path. Although supporters of the Bill would say that there is nothing to stop the patient delaying—on paper, that is absolutely true—the reality of somebody being caught up in a process, where there will be intensity, intrinsic stress and many complex layers of decision making, is that the patient may not be able to properly breathe, reflect and even change their mind.

The process feels like it is pushing the patient down the route towards taking their life, with pace and action. It is regrettable that the Committee did not accept the need for an alternative conversation with a specialist who would be able to provide more comprehensive counselling. Amendment 317 therefore demands that more time be given to enable the patient to test their own determinations without knowing that their next appointment, and imminent death, awaits. It removes pressure by having a proper period of reflection. If the Committee is determined that mistakes are not to be made, I urge them to support the amendment.

Amendment 314 would extend the second period of reflection from 48 hours to seven days in a specific situation. I think we can all agree that 48 hours is not a period of reflection but a micro-pause before an inevitable death. It is not a proper safeguard against rushing through the procedure; the Bill would enable a hastened assisted death without proper reflection, turning this into a process of an assisted death on demand, rather than one with safeguards, reflection and opportunity to explore options. Clause 13(2)(b) relates to a person who is reasonably expected to die within a month. It is therefore completely reasonable to provide for a week to ensure that there is a proper period of reflection. Some people do receive a terminal diagnosis with a poor prognosis, sometimes of less than 48 hours. What is to happen in those circumstances? Does my hon. Friend the Member for Spen Valley expect that to be dealt with through legal challenges to the High Court? I welcome clarification on that. If, as the hon. Member set out, this legislation will safeguard the vulnerable, those who are within a month of death should be given no less than a week in which to decide to take their life. The pressure in such a short period will be more intense than if the patient has longer. The challenges of decision making are therefore even greater.

The Bill either recognises the need for a reflection period or it does not. Therefore, lengthening that period, although not ideal, would at least give the patient some time to work through this very challenging and complex area of decision making. To not have such a reflection period would deny the patient that opportunity, highlighting what many fear: that this legislation leads people to an assisted death, rather than taking a more balanced approach.

Amendment 314 would also require the patient to receive an urgent referral to a palliative care specialist. Clearly, with the patient nearing death, they may have concerns, pain or symptoms that are causing them to make this decision. That is common in palliative medicine and yet, if a patient is able to have an intervention, that could result in a different outcome. There are examples of patients who have significant levels of pain, and whose GP cannot manage that pain. However, when referred, they have a nerve block and become pain-free. That is enough for a patient to continue with their life without experiencing any pain. It will not change the diagnosis but it could very well change the patient's decision to continue with their life or not. The problem is that although what can be offered with palliative care is exceptional, like the rest of the NHS it is so underfunded that a lot of palliative care is not optimised: it is therefore called palliative care but does not provide the interventions that could make the difference between a patient choosing to live or die. We cannot see a hastened death because the system is failing patients. That is the greatest fear for many of us.

The Minister should recognise how poor palliative care services are. The fact that they have been underfunded and stripped to a minimum—if that—with 100,000 people not having access, is a national scandal. If the Minister could commit to getting palliative care right, perhaps we would not be having the same conversations today. I do recognise that he made money available for hospices last week, which was very welcome.

This group of amendments would give the patient better choice.

Kit Malthouse: I rise briefly to oppose all four amendments, which seem to completely ignore the reality of what it is like to receive a terminal diagnosis and then die. In truth, from the moment someone is told that they have some horrible disease that is likely to kill them, their entire life becomes a contemplation or reflection on their mortality, frankly, and on the options that might be available to them. Although we have sought to strike a balance in the Bill by having periods of reflection between the various steps, we have to reflect on the fact that people will be thinking about these things all the time anyway. Although we might be going through the motions and hoping that they seek assistance and advice during that period, I guarantee that it will already be in the forefront of their minds.

These amendments—like so many from the hon. Lady from the beautiful city of York, the hon. Member for York Central—operate on the basis that people will show up at six months, enter the process at six months, do their three weeks of contemplation and then immediately take their lives, which is simply unrealistic and hardly ever going to happen. The vast majority of people will have been wrestling with their disease for months and often years before they get to the six-month period. If

they are diagnosed with less than six months to go, which happens quite frequently, as we discussed in relation to pancreatic cancer yesterday, they will be immediately thinking not just about what their death will be like, but about the things they have to get done in that period—spending time with their family, the people they want to say goodbye to, the arrangements they want to make and the things they want to complete before they leave us. Imposing on people these arbitrary periods of reflection—the ones in the Bill are arbitrary, too—has to be balanced against the notion that these people have other things to do, and a hell of a lot more to think about than the bureaucracy we are trying to put in place.

The other thing to bear in mind, which the amendments do not take account of, is that disease progression is very rarely linear. I am sure the medics will tell us that there is often a period where a person thinks they are going to be okay, and then suddenly they fall off a cliff towards the end. Anybody who has been close to somebody with advanced cancer will know that they can be perfectly well and functioning until the last couple of weeks, or even days, before they suddenly decline and die. We need to design a system that satisfies the requirement for reflection, but also lets these people do what they need to do.

Although the hon. Member for Bradford West says that the amendments do not extend the amount of reflection time by that much, what in total they double it. It goes from 21 days to 42 days, which is a very significant proportion of the time that those people will have left to themselves—to sit, think, wait and go through the bureaucratic process. What most people will want to do is go through the process and secure permission, then take their time and think about what they want to do. They want to get on with their lives and to enjoy what is left because they lose the fear of what their ultimate end is going to be. Then, some weeks or months later, they can make the decision, if they wish to, to take their own lives, and we know that about a third do not because they are in palliative care.

Jack Abbott: On the point about almost doubling the time of the so-called reflection period, I think we have been very fixated on the Committee, and rightly so, on the six-month limit for the terminal diagnosis, but we recognise that for many people it will be much less than that. A reflection period of two months for someone with a terminal diagnosis of three months is a critical problem.

Kit Malthouse: I completely agree. We have to strike a balance here. The point I am making is that, within an envelope of six months, 42 days is far too long, so I am afraid that I flatly oppose the amendments. They are based on a fundamental misunderstanding: the idea that people will just show up at six months, that their disease progression will be linear, and that they will then take the decision immediately, the moment they finish the reflection period. I can tell hon. Members that the entire six months, from the moment someone gets a six-month diagnosis, will be a reflection period.

Naz Shah: I appreciate the right hon. Gentleman's comments. He referred to the same thing twice, yesterday and today, and I just want to clarify it. He said that

most people are ill for a while. I have a genuine question. I do not have the research, but my understanding, as a member of the public and a Member of Parliament, is that for many people who get a terminal diagnosis of six months, it will have been very sudden. Does he have any research to suggest that most of these patients will have been on the kind of trajectory he describes?

Kit Malthouse: It depends on the disease, but many people will struggle with, for example, breast cancer for five years, go through repeated rounds of chemotherapy and undergo terrible operations to try to survive; then, there will come a point when the clinicians and oncologists say, “There isn’t much more we can do for you; we think you have a few months left to live, because there is no further treatment we can offer, so aggressive is your cancer.” Other people have cancer and are free of it within two or three months, because of the nature of the cancer. Some people will reach a six-month point suddenly—it will not be dead-on six months; it might be either side—and some people will be diagnosed with pancreatic cancer with two weeks to go. We have to strike a balance and be humane in what we impose on these people, who will have a lot more to think about than the regulations.

Naz Shah: I want to explore that point a bit further. When I talk about a period of reflection, I am referring to the evidence that we have had from psychiatrists, who said that people’s abilities would be impacted in this situation. That is where the amendments are coming from. To come back to the previous point, is there any research or evidence that would back up the claim that many cases are longer-term illnesses, rather than people who have just got the diagnosis?

Kit Malthouse: Maybe I was not clear: it depends on the disease. For example, the median survival range for pancreatic cancer is six to 12 months, because it does

not exhibit symptoms; people only learn very late that they have it, and that is why the normal survival curve is quite a short one. We need to bear that in mind.

We also need to remember that the more we extend the periods of reflection, the longer people will have to live with the fear of what their death will be like, and with the nervousness about whether they will be allowed to control their own death—we are granting permission here. If I have to wait 42 days, that is 42 days out of whatever I might have left—perhaps 120 days, if I am lucky—that I am spending concerned about whether I am going to die in a particular way. To me, that seems crazy.

Two of the amendments propose extending the 48-hour period to seven days. These are people who have been told they are going to die within a month. They have less than 30 days to deal with their affairs, deal with their children, talk to their family and decide what they are going to do, and the amendments propose that for seven days of that, they will have to contemplate their fear of death, rather than rush it through. It is rushing it through in 48 hours—reflecting the fact that they are going to die.

The misunderstanding is most illustrated by the fact that amendment 314 proposes that, with the extension to seven days, there should be a mandatory referral to palliative care. With a month to go, these people are by definition already being palliated. The idea that somehow they are just waltzing up, unattended to, with a month to go, and that the NHS is going to say, “Actually, we’re not going to do anything to help you” fundamentally misunderstands what disease is like at the end of life. I am afraid that I vehemently oppose these amendments. The balance in the Bill is exactly right, and I hope that the Committee will agree.

Ordered, That the debate be now adjourned.—(Bambos Charalambous.)

5.59 pm

Adjourned till Tuesday 11 March at twenty-five minutes past Nine o’clock.

Written evidence reported to the House

TIAB 415 The National Catholic Bioethics Center (NCBC USA), the Catholic Medical Association (CMA USA), the National Association of Catholic Nurses, USA, (NACN-USA) and the National Catholic Partnership on Disability (NCPD USA)

TIAB 416 Dr Yinting Ta

TIAB 417 Professor Ian Basnett OBE

TIAB 418 Hourglass