PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Twenty-fifth Sitting

Tuesday 18 March 2025

(Afternoon)

CONTENTS

CLAUSES 18 TO 22 agreed to, with amendments.
CLAUSE 23 under consideration when the Committee adjourned till Wednesday 19 March at twenty-five minutes past Nine o'clock.
Written evidence reported to the House.

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

not later than

Saturday 22 March 2025

The Committee consisted of the following Members:

Chairs: † Peter Dowd, Clive Efford, † Sir Roger Gale, Carolyn Harris, Esther McVey

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

Lynn Gardner, Lucinda Maer, Jonathan Whiffing, *Committee Clerks*

† **attended the Committee**

Public Bill Committee

Tuesday 18 March 2025

(Afternoon)

[Sir Roger Gale *in the Chair*]

Terminally Ill Adults (End of Life) Bill

2 pm

The Chair: Good afternoon, ladies and gentlemen. Given the fluidity of matters on the Floor of the House today, my personal view, although it is only my view, is that I should not suspend the sitting at 5 o'clock. Hon. Members may leave the room at any time for a comfort break, but as there is likely to be an interruption and as the Committee may not want to sit too late, my view is that we should bash on, or rather that you should bash on. Mr Dowd will take the Chair at 5 o'clock, so I shall be able to escape. You have your own escape routes.

Sean Woodcock (Banbury) (Lab): One rule for one!

The Chair: Yes, there may be an escape committee.

Clause 18

Provision of assistance

Amendment proposed (this day): 462, in clause 18, page 12, line 20, at end insert—

"(3A) When providing a substance under subsection (3) the coordinating doctor must explain to the person that they do not have to go ahead and self administer the substance and they may still cancel their declaration."—*(Danny Kruger.)*

Question again proposed, That the amendment be made.

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

Amendment 463, in clause 18, page 12, line 34, leave out paragraph (c).

Amendment 497, in clause 18, page 13, line 9, leave out "decides" and insert

"informs the coordinating doctor that they have decided".

This amendment provides that the duty to remove the approved substance arises on the coordinating doctor being informed that the person has decided not to self-administer the substance.

Amendment 498, in clause 18, page 13, line 10, leave out

"that the substance is not"

and insert

"to believe that the substance will not be".

This amendment clarifies the circumstances in which the coordinating doctor is under a duty to remove the approved substance from the person.

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): It is a pleasure to serve under your chairmanship, Sir Roger. My hon. Friend the Member for East Wiltshire was mid-intervention when the Committee adjourned this morning, and I would not want to pull the rug from underneath him. Does he wish to intervene again?

Danny Kruger (East Wiltshire) (Con): I am grateful to my hon. Friend. I was simply asking what causes him to object to physician-administered assistance to die. If he supports the principle of assisted suicide and believes in doctor autonomy, why does he not think that doctors should be able to administer the fatal dose?

Dr Shastri-Hurst: This gets to the root of how the law has operated in another jurisdiction, Switzerland, where Dignitas has managed this scenario over the past 40 years or so. The key—these are the words that its own guidance uses—is ensuring that the power of control remains with the person seeking the assisted death. That provides the individual who is making the choice with the ultimate autonomy at the end in controlling the circumstances and the manner in which they pass.

I have set out why I feel that although amendment 463 arises from good intentions, it would not achieve what is intended. There is a real risk that the constraints that adopting the amendment would create would lead to the regrettable unintended consequence of individuals being forced to have an assisted death at an earlier stage than they would otherwise have wished.

I can deal with amendments 497 and 498 in short order. They would tighten up the Bill by providing greater clarity around the circumstances in which the substance would be removed from the presence of the individual who had previously indicated a wish to have an assisted death. Amendment 497 specifies that the individual would need to set out to the co-ordinating doctor that they no longer desired to go through with the process. In my view, that is eminently sensible. Amendment 498 elaborates on the Bill to provide greater clarity to those who will be operating it. It will make it a much more workable piece of legislation. I support both amendments.

The Minister for Care (Stephen Kinnock): It is a pleasure to serve under your chairship, Sir Roger. Before I speak to amendments 497 and 498, on which the Government have worked with my hon. Friend the Member for Spen Valley, let me address amendments 462 and 463.

Amendment 462 would amend clause 18 to require the co-ordinating doctor to explain to the person that they do not have to proceed and self-administer the approved substance, and that they may still cancel their declaration. Although it is not specified, it is presumed that the amendment refers to the second declaration that the person will have made. The Committee may wish to note that there is already a requirement in clause 18(4)(b) that,

"at the time the approved substance is provided",

the co-ordinating doctor must be satisfied that the person

"has a clear, settled and informed wish to end their own life".

The purpose of amendment 463 is to limit what the co-ordinating doctor is permitted to do in relation to providing the person with an approved substance under clause 18. As the clause stands, subsection (6) sets out the activities that the co-ordinating doctor is permitted to carry out in respect of an approved substance provided to the person under subsection (2). It states that the co-ordinating doctor may

"(a) prepare that substance for self-administration by that person,

(b) prepare a medical device which will enable that person to self-administer the substance, and

(c) assist that person to ingest or otherwise self-administer the substance."

Additionally, subsection (7) provides that

"the decision to self-administer the approved substance and the final act of doing so must be taken by the person to whom the substance has been provided."

Amendment 463 would remove subsection (6)(c), which would result in the co-ordinating doctor being unable to assist the person

"to ingest or otherwise self-administer"

the approved substance. The co-ordinating doctor would still be permitted to prepare that substance for self-administration and to prepare a medical device to enable the person to self-administer the substance. This could mean that a co-ordinating doctor may not be able to provide assistance such as helping the person to sit up to help with swallowing, or explaining how the medical device for self-administering the substance works. This could result in practical difficulties in self-administration of the substance and/or place the co-ordinating doctor in a difficult position.

Sojan Joseph (Ashford) (Lab): Does the Minister think that it is confusing for health professionals when we say that they can assist the patient to sit up or hold a cup of water or put the medication into their mouth? Is it not confusing for medical professionals that we are giving contradictory statements?

Stephen Kinnock: One of the fundamental principles of the Bill, which my hon. Friend the Member for Spen Valley has prioritised, is self-administration. It is not for me as a Minister to opine on that; it is simply there in the Bill. Once that fundamental principle is established, it is about defining what "assistance" means, compared with what "self-administration" means. As I was setting out, I think "assistance" can mean things like helping the patient to sit up; it does not mean actually administering the substance to the patient. It is about the dividing line between assistance and self-administration—hence the term "assisted dying", I suppose, which is very different from the doctor actually administering the substance.

Rebecca Paul (Reigate) (Con): I am going to read subsection (6)(c) again. It says:

"assist that person to ingest or otherwise self-administer the substance."

I would interpret that slightly differently from the Minister. It talks about ingesting, which suggests the substance entering the body, so I would not suggest that sitting someone up would qualify. That in itself shows that perhaps there is some ambiguity here. The Minister has set out something that I had not read into the Bill. Will he comment further on that?

Stephen Kinnock: I will pretty much repeat what I have just said to my hon. Friend the Member for Ashford. There is a dividing line, as the Government see it, between assistance and administration. There is a dividing line between making the patient comfortable, enabling the procedure to take place, and the doctor actually putting the substance into the body of the patient. From the Government's point of view, simply from the position of having a picture of the process in our mind, that dividing line is clear enough in the drafting of the clause.

Danny Kruger: I am grateful that the Minister is allowing us to push him on this, because it is crucial. This is the moment beyond which there is no return. He thinks that helping a patient to sit up would be within the scope of the clause. Does he think that holding the patient's hand and tipping a cup of pills into their mouth would be consistent with the clause?

Stephen Kinnock: My interpretation is that it would not be, because if someone were actually tipping the pills into the mouth of the patient, they would be going through the act of putting the substance into the patient. This Bill is founded on the principle of self-administration. However, there are acts such as helping the patient to sit up that are not direct administration but assistance enabling it to take place. That is where the distinction lies.

Danny Kruger: That is helpful, but if the patient were holding the cup and the doctor held their hand to help them tip it into their mouth, it is not clear to me at what point assistance would end and self-administration would begin. I would be grateful if the Minister could explain that. What about the scenario in which the patient's finger is on the plunger of a syringe and the doctor assists by putting their finger on top of the patient's and assists them to press the button, adding a little force to that being given by the patient? Does he regard that as within the scope of self-administration, or does that cross the line into directly administering the procedure?

Stephen Kinnock: I thank the hon. Member for that intervention. The hon. Member for Solihull West and Shirley pointed out earlier that the scenario that he has just described would constitute more than assistance; it would be moving into administration by the doctor, rather than self-administration. I think that that aligns with the Government's view, so I refer the hon. Member for East Wiltshire to those comments from the hon. Member for Solihull West and Shirley, who has far more clinical experience than I do.

Danny Kruger: I am grateful for that, and I will leave it there, but does the Minister agree that it is incredibly difficult to distinguish who is administering the treatment in that scenario? If both their hands are on the instrument, whatever it is—a cup, a syringe or a button on a computer screen—it is very hard to know who has actually delivered the final act.

Stephen Kinnock: What is hard to do in this Committee is imagine and agree on how many different scenarios there can be. Every circumstance and every individual experience will be different, so it is difficult for us to envision all the different scenarios. Nothing about this is easy, of course. We would not have been sitting in this Bill Committee for hours on end if it were all easy, but from the Government's point of view there is a clear

[Stephen Kinnock]

enough distinction between assistance and self-administration. As long as we are clear on those basic principles, we feel that that gives enough safety to the Bill and enough clarity around the process.

Kit Malthouse (North West Hampshire) (Con): Does the Minister agree that my hon. Friend the Member for East Wiltshire is perhaps unintentionally creating a lack of clarity where there is clarity? Surely there is complete clarity in the distinction between assisting a patient to be in a position to carry out their final desire and act, and performing or even jointly performing that final act with them. Is it not the case that in overseas jurisdictions there is quite a lot of assistance with technology? It needs to be prepared and put in place, but it can put even those who are the least physically able in a position in which the final act of administration can be clearly theirs. In many ways, our life is made easier by modern technology in that regard.

2.15 pm

Stephen Kinnock: The right hon. Member sets out clearly the difference between self-administration—the concept at the heart of the Bill—and the performance of the act either jointly or by the doctor. The latter is not permitted under the terms of the Bill; the former is. That is where we are.

Dr Simon Opher (Stroud) (Lab): The lack of an ability to assist in the final process would put medical professionals in a very difficult position. Would carrying the medicine to the room where the patient is count as assistance? I think we have to have assistance in the Bill, but I also feel that, as the Minister has outlined clearly, someone can help a person to self-administer but cannot administer. That is quite clear to me.

Stephen Kinnock: I thank my hon. Friend, who speaks with considerable clinical expertise. It is about exactly that difference between self-administration and administration. If we cleave to those two principles, that is the basis on which we will achieve the stated aim of my hon. Friend the Member for Spen Valley.

Sojan Joseph: Does the Minister agree that assisting a person to ingest is different from assisting a person to self-administer?

Stephen Kinnock: In order to ingest, there has to be self-administration. The self-administration is the precondition for ingesting the substance. That is my reading. I hope that that satisfies my hon. Friend.

Rebecca Paul: The Minister is being incredibly patient with our questions. The question from the hon. Member for Ashford raises exactly the point with which I am uncomfortable. To me, the phrase

"assist that person to ingest"

means something else. I am really concerned that it could be interpreted differently from how the Minister has laid it out. I want to place that on the record and raise that issue, which I believe the hon. Member was also raising.

Stephen Kinnock: The hon. Member's concerns are absolutely noted. I completely understand that hon. Members are not comfortable with this, but what I am trying to do is set out the Government's view on the workability of what my hon. Friend the Member for Spen Valley is seeking to achieve and the basic principles on which that is built.

Amendment 497, on which the Government have worked jointly with my hon. Friend, would amend clause 18(11), which states:

"Where the person decides not to self-administer the approved substance, or there is any other reason that the substance is not used, the coordinating doctor must remove it immediately from that person."

Under the clause as it is currently drafted, there could be difficulties in relation to the duties of the co-ordinating doctor where the co-ordinating doctor does not know what the person has decided. Amendment 497 seeks to resolve that ambiguity by clarifying that the duty on the co-ordinating doctor to remove the approved substance applies where the person

"informs the coordinating doctor that they have decided"

not to self-administer the approved substance.

I turn to amendment 498. At present, clause 18(11) provides that the co-ordinating doctor has the duty to immediately remove the approved substance where the person decides not to self-administer the approved substance, or there is any other reason that the substance is not used. The amendment clarifies that the duty to remove the substance arises when the co-ordinating doctor believes that the substance will not be used. I hope that those observations have been helpful to the Committee.

Kim Leadbeater (Spen Valley) (Lab): The Minister has covered my amendments 497 and 498 very clearly, so I will not speak to them.

I am happy to support amendment 462, tabled by the hon. Member for East Wiltshire, about which we had a conversation this morning. I only make the observation that there is already a requirement in clause 18(4)(b) that, at the time the approved substance is provided, the co-ordinating doctor must be satisfied that the person has

"a clear, settled and informed wish to end their own life".

Nevertheless, I am happy to support the amendment, because the hon. Member made a very valuable point this morning.

I cannot support amendment 463, however. The Bill states that the patient must self-administer the drugs. Clause 18(7) states that "the final act" of self-administering the substance

"must be taken by the person to whom the substance has been provided."

That is very clear. The hon. Member for Solihull West and Shirley, with his medical background and expertise, has been clear and helpful on this point: it is a question of passive versus active. We have to be clear that the patient must have an active role in self-administration.

Danny Kruger: I propose to press both my amendments to a vote if necessary.

Amendment 462 agreed to.

Amendment made: 496, in clause 18, page 12, line 28, after "professionals" insert ", and such other persons,".—*(Kim Leadbeater.)*

This amendment provides that the coordinating doctor may be accompanied by such persons (other than health professionals) as the doctor considers necessary.

Danny Kruger: On a point of order, Sir Roger. I am sorry if I missed it, but are we not going to debate amendment 496?

The Chair: I put the Question and nobody spoke. I am afraid the moment has passed. Under this Chairman, you have to be fleet of foot.

Danny Kruger: Clearly! Fair enough.

Amendment proposed: 463, in clause 18, page 12, line 34, leave out paragraph (c)—*(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 3, Noes 18.

Division No. 51]

AYES

Joseph, Sojan	Paul, Rebecca
Kruger, Danny	

NOES

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

Question accordingly negatived.

Tom Gordon (Harrogate and Knaresborough) (LD): I beg to move amendment 350, in clause 18, page 12, line 34, at end insert—

"(d) subject to subsection (6A), provide additional assistance to administer the substance in the presence of an independent witness.

(6A) The coordinating doctor may provide the additional assistance under subsection (6)(d) when—

(a) the coordinating doctor is satisfied that the person is permanently and irreversibly unable to self-administer the substance due to—

(i) significant risk of choking as a result of dysphagia, or

(ii) the loss of use of the limbs; and

(b) the person has authorised that the additional assistance be provided."

This amendment would define the eligibility criteria for those who are permanently and irreversibly unable to self-administer the substance and are therefore eligible for additional assistance to administer the substance.

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

Amendment 351, in clause 18, page 12, line 35, after "substance" insert

"or to authorise additional assistance to be provided".

This amendment would ensure the decision to administer the approved substance remains with the person but would allow those who are unable to self-administer the substance to receive further assistance.

Amendment 352, in clause 18, page 12, line 40, at end insert

", unless the criteria in subsection (6A) are met."

This amendment would authorise the coordinating doctor to provide additional support with administration for those who are unable to self-administer the substance.

Tom Gordon: It is an honour to serve under your chairmanship, Sir Roger. I speak in support of this group of amendments, which address the issue of fairness and accessibility in the Bill. The amendments seek to ensure that those who are physically unable to self-administer the approved substance due to their condition are not excluded from the choice of an assisted death.

The principle at stake here is equity: making sure that this opportunity would be available to not only those with the physical ability to self-administer but all eligible individuals, regardless of their condition. The Motor Neurone Disease Association made it clear in its written evidence that conditions like motor neurone disease can be cruel, devastating and progressive, locking people inside their own failing bodies. More than 80% of people with MND lose the ability to speak. Many lose all limb function, leaving them unable to lift even a glass of water, let alone self-administer medication.

There is a common theme here that relates to a point I made in an earlier sitting, when we debated the period of time for eligibility. For these individuals, the Bill in its current form creates a barrier. It states that the final act of ingesting or administering an approved substance must be taken by the person themselves. For someone with advanced MND, that may simply not physically be possible. The MND Association's evidence highlights that in other jurisdictions, such as Queensland in Australia, allowances have been made for people unable to swallow or self-administer. If we fail to include such provision here, we risk excluding some of the most vulnerable people or, even worse, creating a perverse incentive for them to seek an assisted death earlier, possibly abroad, when they may still have physical function.

These amendments are not about lowering safeguards in any way, shape or form. As we know, the Bill has robust safeguards, which these amendments would maintain. It would only be applicable in instances where doctors deem it necessary, and it would not be open to more than those with conditions restricting their ability to self-administer. If the Bill is about compassion, then we must ensure that that compassion extends to everyone; if it is about choice, then we should not deny that choice to those with severe physical limitations; and if it is about justice, then we should not allow injustice to be written into the law.

Naz Shah (Bradford West) (Lab): I rise to oppose amendments 350 to 352, tabled by my hon. Friend the Member for Gedling (Michael Payne). They would allow the co-ordinating doctor to provide additional assistance to administer the substance in the presence of

[Naz Shah]

an independent witness, in some circumstances. Those circumstances would be when, as amendment 350 says, the doctor determines that the person is

"permanently and irreversibly unable to self-administer"

the lethal substance because of an inability to swallow or the loss of use of the limbs. The amendments do not spell out what the additional assistance would be, but I think it is reasonable to believe that it refers to the doctor injecting the lethal substance into a person's circulatory system.

My hon. Friend's amendments comes from genuine concern about the situation that some people may well find themselves in. Some people who might otherwise qualify for assisted dying under the Bill might be unable to swallow or inject the lethal drugs. We should all respect the feeling that lies behind the amendments, but we should reject them. If we pass them, we will have accepted that doctors can help people who have qualified for assisted dying to prepare to inject themselves with lethal drugs or swallow them. The Bill does not say that doctors can do that. I do not know whether the House would have voted for the Bill on Second Reading if it had, but that is beside the point—it was not part of the Bill. If we were ever to consider taking such a radical step, we should only do so after hearing as much evidence as possible on why and how this might be necessary. I urge the Committee to oppose the amendment.

Danny Kruger: It is a pleasure to follow the hon. Lady; I very much agree with her points. I also pay tribute to the hon. Member for Harrogate and Knaresborough, who spoke with his now customary intellectual clarity and moral constituency. He believes in autonomy, and he is doing what he can to resolve the essential contradiction in the Bill, which is designed to enable people to end their lives at their own discretion. He recognises that some of the safeguards in the Bill, which of course I do support, nevertheless represent barriers to what we are now suggesting is a human right, and that that human right will be restricted to a limited number of people, according to the Bill.

It is my view that the pressure, momentum or inherent direction of travel that the Bill sets us on will necessarily result in these sorts of amendments to the legislation in due course, whether in the form of subsequent amendments passed through legislation, the guidance that is issued, or indeed the practice of doctors. As I tried to explain in my comments on the previous group, my concern is that the Bill allows for quite a wide degree of discretion, naturally and necessarily enough, in the form of doctors interpreting their ability to assist in ways that respect the autonomy of patients, but are, in fact, a step beyond what the Bill—quite rightly, in my view—seeks to allow.

2.30 pm

Tom Gordon: The hon. Member mentioned that down the line the Bill could be changed through guidance. I do not think there would be any scope or ability to do that. Does he agree that that point might be a little bit beyond what we all think might be possible under the terms of guidance?

Danny Kruger: I hope the hon. Gentleman is right. Nevertheless, one of my concerns about the Bill is that we are leaving enormous areas of clinical practice, and regulated conduct for the professionals involved in assisted suicide, to be performed under guidance that is still to be set out and that it is the job of future Ministers to determine.

I pay tribute to the hon. Gentleman, because he has correctly identified a group of patients for whom the drafted Bill may present obstacles to the fulfilment of their wish for an assisted death. My belief is that the ability to assist will probably cover almost anybody who wants it and has found a doctor who wants to help them, but the hon. Gentleman is right that there are some groups for whom that might be more of a challenge than others. I think the answer we are going to get—it is one made by hon. Members in the debate already—is that technology will fix it, and I fear it will, because I think we are going to find ourselves in a world in which it is perfectly possible for the administration of death to be enabled through some kind of technological device, which somebody with the most limited physical mobility will nevertheless be able to activate.

I fear the insistence that we have on self-administration. Although we can all acknowledge, as referenced in the previous debate, the conceptual difference between administration and self-administration, we do have this idea that we are individuals cut off from each other and that there is an essential gap between us and other people. At the very end of life, though—in the moments that we are considering and legislating for—that distinction is void, because we are intimately connected with other people, as per the clauses that we are debating. I fear that we are going to find ourselves in a world in which a laptop will be set up and even a movement as small as the blink of an eyelid by the patient will be enough to trigger what will be called "self-administration" of the fatal dose.

I oppose this group of amendments, moved by the hon. Member for Harrogate and Knaresborough, because I do not believe in assisted suicide. I do not understand why other supporters of the Bill are not following the hon. Gentleman's lead, and acknowledging that if we believe in autonomy and assisted suicide, of course we should enable patients to have the final act performed upon them, rather than insisting on this arbitrary distinction that it is possible to insist on self-administration in all cases.

Rebecca Paul: It is clear that the hon. Member for Harrogate and Knaresborough is trying to create equity, which we all understand. We need to think about the patient on the one hand, but also the doctors, nurses and medical practitioners involved. Does my hon. Friend agree that we need to think about the obligation and impact of such amendments on them?

Danny Kruger: Yes. We discussed this briefly this morning. There is an important consideration about the effect on medical staff involved in the administration of assisted suicide, and we have to make sure that those who do not want to participate are properly insulated from any sort of obligation, which I know is the intention of the Bill's promoter, the hon. Member for Spen Valley. Nevertheless, I am concerned about the knock-on effect of participation in assisted suicide spreading across a practice. I agree with my hon. Friend that we have to be mindful of the impact on doctors. The more we widen the scope—as logic compels us to do, as the hon.

Member for Harrogate and Knaresborough suggests—the more it is about not just discretion, but an obligation on doctors to approve.

We need to think about the conversation that doctors will be required to have with patients who are expressing that wish. If the Bill is widely drawn, as it would be if we were to accept these amendments, there is more opportunity for a doctor to feel compelled to assent to a request.

Sean Woodcock: The hon. Member for Harrogate and Knaresborough is clearly trying to right what he believes to be an inherent injustice in the Bill, but is the hon. Member for East Wiltshire concerned, as I am, that if the amendment were to pass, it would take the debate from a place of being about assisted dying towards what many people would term euthanasia? That is not something that the House in any way endorsed by voting for the Bill on Second Reading.

Danny Kruger: I am absolutely certain that if the amendment had been in the original Bill, the Bill would not have passed Second Reading, because it would have validated the argument that many of us made that the implication of assisted suicide is euthanasia. The distinction between them, while valid in the abstract, does not apply in practice, and that distinction will be quickly overridden in time. I agree with the hon. Gentleman.

Dr Shastri-Hurst: Although I have certain sympathies with these amendments, I do not feel that they are necessary or desirable. They are not necessary because of the provisions that are already stipulated in clause 18(6)(b), which provides the co-ordinating doctor with the ability to prepare

"a medical device which will enable that person to self-administer the substance".

That subsection, in effect, negates the scenario that is put forward in amendment 350 around dysphagia or the loss of a limb. It would permit, for example, the use of a nasogastric tube or a percutaneous endoscopic gastrostomy feeding tube to be used for the administration of the substance in the case of dysphagia. In the case of the functional loss of limbs, as was discussed in the debate on the previous group, a range of assisted technologies are available that would remove the barriers that that would present.

Beyond the necessity, or lack of necessity, of these amendments, I fear that they create legal uncertainty, which is clearly undesirable and, in this instance, could have a serious and significant unintended consequence through the amendments' interaction with clause 24. Subsection (3) of that clause inserts proposed new section 2AA of the Suicide Act 1961, which is an exemption to that Act in respect of the assistance provided under this Bill. In effect, proposed new section 2AA disapplies sections 2(1) and 2A(1) of the Suicide Act where the provision of assistance is done in accordance with the Bill. Those sections specifically relate to an act

"capable of encouraging or assisting the suicide or attempted suicide of another person".

Introducing the concept of additional assistance, as these amendments would, creates a legal uncertainty. The word "additional" creates a further concept that is beyond assistance but is, thus far, ill defined. Would it go as far as, for example, the clinician taking full control of administering the substance? It is entirely unclear. It would therefore place the clinician in an invidious position as to what it would mean for them to provide additional assistance in such circumstances. As I read the interplay between the Suicide Act and the proposed legislation, the clinician would not then be exempt by virtue of clause 24(3), leaving them open to prosecution under the Act.

Danny Kruger: I am grateful for that; I particularly respect my hon. Friend's concern to protect the doctors from any confusion in the law they might be operating under. Just to take him back to the question of technology resolving what I regard as an insuperable problem—the difference between assistance and administration—is it my understanding that my hon. Friend would oppose a patient's being able to ask a doctor to administer a lethal drug to him or her, but that he would support a patient's being able to ask a computer to administer a lethal drug to him or her? Would he accept the computer performing the act at the patient's request?

Dr Shastri-Hurst: My hon. Friend hits the nail on the head, because it is the patient who is driving the decision. They are making that act by activating the electronic device—the computer or whatever it may be in terms of assistive technology—but they have the power and control over that decision-making process, which is completely distinct from a clinician doing that act. It is distinct because it is activated by the patient—by the person making that decision—and that is why I draw the distinction. My hon. Friend may not agree, but that is my rationale for drawing a distinction between the two.

Dr Opher *rose—*

Dr Shastri-Hurst: I am being ambushed by the left.

Dr Opher: I agree with all the hon. Gentleman's points. In terms of assistance, what we are talking about, potentially, if the technology arrives at that, is that the doctor may be able to put a Venflon into the patient's vein, but they would not put the drug through the Venflon into the vein. That would enable the patient to have control. That is the type of assistance that could be quite useful in this scenario, but it would not involve the doctor actually delivering the drug.

Dr Shastri-Hurst: I am grateful for that helpful and thoughtful intervention.

For the reasons I have set out, I consider that the amendments create unnecessary and highly undesirable legal confusion, so I shall not support them.

Stephen Kinnock: Currently, clause 18(6) permits the co-ordinating doctor, in respect of an approved substance provided to the person under subsection (2), to undertake the following activities: prepare the approved substance for self-administration; prepare a medical device to enable self-administration of the approved substance; and assist the person to ingest or otherwise self-administer the substance. Furthermore, subsection (8) expressly provides that subsection (6)

[Stephen Kinnock]

"does not authorise the coordinating doctor to administer an approved substance to another person with the intention of causing that person's death."

Amendment 350 seeks to enable the co-ordinating doctor, in the presence of an independent witness, to provide "additional assistance" to the person to administer the approved substance. Such assistance can be provided only where the person has authorised it, and where the person is

"permanently and irreversibly unable to self-administer the substance"

due to a significant risk of choking due to difficulty swallowing—dysphagia—or loss of the use of their limbs. The term "additional assistance" is not defined in these amendments.

Amendment 351 is consequential to amendment 350 and would require any decision to authorise additional assistance for the self-administration of the substance to be made by the person to whom the substance has been provided. Amendment 352 would create an exception to the condition in clause 18(8), and would have the effect of permitting the co-ordinating doctor to administer an approved substance to another person with the intention of causing that person's death where the criteria introduced in amendment 350 are met—that is, where the co-ordinating doctor is satisfied that the person is permanently and irreversibly unable to self-administer the substance, and that the person has authorised that the additional assistance be provided.

Our assessment is that the amendments would enable the co-ordinating doctor to administer the approved substance to the person, rather than merely assisting the person, in the limited circumstances provided for in clause 18(6), to self-administer. That would be a significant change to one of the fundamental principles of the promoter's Bill—that the final act of administering the approved substance must be taken by the person themselves, and not by a co-ordinating doctor. That is a policy matter and a decision for the Committee.

However, should the amendments be accepted, further amendments may be needed to ensure that this provision is fully legally coherent and workable in several areas. First, amendment 350 does not define who qualifies as an independent witness—for example, whether this would have to be a health professional or whether it could be a family member. Secondly, it does not address whether anyone would be disqualified from being an independent witness, as provided for through clause 36, which is entitled "Disqualification from being witness or proxy".

Finally, as drafted, amendment 350 does not detail how authorisation of the additional assistance must be obtained and/or recorded in order to be valid. It also does not require that any details about the independent witness be recorded. This could lead to difficulties in complying with and/or evidencing that the requirements to provide the additional assistance have been met. By extension, there will be a lack of clarity over when and how the criminal provisions are to apply. I hope that those observations were helpful.

2.45 pm

Kim Leadbeater: I completely understand where these amendments are coming from. In many jurisdictions where assisted dying laws are in place, this would be an accepted part of the process. However, as I have said repeatedly, our Bill stands in its own right, and its safeguards are stronger than those anywhere else in the world. One of those safeguards is that the line cannot be crossed between a person shortening their own death by administering the drugs themselves and by having another person—in this case the doctor—do it for them.

While I am hugely sympathetic to the argument, that is a line that I do not believe the Bill should cross. I concur with the comments of my hon. Friend the Member for Bradford West about Second Reading and what the House voted for, and with those of the hon. Member for Reigate about medical profession levels, which we discussed this morning. I also agree with the Minister's comments about the concept of an independent witness, and with the comments from the hon. Member for Solihull West and Shirley about the concept of additional assistance. On that basis, I will not be supporting the amendments.

Tom Gordon: I will keep it short and sweet. I had not intended to push the amendments to a vote and will not be doing so. A lot of important points have been raised. Irrespective of whether the amendments were going to be pushed to a vote or would have been successful, it is important that we listen to and take into account the voices of people with different diseases who might wish to access an assisted death. We must also take into account the evidence that organisations have submitted, because it is important that those voices are heard too. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Danny Kruger: I beg to move amendment 435, in clause 18, page 13, line 6, at end insert—

"(9A) Where the procedure has failed, the coordinating doctor must escalate the care of the person by making the appropriate referral to emergency medical services."

This amendment would require the doctor to escalate the care of the person in cases in which the procedure fails.

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

Amendment 429, in clause 18, page 13, line 7, leave out subsection (10).

Amendment 436, in clause 18, page 13, line 8, after "provided" insert—

"(10A) If complications occur as a result of the provision of assistance the coordinating doctor must—

(a) make a detailed record of the complications in the patient's medical records,

(b) make a declaration on the final statement issued under section 21, and

(c) make a report to the relevant Chief Medical Officer and the Voluntary Assisted Dying Commissioner."

This amendment would require the coordinating doctor to record any complications in the patient's medical records, to make a declaration on the final statement issued under section 21, and make a report to the relevant Chief Medical Officer and the Voluntary Assisted Dying Commissioner.

Amendment 464, in clause 18, page 13, line 8, at end insert—

"(10A) If the person loses consciousness and it appears to the coordinating doctor that the procedure is failing, the coordinating doctor—

(a) must not do anything with the intention of causing the person's death, and

(b) must seek to revive the person."

Amendment 532, in clause 18, page 13, line 12, at end insert—

"(12) The Secretary of State must by regulations make provision about what the coordinating doctor is legally permitted to do if it is determined by the coordinating doctor that the procedure has failed.

(13) The regulations under subsection (12) must include what specific actions can legally be taken by the coordinating doctor if—

(a) there is a greatly prolonged time to death,

(b) the person has been rendered unconscious, or rendered unfit to make a second attempt at self-administration, but has not died, or

(c) the person is otherwise undergoing complications."

Amendment 533, in clause 18, page 13, line 12, at end insert—

"(12) For the purposes of subsections (2) to (11), the Secretary of State must, by regulations, specify where the provision of assistance under this Act may take place.

(13) Before making regulations under subsection (12), the Secretary of State must consult such persons as the Secretary of State considers appropriate.

(14) The persons to be consulted under subsection (12A) may include—

(a) persons requesting or considering requesting assistance to end their own lives, and

(b) professionals working in palliative and end-of-life care, including hospice staff, and

(c) persons from disadvantaged and marginalised communities, and

(d) registered medical professionals and other healthcare professionals."

Amendment 430, in clause 30, page 18, line 30, at end insert—

"(da) responding to unexpected complications that arise in relation to the administration of the approved substance under section 18, including when the procedure fails;"

Amendment 255, in schedule 6, page 32, line 13, at end insert—

Means of administration of approved substance	....."

This would add the means of administration to the final statement set out in Schedule 6.

Danny Kruger: I am supportive of all the amendments in this grouping, including amendment 255 in the name of the hon. Member for Filton and Bradley Stoke (Claire Hazelgrove) about the importance of recording the means of administration of the substance. We have discussed that a bit, and I think it is important to include it. The amendments tabled by the hon. Member for Bexleyheath and Crayford are also important, as they insist on the actual physical presence of a doctor while the treatment is being carried out. His amendments also suggest that there should be a code of practice about what should happen when things go wrong; I want to go further than that, but I do approve of that measure.

On amendments 532 and 533, tabled by the hon. Member for Ipswich, I again support in principle the requirement—although there is a little too much regulation by the Secretary of State, in my view—that we be clear about where the act should take place and make provision about what the co-ordinating doctor is legally permitted to do if they determine that the procedure has failed. That is the point I really want to discuss; the amendments tabled by the hon. Member for York Central (Rachael Maskell), and the amendment that I tabled, would impose an obligation on the co-ordinating doctor to provide assistance if the procedure fails.

Let me take a moment to explain to the Committee how important it is that we recognise the genuine risk of that eventuality in the case of assisted suicide being performed. There is significant evidence—even given the lack of adequate data collection and the paucity of record keeping, with over half of assisted deaths not properly recorded at all in many places—that in places such as Oregon, which is one of the worst offenders when it comes to data collection, there are significant rates of complication. These can be difficulty with ingesting the drugs, regurgitation and seizures. As I said, 72% of deaths do not record whether complications have occurred, but among the quarter that do, there are significant rates of complication.

Sometimes death can take days, and there can be a long time of unconsciousness. The Committee has heard from me and others in previous debates about the extent to which there is real concern about the actual experience of the administration of assisted death. But it is striking how ill-defined the current Bill is on the point about complications, compared to jurisdictions where such laws are in operation. In other countries, there is clear guidance in law for what should be done. In the Netherlands, euthanasia is recommended when assisted suicide seems to be failing; in Canada, doctors are likewise given licence to administer the death themselves if it fails. The Committee has decided not to proceed down that road. Nevertheless, the question arises as to what on earth patients should do.

To the point that we are talking about a small or non-existent population group—those we might have to worry will experience complications after the administration of fatal drugs—I refer back to a previous debate, when the hon. Member for Stroud, referring to me, said:

"The hon. Gentleman is bringing up lots of rather horrible stories about assisted death. That is why, in Australia, Switzerland and Holland, they have decided, instead of using the regime that he is talking about, to use pentobarbital…One of the reasons why Dignitas uses it is that it is so effective and it does not have those effects."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 11 March 2025; c. 925.]

Having looked into the issue and consulted other medics, I am afraid that the fact is that the safety of pentobarbital is highly contested. It has been debated in litigation in the United States because of its use as a death penalty drug. The executioners who used it said that the deaths were peaceful and akin to falling asleep, but lawyers for inmates on death row have said that

"pentobarbital caused flash pulmonary edema, in which fluid rushes through quickly disintegrating membranes into lungs and airways, causing pain akin to being suffocated or drowned."

[Danny Kruger]

That is evidence from professionals who have examined the effect of pentobarbital on deceased people.

The anesthesiologist Joel Zivot of Emory University hospital in the United States testified to the Canadian Senate on the subject of assisted suicide drugs. He said that when he researched the autopsies of those executed by lethal injection, he stumbled on an alarming discovery:

"When I looked at the autopsies, to my surprise, I found that, in most of the cases, the individuals who had been executed by pentobarbital had fluid congested in their lungs. The lungs of these individuals were twice the normal weight, full of water. Now, the only way that this could have happened would have been as a direct consequence of the pentobarbital that was injected into these individuals."

What is the relevance of that for assisted dying?

Kim Leadbeater: I am not aware of the situation in America, but is the hon. Gentleman not reassured that the evidence from Dignitas, which we all now have access to, says that there have been

"no cases of failure at Dignitas using this medication"?

Danny Kruger: Let me come on to that, because I am not aware of any evidence from Dignitas that disputes the assertion that is being made—certainly none that would meet the concerns raised by the genuine evidence of the effect of pentobarbital on death row patients. Again, the absence of evidence is not evidence of absence. I do not think that Dignitas has supplied evidence to contradict the point that I am making.

Kim Leadbeater: For the hon. Gentleman's reference, I believe that the evidence is TIAB 425.

Danny Kruger: I am grateful to the hon. Lady. Let me let me look that up later. I am happy to exchange data, because this is clearly something we should be trying to get right.

Nevertheless, I want to try to explain why I am suggesting that we have a problem with the drugs that are used in assisted dying and that it has been suggested we use here. Let me continue the quote from Dr Zivot:

"When one watches an execution, it's not clear that this is happening"—

meaning that it looks like a peaceful, painless death. He continues:

"There is not much to see. Executions, like, I imagine, medical assistance in dying, are a rather bloodless event; not much can be seen outwardly. But the autopsies revealed a very disturbing and surprising finding."

He makes the point that that is particularly disturbing, given that assisted dying often uses a paralysing drug, which induces the impression of peace and calm in the patient, when in fact something else might be going on below the surface.

To conclude my quote from Dr Zivot, he says:

"To claim that this is a death that is peaceful, well, it can be nothing else because now a person is unable to move in any way, but whether or not they have any conscious experience of what is happening is unknown…it should be clear to the Canadian public that the kind of death that they will experience…will be something other than the way it is represented. It could be exceedingly painful and more akin to drowning."

I cannot judge whether Dr Zivot is right, but we should be very wary of any claims that there is a simple answer to the question surrounding lethal drugs. To the point made by the hon. Lady, and I think by the hon. Member for Stroud, there is no evidence in the many reports from Dignitas, which has a regime very similar to the one we are imagining here—I will certainly look at the evidence mentioned made by the hon. Lady—that contradicts the concerns raised by Dr Zivot.

Sojan Joseph: Does this not show that clinical documentation is very important? We debated the issue in Committee earlier, when we talked about professionals being required to complete all relevant documentation. Maybe we are missing certain data because these things are not clearly documented in other places. Should we not take from that the learning that if we go ahead with this proposal, we should have proper documentation and make it clear to the clinician what they should and should not document?

Danny Kruger: I entirely agree that there is great concern about the lack of evidence in countries on which we are constantly relying for evidence of why this proposal is safe. I have suggested that, from the quite limited evidence we have, that it may not be safe. The hon. Gentleman is absolutely right that if we are to proceed, we need to be extremely strict about data collection.

To the hon. Gentleman's point about making it clear to clinicians what drugs they are permitted to use, we also need to have a proper regime of clearing and approving those drugs. In earlier clauses, we debated the imperative on the NHS, the Medicines and Healthcare products Regulatory Agency and the Department of Health to properly authorise the specifics of what drugs will be used. It is not clear at the moment what those would be, and I very much agree that we need to be clearer on that.

I finish with a reference to an earlier debate, in which it was suggested, on the basis of the Australian example, that there is no evidence of complications. The hon. Member for Stroud talked about horrible stories from the United States and Canada. He also referred to Australia, where there is apparently no evidence of problems. In fact, I understand that of the six states, only Western Australia records complications, and it does so in relation only to practitioner administration—when the doctor administers the drug—which we do not propose to do here. It does not record complications in relation to self-administration, which is what the Bill proposes. In Western Australia, complications have been reported in 4.3% of cases involving practitioner administration. Again, we are dealing with the great mystery and enigma of how death happens with assisted suicide, and it is certainly unclear what we should do about it.

3 pm

My last quote is from evidence to the Health and Social Care Committee from Baroness Finlay, a leading palliative care specialist and, of course, an opponent of assisted dying:

"Many years ago, I asked for somebody to do a study to see whether patients, given these cocktails in euthanasia, regained consciousness before they died. There was a study of lethal

injections in executions that showed 80% of people probably regained a degree of consciousness. Nobody has undertaken that study, so we are dealing with something that is unknown."

I am afraid that goes for the whole field. There is a great mystery in this space, and the Bill does not clarify it, I am afraid to say.

Naz Shah: Following the intervention of my hon. Friend the Member for Spen Valley, I have just looked at some of the evidence, and it does not cite any papers. In effect, the evidence says the effect can be seen in three documentaries. Nor does it explain why Dr Zivot's concerns are scientifically accurate. Does the hon. Gentleman want to speak to that?

Danny Kruger: There is great anxiety about the validity of much of the evidence in this space. I have great respect for the work of Dr Zivot, because nothing else gets us close to understanding the actual effect of these drugs, once somebody has died.

Kim Leadbeater: In response to the intervention of my hon. Friend the Member for Bradford West, the evidence from Dignitas is really clear: there have been no cases of failure when using this medication.

Danny Kruger: My strong suspicion is that this is because the evidence is not being accurately collected or reported. With Dignitas and in all these jurisdictions, as the hon. Lady has acknowledged, there are significant failures of data and record keeping. Obviously, it is very much in Dignitas's interest not to collect and certainly not to publicise evidence of things going wrong. However, that clearly happens in jurisdictions where data is properly collected.

Naz Shah: I recognise that the written evidence, particularly TIAB 425, says there have not been any failures at Dignitas, but it does not cite any published, let alone peer-reviewed, research, nor does it challenge the analysis of scientists such as Dr Zivot. That remains a grey area.

Danny Kruger: I agree.

Dr Opher: Actually, if we did an autopsy on any person who has died, pulmonary oedema would almost certainly be found because that is what happens in death—the heart stops and the lungs fill with fluid. I would also like to correct the idea that there is neuromuscular paralysis with pentobarbital. There is no way that barbiturates act in that way. All they do is sedate and put the person to sleep, and death comes afterwards.

Danny Kruger: I was not suggesting that pentobarbital has a paralytic effect. Often in assisted dying, a paralytic is administered first as part of the cocktail of drugs. Subsequently, we discover that while the patient may have appeared entirely calm, sleeping peacefully, significant trauma may have been occurring beneath the surface.

I defer to the hon. Member's knowledge, but my understanding from the scientific evidence I have read, and that medics have given to me, is that the extent to which people executed by lethal injection, by pentobarbital, have their lungs fill with fluid is peculiar—it is remarkable. They effectively drown beneath their peaceful exterior.

I intend to press amendment 464 to a vote, and I intend to support other amendments in this group. Although I support the aspiration of amendment 532 to make provision for what to do in the event of a procedure's failure, I think it gives too much leeway to the Secretary of State, so I will oppose that amendment. I think the amendments that the hon. Member for York Central and I have tabled are preferable.

To make the obvious case for those amendments, and as I said in a previous debate, there are three choices in the event of failure. The first is to ignore the plain signs of distress, of things going wrong and of the patient suffering, which is clearly a failure of the doctor's duty of care. The second is to expedite the death, which we have decided would be illegal under the Bill. Therefore, the only option is to revive the patient and escalate treatment, rather than actively or passively facilitate their death.

I hope Members will agree that, on the rare occasions when assisted suicide goes wrong, it is right that the patient is immediately revived and taken to hospital, or for the doctor to take whatever action is necessary. I am interested to understand why those amendments should not be supported.

Daniel Francis (Bexleyheath and Crayford) (Lab): It is a pleasure to serve under your chairship, Sir Roger. I will speak to amendments 429 and 430 in my name. During oral evidence, we discussed the issues in subsections (9) and (10) of clause 18 and whether there is a contradiction. Subsection (9) states that the co-ordinating doctor

"must remain with the person"

and subsection (10) says:

"For the purposes of subsection (9), the coordinating doctor need not be in the same room as the person".

We also discussed how that works in other jurisdictions. My amendment 429 would deal with that conflict. If the Bill were to become law, that conflict could be queried.

We also need to consider the possibility of complications. Clearly, if there are complications and the doctor is not in the same room, they would not necessarily be aware of those complications. I accept that, in some normal circumstances, doctors and medical professionals are not present in the room at the time of death; at other times, they are present. The amendment would mean that if something were to go wrong and someone was having a painful reaction to the drugs, the doctor would be there to see and help.

I do not understand what the Bill means when it says the doctor does not have to be in the same room. How far away would the doctor have to be? One subsection says the doctor has to remain with the person, and the following subsection says they do not have to be in the same room. If the Bill were to pass, we would be asking doctors to do something that is unprecedented. If the person were to suffer complications such as seizures or vomiting, or if they were exhibiting signs of distress, it appears that the doctor should be present. Members may think this could encroach on a patient's privacy, but I think there is a discrepancy between the two subsections.

[Daniel Francis]

On amendment 430, I am conscious that my hon. Friend the Member for Ipswich has tabled a similar amendment. The intention of my amendment is to ensure there are regulations in responding to any unexpected complications that arise in relation to the administration of the approved substance, including when the procedure fails. I am conscious that if a doctor intervenes, they could end up in breach of the Suicide Act 1961. I therefore left the wording in that vein, as I understand that we will receive more information in due course.

Again, we received oral evidence from a number of people that what a doctor is meant to do in the event of unexpected complications is a matter of concern from both a legal and a medical perspective. We know from the evidence received from other jurisdictions that—I accept in a small minority of cases—there can be complications or the death can take much longer than expected. We also received evidence that, on rare occasions, death can take days.

Amendment 430 would show we have thought about those circumstances and provided for them by giving doctors a code of practice to refer to, rather than being left in the dark if a difficult situation arises at the time of death. We must not find ourselves in a circumstance in which doctors and patients are unprepared. It is important for us to think through, provide for and safeguard against all possible scenarios, however rare they might be. Of course, we would not want them to happen, but in some circumstances they might, and we would not want there to be a legal hole. Accepting the amendment would mean the Secretary of State has the opportunity to provide a code of practice for such circumstances. I hope hon. Members will be able to support the amendments in my name.

Sarah Olney (Richmond Park) (LD): It is a pleasure to serve under your chairmanship, Sir Roger. I support amendment 429, tabled by the hon. Member for Bexleyheath and Crayford.

I do not understand how subsection (9) can require the doctor to remain with the person until they have self-administered and died, or until they have decided not to self-administer, while subsection (10) states that the doctor need not be in the same room. The Bill becomes even less coherent when we consider subsection (11), which requires the doctor to remove the substance immediately if the person decides not to self-administer—how can the doctor do so if they are not in the same room? Amendment 429 would make the scheme more coherent and I support it for that reason.

I accept that there are downsides to having the doctor present, especially before the administration, as people have a normal desire for privacy, but that needs to be balanced against the risk of someone else taking the substance or something going wrong in the process of self-administration. In Australia, there is no requirement for the doctor to be present, which has led to some cases of abuse. I understand why the Bill's promoter has chosen not to go down the Australian route, but the position arrived at in subsection (10) lacks coherence and is unclear.

What does it mean to remain with the person without being in the same room? Does it mean being in the corridor just outside the room, but with the door open? What if it is closed? What if, as a result of the door being closed, the doctor is no longer within earshot? I am not the only one who is confused, as so are the doctors who will have to apply the legislation. For example, Dr Janet Menage, a retired GP, told us in written evidence—TIAB 182—that the provisions

"are mutually exclusive: doctor 'must remain with the patient' but 'not in the same room'…This makes no sense. In any case, if the attending doctor is not in the same room there could potentially be an intervention by another person to the patient's detriment. Or the patient may wish to cancel the suicide at the last moment and be unsupported in voicing that decision."

With or without subsection (10), I would like to know whether the Minister has made an assessment of the workforce impact of such a requirement for the doctor to be present. As Dr Rebecca Jones told us:

"As the death may take many hours, I'm uncertain of the practicalities of this".

Sean Woodcock: The hon. Lady is making an important point about the lack of coherence that amendment 429 is trying to sort out. Throughout these weeks of debate in Committee, we have heard about the importance of clarity for practitioners. This provision introduces severe doubt as to exactly what a practitioner is meant to do. I understand that we do not want to say, "You have to do this and this, and in this order", and that amendments have been rejected on that basis, but this clause opens a massive loophole in the law and practice, which concerns me. Does the hon. Lady share my concern?

Sarah Olney: The hon. Gentleman is absolutely right. It is fundamental that, with this legislation, we provide very clear guidance to the medical practitioners who will be engaged in assisting patients with this matter. This is not only for their peace of mind that what they are doing is acceptable under the law, and accords with what Parliament has decided, but for the protection of patients. It is incumbent on us to be really clear about what we mean, and I do not believe we are as the Bill is currently drafted.

3.15 pm

Sojan Joseph: We repeatedly talk about doctors, but nurses, healthcare assistants and other professionals will definitely be involved in a hospital environment. The Bill does not talk about other professionals. Furthermore, within a hospital environment, NHS wards may be bays without individual bedrooms. Does the hon. Lady think we need to be clearer on the procedures that will happen in those areas?

Sarah Olney: I am grateful for the hon. Gentleman's professional experience, which is extremely helpful. He is absolutely right. Following the point made by the hon. Member for Banbury, we cannot define the circumstances in which a patient will find themselves when this is taking place. That is why it is incumbent on us to make sure we provide very clear guidance on precisely what Parliament intends.

As Dr Rebecca Jones told us in written evidence:

"As the death may take many hours, I'm uncertain of the practicalities of"

doctors remaining with the patient

"for many doctors…have competing demands on their time."

In written evidence, Dr Chris Ainsworth asked how this will work in cases where death takes several days, as has happened in Oregon, while Dr Trevor Stammers wrote:

"If the doctor is required to be present until the patient's death, this may require hours of practitioners' time to fulfil and is unlikely to be adhered to in many cases if the dying process is protracted."

Dr Rachel Fisher said in her written evidence that for Australian doctors, who are not required to be present at the final act, each assisted death requires around 60 hours of professional time. For British doctors, we will need to add the time it takes for the self-administration to result in death. Dr Fisher also raised the real impact on doctors, writing,

"imagine the practicalities of those who must deliver it. The GP, motivated by a deep desire to preserve life and relieve suffering arrives at the home of the patient with a cocktail of powerful drugs. What if the patient has symptoms? Who will collect their child from nursery or school if the patient takes a long time to die? How will they know when to decide the death was unsuccessful? Will there be counselling for GPs observing and feeling complicit in a potentially drawn out and symptomatic death?"

Finally, Dr Paul Shaw asked in his written evidence:

"How will this service be funded? What support will be required from the NHS when things go wrong or death takes longer than expected? Will this be a 0900-1700hrs service? What will be the out of hours arrangements?"

A lot of the written evidence touches on the practicalities of a doctor being required to remain with the patient until they die. Amendment 429, in the name of the hon. Member for Bexleyheath and Crayford, seeks to clarify whether "being with the patient" requires the doctor to be physically present in the room.

Dr Opher: I understand that hon. Members are coming from a good place, but I do not understand how amendment 429 would stop the doctor having to stay with the patient until they die. I agree that it is an important issue, so could the hon. Lady elucidate on that?

Sarah Olney: The hon. Gentleman gives me an opportunity to conclude my remarks. I support amendment 429 because it is important to provide clarity that when we say "with the patient," we mean in the room. However, I invite the Minister to expand further on the resource requirement of assisted dying. I want the doctor to remain with the patient, which I think is critical. That is why I support amendment 429, but the implication of the Bill is a considerable resource requirement, particularly for GPs, and I would like the Minister to respond to that.

Jack Abbott (Ipswich) (Lab/Co-op): I rise to speak to amendments 532 and 533, standing in my name, and in support of amendments 429 and 430, tabled by my hon. Friend the Member for Bexleyheath and Crayford. I appreciate that my amendments are similar to amendment 430. They go a little bit further, but probably not as far as we have previously discussed in the Committee.

I totally understand the concerns about the Bill being overly prescriptive about the regulations that could be passed down to the doctors making such decisions. However, it is important that we enable the Secretary of State to provide guidance, in addition to GMC regulations, on what the co-ordinating doctor must do if the procedure has failed. At the moment, the Bill simply states:

"The coordinating doctor must remain with the person until"

that time. However, I appreciate that amendment 429, if passed, would cover that issue.

Clause 9 states:

"The assessing doctor must…discuss with the person their wishes in the event of complications arising in connection with the self-administration of an approved substance under section 18".

However, the Bill as drafted is not clear about what a doctor is legally permitted to do in the event of such complications. That is particularly important, as the Bill expressly states that the final act of administration must be taken by the person themselves. Therefore, the Bill as it stands stipulates that the doctor must discuss the patient's wishes in the event of complications without stipulating what actions the doctor can take in such an event and thus what the patient's options actually are.

There is a gap in the Bill and a lack of clarity on that critical issue, which has been raised frequently in both written and, to an extent, oral evidence. Dr Alexandra Mullock argued that, as

"the Bill would only permit"

a doctor only to assist in the patient's self-administering a substance,

"administering drugs to end the life of a patient who might be unconscious (but not dying) is not permitted."

She also raised the possibility that a patient might regain consciousness, but

"be too ill to make a second attempt"

at self-administration. What should a doctor do if that occurs? Unless the Secretary of State clarifies what a doctor can do in that situation—my amendment would not do that; it would merely give the Secretary of State direction to do so—the co-ordinating director could be placed in a difficult position.

Professor Alex Ruck Keene argued that the Bill as it stands could lead to the potential for medical professionals to be "required to stand by", yet without being able to take steps to respond to complications so as to ensure that the process is completed. I fully appreciate that all doctors would use their good training, common sense and years of extensive practice to make a best-case judgment, and we would always support them in that, but the Bill has the unintended consequence of not giving doctors true cover in that area.

Dr Mullock also asked what should occur if the patient survives a procedure, "but is badly affected". What treatment should be provided? Should the patient be moved to hospital? Should the patient be sedated or made comfortable until a natural death occurs, or should the doctor be able to take steps for the patient to die following the initial failed attempt? We need answers to those questions. Amendment 532 does not seek to answer them, but it would stipulate that the Secretary of State must do so at a certain point.

Danny Kruger: The hon. Gentleman is making an excellent speech, setting out the gap at the heart of the Bill. Does he agree—I think that he does, as he has just explained it—that there are quite straightforward choices: to expedite a death, which is illegal; to do nothing, which is inhumane; or to treat, revive or resuscitate? Why does he think that should not be clearer in the Bill?

[Danny Kruger]

Why does he want to leave it for the Secretary of State to determine that in the future? Why do we as Parliament not get to decide what the right options should be?

Jack Abbott: I appreciate the hon. Gentleman's question. In short, the answer is because we are not medical professionals. *[Interruption.]* Well, some members of the Committee are medical professionals, but not all of us are. I do not think that it is for the Committee to make a judgment on whether to put that in the Bill. I am happy and comfortable to leave such a directive and further recommendations, in addition to the GMC guidance, as further work to do in the coming months and years ahead of the Bill's implementation. I think that is a healthy and strong thing to do. This is an important compromise to some of the conversations we have had in this Committee over the weeks. The amendment seeks to give a clear direction that these sorts of regulations and procedures should be stipulated at some point down the line.

Danny Kruger: The hon. Gentleman suggests that this is something that should be left to the medics. Nevertheless, here we are legislating for medics to be able to administer lethal drugs to people; we are responsible for what happens subsequent to the administration. Let me put this another way: does the hon. Gentleman foresee any scenario in which the guidance from the Secretary of State could be anything other than that the patient should be revived and helped to live in the circumstances where there are clearly complications under way? What else could be the appropriate direction given by the Secretary of State?

Jack Abbott: I appreciate the point that the hon. Gentleman is trying to make. We have discussed this point at length, across a range of subject areas, but we cannot legislate for every single permutation that could possibly happen. That could be about the initial conversations, when the patient is given a terminal diagnosis. Where do those conversations leave us? Clearly there will be a number of different scenarios, which could occur to various degrees.

I do not think it is possible to legislate for every single eventuality. I do not believe that whether to revive or not revive will be so black and white; it will completely depend on the scenario at that particular moment in time. Therefore, further work would need to be done over the coming months and years before the final introduction of the Bill. I believe that it is important to allow the time for that work to happen alongside the existing guidance as it stands.

I do not seek in my amendment to stipulate exactly what every single permutation might be—indeed, that could run to many pages and beyond. The amendment seeks to empower the Secretary of State and the Department to make sure that those eventualities, and the concerns that the hon. Member for East Wiltshire has raised, are covered by regulations over time.

In my view, the failure to provide a clear answer to these questions is an oversight. Data from Oregon shows that it is unfortunately not totally uncommon for patients to suffer complications following the administration of a lethal substance. In 2023, of the 102 patients for whom we have data on whether they suffered complications—out of a total of 367 patients who died by assisted death in Oregon in that year—10 suffered complications. That is just under 10% of the patients we have data for.

Of those 10, eight had difficulty ingesting the substance or regurgitated it. One suffered a seizure, and for one we have no data of what complications occurred. If I may say so to the hon. Member for East Wiltshire, that goes back to the variances that I referred to. It is not as simple as whether to resuscitate or otherwise. There are a number of different factors. Although that is a relatively small sample size, it shows the diversity of the challenges ahead.

In Oregon, information about complications is reported only when a physician or another healthcare provider is present at the time of death, which means that we evidently have less data on this issue than is desirable. However, despite the small sample size, that data would put the complication rate at one in 10. It would not be a completely uncommon occurrence for patients to experience complications following the administration of a lethal substance, although it would be rare.

Kim Leadbeater: My hon. Friend is referring to Oregon. Obviously every jurisdiction has its own methodology when it comes to assisted dying. Is he reassured somewhat by the evidence from Dignitas that for not one person did the procedure fail? A survey from Victoria in Australia showed that 1,076 deaths from the self-administration process took place, and 86% of patients died within one hour. There are different models, and it is important to look more broadly at this if we can.

Jack Abbott: I fully accept my hon. Friend's points, and I agree. To reiterate, complications are not a regular occurrence by any means. They are relatively uncommon. In saying that, there are still 10% of people who did experience them. As she says, these complications are not huge, but there were issues with being able to ingest the substance or with regurgitating it. The figure of 86% that my hon. Friend refers to is absolutely correct, but that would suggest that for 14% of people it took longer than an hour. In my view, that is a relatively high percentage for what we are talking about here.

As I say, my amendment does not seek to stipulate in the Bill exactly what measures have to be taken in every single scenario. I am not suggesting for a moment that we have to legislate about what we must do in the event that, for instance, someone has difficulty ingesting the substance; I am sure that will come naturally with the GMC regulations. I fully appreciate the points made about how this will probably naturally occur, but it is important to provide a reassurance that we are looking at the long-term effects in such scenarios.

3.30 pm

Sojan Joseph: Does my hon. Friend think that 10% is a high number? Does he also think that if we informed patients about the side-effects of those medications from the beginning, the number of patients opting out would probably be higher?

Jack Abbott: I thank my hon. Friend for the question; I agree that 10% is a statistically reasonable figure and should be noted, which is part of the reason for my amendment. However, this is still relatively uncommon from the small sample sizes we have. For example, while it is important to refer to the Oregon example, the sample size is only 100 people, so we should always keep that in context. Will fewer people choose to go down that path because they feel, for example, there is potentially a small chance they might struggle to ingest the substance? To be perfectly honest with my hon. Friend, that will completely be their personal choice, and it is really important that, in every stage of the process, we are very clear with those looking to go down this path about what those eventualities might be.

Everyone will take their own personal opinion about that, but we want to be very clear about any risks that might come about, and we have already stipulated that this will be part of the process. Everyone should be very clear about the process—what it will look like and the associated risks. Many people will look at this and still say, "This is the path for me", but that of course will be their own judgment.

Danny Kruger: I wonder whether, in the hon. Gentleman's view, it might be appropriate for the Secretary of State, when framing the guidance he requests, to leave it to a doctor's discretion. Would that be an appropriate outcome that he would be happy with? My concern is that we will end up with a Bill that has a blank space when it comes to what should be done in the event of complications, as it does currently, and that the Secretary of State might find it equally confusing and unclear and might be reluctant to specify too precisely what should be done in the range of different circumstances that the hon. Gentleman has mentioned. Will we not end up with a further passing of the buck to clinicians to make that decision? Given that, is it not even more appropriate at this stage for us to give a direction to the Secretary of State stipulating that, whatever the guidance will be, it is entirely inappropriate for a doctor to expedite the death of the patient in any way?

Jack Abbott: In the case of this Secretary of State, he is more than happy, as we have seen in the last week or so, to take decision making back in-house and make them himself as well, although that is perhaps a separate political point.

Danny Kruger: I trust this Secretary of State.

Jack Abbott: Absolutely, I know. I am sure the Committee supports him as well.

I would also point the hon. Gentleman to proposed new subsection (13), which my amendment 532 would introduce, saying what "specific actions" can legally be taken, for example, if

"there is a greatly prolonged time to death",

the person has been "rendered unconscious" or

"the person is otherwise undergoing complications."

That quite clearly states that we expect the Secretary of State, through this amendment, to take specific co-ordination actions on that. Under proposed new subsection (12) alone, the Secretary of State would have to make provision on that, which could lead to what the hon. Gentleman is alluding to. However, what I propose in proposed new subsection is very clear: that we would expect specific actions from the Secretary of State in that area.

Naz Shah: My hon. Friend is making an important speech. He talked about percentages earlier. Is he aware of a study in the Netherlands that concluded that 21 people—18% of the cases in the study—were assisted with lethal injection? In five of those cases, that was because the person could not swallow, but in the rest, they were unable to complete.

Jack Abbott: I have used the statistic of 10%; we might find additional statistics from different jurisdictions that put that figure slightly higher or slightly lower. The point I am trying to make is that this is a relatively uncommon occurrence; none the less, this is an area of the Bill that we can make stronger with additional provisions.

I will make some progress on amendment 532. I have made the basis of my point and want to get on to amendment 533. As I have said, amendment 532 seeks to provide clarity on what doctors can do if the procedure fails or is failing by stipulating that the Secretary of State must specify in regulations what actions the co-ordinating doctor can legally take if there is a prolonged time to death; if the person has been rendered unconscious or unfit to make a second attempt at self-administration, but has not died; or if the person is undergoing complications following the initial attempt.

While there is existing GMC guidance, if no further guidance comes forward in the coming years, we risk placing some doctors in an incredibly difficult position. We always say that we should abide by good practice and the experience of many doctors, but additional cover is no bad thing. We need to say what doctors are legally permitted to do in the event of a patient undergoing severe complications. Leaving aside the doctors, that presents a risk to the patient, who may suffer needlessly and intolerably because the co-ordinating doctor does not know what they are legally allowed to do and is thus seeking to avoid legal ramifications of actions. We do not want them to take steps to respond to those complications or support the patient to die in a painful manner.

I will speak briefly to my amendment 533, which is about where assisted dying can take place. The Committee has already touched on that, and I do not want the Bill to be too prescriptive, which is why I have not stipulated exactly where the locations should be. However, this question was raised a number of times in the submitted written evidence. It is incredibly important that we address this question to ensure that assisted dying takes place at a certain location and does not have a detrimental effect on that location or community, and that the implementation of assisted dying does not exacerbate existing healthcare inequalities or deepen the mistrust of the healthcare system that exists among some ethnic minority communities in particular.

We have a duty to ensure that anyone seeking an assisted death under the Bill feels that it is safe to do so, is able to experience the positives of assisted dying and is not traumatised or retraumatised by the process. That is not possible if assisted dying takes place in

[Jack Abbott]

settings in which people feel unsafe, which they feel unable to control or in which they have no agency. The amendment seeks to ensure that the question of where assisted dying can take place is properly addressed and that the possible impacts of assisted dying taking place at any particular location are fully considered. Only then can we address and mitigate its possible detrimental impacts.

That is a particularly important point because the criterion in the Bill that the doctor must remain with the patient until they have died realistically precludes assisted dying taking place at home, as there may be a prolonged time to death. As my hon. Friend the Member for Spen Valley said, 86% of patients in Western Australia died within the hour, but 14% took longer than that. To use another comparison, in Oregon, 87.7% of those who died via an assisted death in 2023 did so at home. If we are essentially precluding assisted dying from taking place at home because of the stipulation that a doctor has to be in attendance, we must answer the question of where it can take place.

In written evidence, Sue Ryder and the National Care Forum cited concerns about the impact on the wellbeing of staff and the other residents of hospices and accommodation-based services, should assisted dying take place within those communities. Dr Jamilla Hussain, in arguing that the question of where assisted dying could take place needed to be addressed, stated that her consultations with

"ethnic minority groups across Bradford highlighted the risk that AD could significantly deepen mistrust in healthcare services, including but not limited to palliative care."

She argued that that needed to be considered when determining where assisted dying would take place, and because of that it would be preferable to avoid

"healthcare settings that these communities rely on, such as hospitals and hospices."

Again, amendment 533 does not seek to specify where assisted dying should take place—I think further work is possibly needed over the coming months and years before this policy is potentially implemented—or to prohibit any particular location, I must add. The rationale behind the amendment is to ensure that through extensive consultation with relevant parties, the possible impacts of assisted dying taking place at any particular location are fully and comprehensively considered, and thereby any potential harm is addressed and mitigated against.

Danny Kruger: Will the hon. Gentleman give way?

Jack Abbott: I was just finishing, but the hon. Gentleman has timed it perfectly, so I will.

Danny Kruger: I think the hon. Gentleman is right about this one. Does he agree that the hospices that have written to us have a very valid point of concern that they might be required to facilitate assisted dying on their premises, even if many members of staff or other residents do not wish that to happen? Does he agree that it is important that we protect hospices from having to have anything to do with assisted dying?

Jack Abbott: I appreciate that point. Throughout this process we have spoken about the absolute need to ensure that very good palliative care options are being presented to everybody along this pathway. I do not think you can separate care homes and hospices from the Bill, but I fully appreciate and sympathise with what the hon. Gentleman is saying. As I have said, there may be some hospices that are simply not appropriate for this, so although amendment 533 does not seek to put that on the face of the Bill in terms of precluding any particular areas of our healthcare system, it would require the Secretary of State, through consultation, to make sure that the legislation is used properly, and make suitable recommendations.

Naz Shah: I rise to speak to amendment 436, tabled my hon. Friend the Member for York Central. The amendment concerns what would happen after a patient has suffered complications while going through the administration of lethal drugs. Let me stress that we know that people suffer complications when they are undergoing assisted deaths. Unfortunately, one thing we do not know is how common those complications are. Another thing we lack is data that would allow researchers to investigate whether certain drugs, perhaps in combination with certain medical conditions, were more likely to cause complications.

The reason that we do not know those things is because of the many gaps in the data collected in places that have assisted dying laws. It has been mentioned before, but very much bears mentioning again, that the Australian states' reports on assisted dying do not publish data on complications suffered by patients who self-administer drugs, and that is the overwhelming majority of assisted deaths in Australia.

Western Australia's most recent report does tell us how frequently there were complications in the cases that involved practitioner administration of lethal drugs—4.3% of those deaths were affected. I understand that the Bill does not allow practitioner administration, but that is not the relevant point. What is relevant is that first, the Australian data shows that some people given lethal drugs suffer complications, and secondly, those complications were ones that we would not wish on someone in their last minutes or hours of life. For example, five out of 198 practitioner administration deaths involved "other complications", which included people coughing and/or reporting a burning throat after they were helped to swallow drugs,

"hiccups with gastric reflux, involuntary muscular contractions, and delayed loss of consciousness."

Western Australia could be much better than other states on average in avoiding complications, or it could be worse. I am afraid that we really do not have the robust data that would allow us to make those comparisons. I repeat: the Australian state does not publish data on complications affecting the majority of assisted dying cases. They do not because they cannot, since no one is mandated to stay with the patient and observe their condition. We do not know, therefore, how common those complications are.

Record-keeping in other jurisdictions is also concerning. This House's Health and Social Care Committee examined the records kept by the state health department in Oregon while inquiring into assisted dying. They found

that Oregon authorities kept very poor records into how many patients suffered complications and what those were.

Amendment 436, tabled by my hon. Friend the Member for York Central, would take a very different approach. Under this amendment, the doctor attending the person having an assisted death would have to make "a detailed record" if the person suffered complications. They would then have to declare that the person had suffered complications, on the final statement concerning that case. Finally, they would have to make a report, to both the chief medical officer for either England or Wales and the voluntary assisted dying commissioner.

3.45 pm

If we do not gather data on a problem, we do not know how widespread it is, and we will find it very hard to solve that problem. That is what is happening with the problem of assisted dying complications in Australia and Oregon. We need to gather clear data on how many complications occur and on the circumstances around each one. We need complications to be clearly flagged on the final report, and we need both the chief medical officers and the voluntary assisted dying commissioner to have an absolutely accurate figure for the occasions when people suffered complications.

I frankly struggle to see what objections hon. Members could have to amendment 436. If it is that doctors will be gathering that data as part of their good practice, then we are hardly adding a burden to them by including it in the Bill. If we say that doctors will in any case be putting this information on their final report, then again, putting that requirement in the Bill is hardly a great burden for anyone. If we say that doctors will in any case be reporting the data to the chief medical officer, then I am rather more sceptical, but again, if they were doing that as a matter of routine then there is hardly any problem with requiring them to do it as a matter of law.

If England and Wales are to have assisted dying, it should not be conducted as it is in other jurisdictions. The states that currently have it gather patchy and incomplete evidence on the complications that people suffer. Let me repeat that those complications include pain, vomiting and lengthy deaths. We want to avoid people suffering those, and one way that we can do that is to gather data on how often it occurs. The amendment would do exactly that, and I hope all members of the Committee can support it.

Dr Opher: I am glad to serve under your chairmanship, Sir Roger. First, I will briefly address the whole area that we are talking about. GPs who are involved in terminal care will go and see a patient as they are slowly dying; we do not know at any point what will happen, and almost anything can happen. I have sat with people who may at any point have a massive pulmonary haemorrhage and drown, for example, or they may just quietly go to sleep—or they may start vomiting.

What those of us in terminal care do is react to what is happening with the patient. For example, if they start to be sick, we would give them an anti-emetic; if they start to become very agitated we would then give them midazolam. What I am saying is that this is normal medical care. We have to be very careful not to stipulate in the Bill what is actually normal medical care.

I understand that what we are proposing is a new option that has not been there before, and we know that there are complications. But in a terminal situation, there would be no occurrence where we would call an emergency ambulance and take them to hospital, for example.

Sean Woodcock: My hon. Friend speaks with a lot of knowledge, and every time he contributes I learn something about the medical profession. My challenge to him is that while he is right that at the end of someone's life GPs and doctors are used to looking after somebody, and there are lots of different complications from medical treatment, in the situation we are talking about the treatment—if we can call it that—is to end their life. That is a distinct difference. Something has gone wrong if their life has not ended suddenly or peacefully, as they were hoping. That means that they might die hours or days later, potentially in agony, or they will linger on, potentially also in agony. The amendment is to try and clarify what then happens, because I would suggest that this is very different from a normal medical procedure.

Dr Opher: I thank my hon. Friend for his sensitive and clear worry. But it is important to note that we would not in any circumstances try to do something that would finish someone's life after they had been given their self-take medicine, because that is against the law. In the Bill we have made a clear distinction between the doctor—a euthanasian, if you like—taking the life, and the patient taking medicine that finishes life. What we need to do is simply support the patient. If, as my hon. Friend suggests, they are in pain we would give them a morphine drip, which is in common use in terminal care. I absolutely respect what he says, but the same treatment principles would be in place as in terminal care.

Danny Kruger: Even in terminal care, when it is understood that a patient is close to death, doctors would surely not overlook a patient for whom an assisted death is clearly failing. The hon. Gentleman suggests that it would be inappropriate to—and that he would never—call an ambulance, or send a patient to A&E; I wonder whether he also means that he would never seek to revive a patient or bring them back to life, as it were, if they were experiencing complications. To his often-repeated suggestion that there is no difference between this and normal medical treatment, there is an enormous difference. Doctors administer lethal drugs to a patient, and are then also supposed to be somehow caring for the patient in the traditional way that doctors should. These things are inherently incompatible, and there is a choice between the two : is the doctor helping the patient to die, or is he helping them to live? That questions remains, and does he not acknowledge that there will be circumstances where it would be appropriate to revive the patient, and seek to support them as if they were living?

Dr Opher: I almost agreed with the hon. Gentleman earlier, when he asked at one point, should we not just leave this to doctors?

One of the key things the hon. Gentleman said is that the doctor administers the drug. This is self-administered, first of all, so that is a very clear line. However, also, in a

[Dr Opher]

case of terminal care—this is what I am trying to get across to the Committee—we know the patient is dying, and therefore if they are becoming worse we simply do things to make them comfortable, and we do not try to revive them, because they are dying. It is important that we realise that this is a very different medical situation from normal care, and that it actually needs very different skills as a doctor. Here, a doctor is not trying to prolong life, but trying to make a death as comfortable as possible.

That is why I support the Bill—because I think it will enhance a comfortable death. I wanted to make it clear that that is normal practice now in terminal care: we do not revive a patient with a terminal diagnosis who is in terminal care, but we make them comfortable.

Sojan Joseph: This is a very good discussion, and with a clinician as well—maybe my hon. Friend can help here. Are we leaving the Bill to professionals to administer, who might be confused and not clear about what they should be doing? In normal current practice, when somebody has a poor prognosis and is very fragile; we use "do not resuscitate" or "do not attempt CPR" decisions. Why do we not build that into the Bill—that everyone who is going through this process should have a DNR or DNACPR in place?

Dr Opher: I thank my hon. Friend for his experience in a clinical setting. I would remind everybody that in the Bill we are trying to help people die in a comfortable way, and I do not feel it is the Bill's job to define exactly how we treat nausea or abdominal obstruction and so on. What we would like to do here is ensure that a patient has a pain-free death, and a death that they are in control of.

Rebecca Paul *rose—*

Dr Opher: I will make a little progress and will then take my hon. Friend's intervention.

On amendment 436, all medical practitioners are required under their code of practice to record any event they come across. I feel there should be better data and I agree with the hon. Member for East Wiltshire that we need to collect data. We are actually very good at doing that in the NHS. Under clauses 21 and 22 there are provisions for the Secretary of State to collect data on complications. I am therefore not sure that particular amendment tabled by my hon. Friend the Member for York Central is necessary. I think I have covered amendment 464, from the hon. Member for East Wiltshire.

On amendment 429, about the doctor being in the same room, I totally understand the anxieties presented by my hon. Friend the Member for Bexleyheath and Crayford, but I feel that whether the doctor is there should be the choice of the family and the patient. There may be some confusion about this, but to me, what the Bill implies—I am interested to hear the Government's opinion—is that the doctor should deliver the medicine to the patient, check that the patient is willing to take the medicine as per amendment 462 from the hon. Member for East Wiltshire, give the medicine to the patient, and then ask the family whether they want them to be there or in the next room. They need to be available, but do they need to be in the same room? I think that should be the choice of the family.

Daniel Francis: I hear what my hon. Friend says, but the wording of clause 18(9) and (10) is ambiguous. Subsection (9) says that the co-ordinating doctor must remain with the person until "the person has died", but subsection (10) says that the doctor

"need not be in the same room".

I do not want to get into measuring metres, but where exactly is that place? Is it in the same room or is it in the same building? If it is in the same building, you cannot possibly be with the person until they die. Does my hon. Friend have comments on that?

Dr Opher: I am interested to hear what the Government say about the wording around that amendment and whether it is safe. I would defer to the Minister on that.

Amendment 430 from my hon. Friend the Member for Bexleyheath and Crayford, about a code of practice that must address complications and failures, is quite a strong amendment and I am willing to support it. If as doctors we have a code of practice about how we handle this type of thing, the amendment would potentially help, and perhaps answer some of the questions from my hon. Friend the Member for Banbury.

I do not believe that amendment 255 from my hon. Friend the Member for Filton and Bradley Stoke is necessary. I believe it should be dealt with under clause 21.

I believe that the very well put amendments 532 and 533 from my hon. Friend the Member for Ipswich could be covered by amendment 430.

Naz Shah: Will the hon. Member give way?

Dr Opher: Yes. I am sorry; I was going to give way to the hon. Member for Reigate at some point too.

Naz Shah: Many doctors have written in to us because they are confused by the Bill. Just as the hon. Gentleman is making his case here, there are many doctors who are writing in to us. I wondered what his response to that was, especially because he is a doctor.

4 pm

Dr Opher: I am in two minds about the doctor being present until the patient dies. In the circumstances, we need to encourage this to happen at home predominantly, because I think that is where most people would prefer to do this action. We perhaps need to look further at whether the doctor needs to stay, in the rare situation where the patient goes on.

Let me conclude by saying that I know that the amendments all come from a good place, and that this is an anxious time, but terminal care is an anxious time for doctors, for patients, for everyone, because we do not know exactly what is going to happen. The Bill allows someone a way of dying, when they have a terminal illness, that has a bit more exactitude than normal practice.

Jack Abbott: I fully understand and am very sympathetic to my hon. Friend's point about the family having privacy and space in the last moments. However—this is a genuine question—what happens if things start to go wrong? Although it is uncommon, we know it is possible. Do we expect the family members who are going through the last traumatic moments to have to go out of the room to find the doctor, albeit they might just be behind the door? I do not know that that would necessarily make it less traumatic, and for some people it could make it worse if the doctor is not there and present next to their bed.

Dr Opher: I think there is some truth in that, to be fair, but I believe we should leave it open to the family's discretion, with the proviso that the doctor should be close at hand, whether that means outside the door or whatever. We need Government advice on whether amendment 429 is safe. I have nothing further to say.

Lewis Atkinson (Sunderland Central) (Lab): It is a pleasure to serve under your chairship, Sir Roger. I will cover a few of the amendments, and follow on from my hon. Friend the Member for Stroud, whose points I broadly agree with.

When it comes to the location and, actually, a lot of the elements, I fear we are trying to over-specify practical matters. As in so many cases, this is not about capacity, coercion, assessment and so on; it is about the practicalities of death, and it is right that we allow the healthcare team for dying people and their families to operate with the professional skill with which they currently operate.

On amendment 429, on the doctor being in the same room, I can think of many instances in healthcare in which a healthcare professional is in an adjoining room, potentially even with a door open so there is a line of sight, and that is entirely appropriate. I think of observations, for example, in various settings. That provision is absolutely necessary and allows an appropriateness of proximity without intrusion. I am sure the doctor will be in the room at the point at which the substance is taken, but if someone then goes into unconsciousness fairly quickly, as would happen in the vast majority of cases, and then takes half an hour or so to die, it is entirely unnecessary for a doctor to be standing there in the same room, towering over the family, when they could be near at hand. I just do not think we need to specify that in the Bill.

I have some sympathy with amendments 532 and 533, tabled by my hon. Friend the Member for Ipswich, on the Secretary of State setting out regulations, but I fear the hon. Member for East Wiltshire did an excellent job of persuading me that they should not be accepted, because when a "must" is included in that way, we get into saying, "The Secretary of State must tell a doctor exactly what they must do in every situation." The legal parameters are clearly set out in the Bill as drafted. There is no administration by a doctor on a person's behalf; it must all be self-done. Additionally, we have not yet mentioned the existing provisions in clause 9(2)(c), which requires, at the point of assessment, a conversation between the assessing doctor and the patient about their wishes in the event of complications or any sort of delay.

Jack Abbott: I appreciate what my hon. Friend is saying about the Secretary of State not stipulating every dot of every i and cross of every t in the regulations, but we are talking about something that has not been practised in this country, so we do not have existing guidance anywhere about what to do in this event. My hon. Friend may correct me, but I think it is really important that the Secretary of State has to give some direction through regulations on what a doctor is able or not able to do in these situations. I appreciate that there must remain room for a doctor's best-case judgment in certain situations but, from a legal perspective and otherwise, the Secretary of State and the Department will have to give some thought to exactly how the regulations work.

Lewis Atkinson: To me, amendment 430, tabled by my hon. Friend the Member for Bexleyheath and Crayford, strikes the right balance. Under clause 30 the Secretary of State "may" make provision for codes of practice on these matters if that is required; I am uncomfortable with saying that the Secretary of State "must" do so, when it is likely that it will be more appropriate for the GMC or some other body to make those regulations. We get into a difficult precedent if the Secretary of State must specify the reaction in certain medical circumstances but we routinely leave that to medical regulation and practice more widely. I think a "may" power, as set out in amendment 430, would allow that backstop provision, but would not get into the issue of "must". It is also likely to be more respectful of the conversations as outlined in clause 9.

Sarah Olney: I am listening to what the hon. Gentleman is saying, and a lot of what he is talking about in terms of giving doctors discretion makes a lot of sense in a routine medical intervention, but this is not a routine medical intervention. This is a very serious point, and the doctor's judgment in this case could well fall either side of what is permissible by the law. That is why it is so important that it is really clear. Whether we decide in Committee that it must be on the face of the Bill, or whether we want, as per the hon. Member for Ipswich's amendment 532, to leave it to the Secretary of State, it must be clear and specific.

Lewis Atkinson: I think the Bill is very clear on the legal parameters. A doctor may not act, in terms of administering the substance, in a way to hasten death. Within that, we are back into the realms of normal medical practice, as my hon. Friend the Member for Stroud set out. I am sure that there will be legal guidance, whether that be from the GMC or elsewhere, if and when the Bill were to pass. The Secretary of State would have the powers anyway under clause 30, but for the avoidance of doubt, amendment 430 strikes the right balance in giving backstop permissions to the Secretary of State to clarify anything if needed.

Kim Leadbeater: On the hon. Member for Richmond Park's point, which a couple of people have made, I do not think anyone is saying that this is not a new situation—of course it is, as we are all aware. My hon. Friend the Member for Stroud's point was that a doctor being with a patient who is dying is not a new situation. That is the important distinction.

Lewis Atkinson: My hon. Friend is absolutely right and articulated that better than I was managing to.

Danny Kruger: We are not necessarily talking about someone who is dying right here and now in consequence of the drugs they have taken—we could be talking about someone who is many months away from their death. The scenario we are envisaging is that fatal drugs —poisonous drugs—have been administered to the patient's body and we are asking doctors to be normal doctors in that scenario. In a genuinely normal scenario of doctors being doctors, they would attempt to revive the patient and to save their life in that circumstance. If the parallel is with the last moments of someone's natural death, the doctor's job is simply to make them comfortable, but that it is not the scenario. The scenario is some months away from their natural death, when they have months to live. They may not even be exhibiting extreme illness—they may just have a terminal disease. If they have been given fatal drugs, what on earth is the doctor to do in the scenario where the drugs are not working? Surely that is a question for all of us, rather than just leaving it up to the doctors.

Lewis Atkinson: I disagree. As clause 9 makes clear, the doctor will have had a conversation with the patient about their wishes in advance, in exactly the same way as a surgeon would have a conversation with a patient in advance of high-risk surgery—

Sarah Olney *rose—*

Lewis Atkinson: I am not going to take any further interventions; I am going to answer this point and make some progress.

The surgeon would say, "If this procedure fails, would you wish me to attempt resuscitation? Would you wish to be put on a support system?" The hon. Gentleman misunderstands current practice on consultation with patients, in advance of procedures, about their wishes, which is where there is significant established evidence.

Danny Kruger *rose—*

Lewis Atkinson: I am going to finish on this point.

On amendment 533, tabled by my hon. Friend the Member for Ipswich, I suspect that, in dealing with a later clause, we will have a conversation about issues around hospices and care homes, but again I find the requirements under the amendment unduly onerous. As my hon. Friend the Member for Stroud and others have said, often people's preferred place of death is at home. Are we really saying that the Secretary of State would specify addresses or the nature of places where these procedures should take place?

Jack Abbott: No, is the short answer to that question. Because a doctor has to be present, are we saying that doctors have to go to someone's home to administer this? Would the Secretary State say, for example—this is not my personal view; it is for discussion—that it would have to take place in a medical facility, or could people choose to have an assisted death at home? The amendment stipulates that the Secretary of State would have to give that guidance at the time. I do not see how we can have doctors going out to individuals' homes to assist the process.

Lewis Atkinson: It is by no means clear that doctors would not go out to people's homes, but my hon. Friend asks whether doctors would have to do that—there are no powers of compulsion anywhere in the Bill, because the entire model is an opt-in model at every stage, including the example he gave in respect of hospices. It is a matter between the resident of the home and the treating medical practitioner.

In reality, healthcare procedures do not happen ubiquitously: they happen in appropriate places with appropriate cultural sensitivity. We do not specify in primary legislation for that to happen. Health professionals, and those involved in the management and commissioning of health services, currently have ample opportunities to co-ordinate and consider such matters.

Jack Abbott: I appreciate my hon. Friend giving way again. For people in the Committee and our colleagues across the House, there has to be clarity. Perhaps it is a question for the Bill promoter's and the Government. As I said, I have no personal problem with it, but is there an expectation that assisted dying will take place at home as well as in medical facilities?

Lewis Atkinson: I cannot speak for the Bill's promoter or for others, but a significant number of people wish to die at home.

4.15 pm

Kim Leadbeater: I can help my hon. Friend out on this point. There is an expectation in the jurisdictions where assisted dying happens that it happens in different locations, very much centred around the patient's wishes, which is the approach we should take.

Lewis Atkinson: That is exactly right. That will quite possibly include people's individual homes as well as not in their homes, in places of appropriate care and peace and tranquillity.

Kit Malthouse: The hon. Member might be interested to know that many hospices and, in fact, the hospice movement have developed what they call hospice at home, which is for people in the advanced stage of illness who want to die in their own home. Services are provided to them to palliate them as they reach death at home.

Lewis Atkinson: The right hon. Gentleman is absolutely right. Another point we have not yet mentioned is that the Care Quality Commission regulates healthcare on the basis of location of delivery. Hospice services cannot just be provided from a random place: the place has to be registered with the CQC as suitable for the provision. I am sure that regime would continue in this instance.

Stephen Kinnock: Amendment 435 would require the co-ordinating doctor to escalate the care of an individual to the appropriate emergency medical services if the assisted dying procedure has failed. Requiring the

co-ordinating doctor to make a referral may engage article 8 of the European convention on human rights—the right to family and private life—if the person has indicated that they do not wish to be referred to emergency services or do not wish to be resuscitated. In a situation where the procedure has failed, doctors would, as in their normal duties, support a person in line with their professional obligations and their understanding of the person's wishes. This could include the involvement of the emergency services, but it would be unusual to specify a particular approach in legislation.

As currently drafted, clause 18(9) provides that:

"The coordinating doctor must remain with the person"

once the approved substance has been provided, until either

"the person has self-administered the approved substance and…the person has died, or…it is determined by the coordinating doctor that the procedure has failed",

or, alternatively, until

"the person has decided not to self-administer the approved substance."

Amendment 429 would remove the clarification currently provided for in clause 18(10) that the co-ordinating doctor does not have to be

"in the same room as the person"

once the approved substance has been provided. However, clause 18(9) requires the doctor only to

"remain with the person".

It may still be possible that the co-ordinating doctor could remain with the person but in a different room if they decide that is more appropriate.

Amendment 436 would increase reporting obligations on the co-ordinating doctor in cases where complications have occurred. It is not clear in the amendment what would be considered a complication and therefore trigger the reporting requirement. It is also not clear what details should be set out in the person's medical records or in the report to the chief medical officer and voluntary assisted dying commissioner.

Naz Shah: I am struggling with this. When amendments were tabled last week, there was a concise direction from the Minister that he understood the intention of the amendments. Could that approach not be applied to these amendments—that there is an understanding of the intention, and they can be tidied up in the wash-up process to make them tight? Could that not happen?

Stephen Kinnock: My job and that of my hon. and learned friend the Justice Minister is to defend the integrity and coherence of the statute. The concern that we have with the word "complication" is that it is a wide-ranging term and concept, and its inclusion could potentially undermine the integrity of the legal coherence of the Bill and how it could be interpreted in terms of its implementation. I am simply flagging the risk that if the Committee chooses to accept the amendment, there could be a muddying of the waters in terms of its meaning in law.

Rebecca Paul: Following on from the point made by the hon. Member for Bradford West, has the Minister taken into account the guidance on private Members' Bills? It says exactly what the hon. Member has just set out: the spirit of amendments should be taken, and it is for the Government to ensure that the integrity of the statute is respected with the final version. That is to allow a free-flowing discussion and to ensure that we capture everything we need to in the Bill, in the light of the fact that many of us are not lawyers or experts.

Stephen Kinnock: Absolutely, if the Committee chooses to accept the amendment, it goes into the Bill. If the Bill gets Royal Assent, it becomes the responsibility of the Government to ensure that the Bill, as passed by Parliament, is implemented in the best possible way.

The hon. Lady is right that the Government's responsibility is to take on whatever passes through Parliament and implement it to the best of our ability. My job in this Committee is to raise concerns about risks of amendments that could potentially muddy the waters more than other amendments, or more than the Bill as it currently stands. It is a balanced judgment about whether we are better off with the Bill as it currently stands, whether the amendment would improve the Bill, or whether it could lead to concerns about the integrity of the statute if it were included.

Rebecca Paul: I thank the Minister for that explanation. I suggest it would also be appropriate for him to set out the changes that could be put in place in order for the amendment to work in that way. To my mind, that would give the true neutrality that he is seeking to achieve. Rather than set out why something does not work, he could set out how it could work in order to deliver the spirit of the change.

Stephen Kinnock: I think what I am saying is that the word "complication" contains a multitude of potential interpretations and meanings. The work that would need to be done by the Government to unpack it and understand what it means certainly could be done if the amendment passes, but the Government are saying that, as it stands, it is not clear. The drafting of the amendment is so ambiguous that it causes the Government concerns about its inclusion.

Naz Shah: This is a genuine question because I continue to struggle with this. What kinds of complications would we envisage if a lethal drug is being administered to a patient who has chosen assisted dying? What kinds of examples are there? Can the Minister help me understand?

Stephen Kinnock: With all due respect, I think it is more the responsibility of those who draft and table amendments to draft and table them in a way that leaves no room or as little room as possible for ambiguity. I think my hon. Friend would be better off addressing her question about the potential complications to somebody with clinical expertise, who could list off a series of potential physical manifestations. I am not qualified to do that. I do not have a clinical background so I am not able to answer her question.

Amendment 464 would impose a duty on the co-ordinating doctor not to do anything with the intention of causing the person's death and to seek to revive the person if it appears to them that the procedure is failing. It is unclear what "appears to be failing" would

[Stephen Kinnock]

mean, and what criteria would need to be met for the co-ordinating doctor to consider the procedure to be failing. It would be unusual for primary legislation to seek to mandate a clinical course of action in the way proposed by the amendment. In addition, the amendment could potentially create conflict for the co-ordinating doctor if the person has a "do not attempt cardiopulmonary resuscitation" order or a legally effective advance decision is in place, as the doctor would have to resuscitate them even if they had stated wishes to the contrary. That could give rise to engagement of article 8 of the European convention on human rights on respect for private and family life.

Amendment 532 would introduce a new duty on the Secretary of State to make regulations setting out what the co-ordinating doctor is legally permitted to do if they determine that the procedure under clause 18(2) has failed. Under the amendment, the regulations would also include specific actions that the co-ordinating doctor can legally take if there is a greatly prolonged death; if the person is unconscious and unable to make a second attempt at self-administration; or if the person has other complications. If specific actions that the co-ordinating doctor can legally take are set out, there is a risk that, when complications arise, they would be unable to take actions that are not listed. That may lead to uncertainty and restrict what the doctor can do, using their professional judgment, to respond to particular circumstances. It is unusual to set out a particular clinical approach in primary legislation.

Amendment 533 places a duty on the Secretary of State to make regulations specifying where the provision of assistance under the Bill may take place. It sets out a requirement on the Secretary of State to

"consult such persons as the Secretary of State considers appropriate"

prior to making such regulations, including certain specified groups.

I turn to amendment 430, which would broaden the Secretary of State's power to issue codes of practice under clause 30 of the Bill. It would explicitly enable the Secretary of State to issue a code of practice in connection with

"responding to unexpected complications that arise in relation to the administration of the approved substance under section 18, including when the procedure fails".

Naz Shah: I respectfully point out that the Minister says that it is not for him to make interpretations and that he has not got the clinical expertise. I genuinely appreciate that, but I am also trying to understand why he accepts provisions that are not clear in the Bill. Why is he okay with those but not with the amendments?

Stephen Kinnock: My hon. Friend will have noted that a number of amendments have been drafted in collaboration with the Bill's promoter, my hon. Friend the Member for Spen Valley. I think that demonstrates that when the Government have seen a lacuna, a lack of clarity or ambiguities in the Bill, officials, along with the Justice Minister, my hon. and learned Friend the Member for Finchley and Golders Green, and I, have worked with my hon. Friend to table amendments to tighten up the Bill. We are doing that in areas where we feel that ambiguity exists. However, when we feel that the Bill, as drafted, does not give rise to such concerns, our position on the amendments is according to our position vis-à-vis the current wording of the Bill.

Danny Kruger: The Minister said that the Government find it impossible to understand the word "complications" —that it is too complex and full of ambiguity. Yet in clause 9 of the Bill, we have that very word. The suggestion is that the doctor should

"discuss with the person their wishes in the event of complications".

Is that unclear? If not, what is the difficulty with specifying "complications" in clause 30?

Stephen Kinnock: The challenge with amendment 436 is that the policy intent is not as clear as it is in clause 9. That clause is about conversations in advance of decisions about committing to the procedure, whereas when it comes to complications that have arisen in a rapid and fast-moving situation, the view of the Government is that it is adequate to rely on the professional judgment of the medical practitioner to take the decision that best suits that situation.

One is a conversation that can be explored between the clinician and the patient in advance, in a managed environment; the dialogue can take place in a considered manner. The second situation is one in which there is a particular physical manifestation and it is up to the clinician to take a rapid position and to decide, according to all the elements that they usually use, such as the GMC's "Good medical practice", other codes of practice and their own professional judgment.

Danny Kruger: The Minister suggests that it is appropriate for the patient to give some advance indication of what should be done in the event of complications, but that it would not be right for Parliament, too, to give advance direction of the sorts of responses that would be appropriate in the circumstances.

I am afraid that I do not understand the Minister's distinction. Either it is possible to set in advance the sorts of responses that would be appropriate in the event of complications—the word "complications" is already in the Bill, so is clearly acceptable—or it is not. In the event of complications arising when the patient has not given clear instructions in advance, surely it is appropriate for the doctor to be able to rely on guidance, whether that is in the Bill or set out by the Secretary of State subsequently.

There needs to be clarity about what to do because, to repeat the point, this is not normal medicine—a fatal drug has been introduced into the body. That is not a normal medical situation in which a doctor just uses their clinical judgment; the only appropriate clinical judgment in such circumstances is to attempt to save the patient's life, because that is what doctors are supposed to do. But we are telling them that they have been allowed to help a patient to die artificially. In that circumstance, what are they supposed to do when that is clearly not working?

4.30 pm

Stephen Kinnock: How amendment 436 is drafted makes for a real challenge, because it is not clear what detail should be set out in the person's medical records

or in the report to the chief medical officer and the voluntary assisted dying commissioner. There is ambiguity in the drafting of the amendment.

Kim Leadbeater: To try to tie this together, I should say that there seems to be consensus that something has to be recorded in the event of complications. It feels to me as though what the Government are saying is that this is not the best crafted way of doing that—that is the worst sentence ever; I apologise. We have to look at the best way of achieving the intention of a number of amendments. I am looking at amendment 430, which I think achieves the objective. This feels as though it is a drafting issue, rather than necessarily a policy issue. I might be wrong.

Stephen Kinnock: Of course, if we can find ways to improve the Bill, we should—that is what this Bill Committee is for. But the input from my officials and parliamentary counsel legal advice have raised red flags about the amendments because of how they are drafted and the ambiguity that they give rise to. Clearly, it is up to the Committee to decide whether it wants to include the amendments or whether those issues could be looked at later—either on Report or when the Bill is going through the other place.

Naz Shah: We cannot have things both ways. I have re-read amendment 436 and I am not convinced that the issue is the drafting. It is very clear:

"If complications occur as a result of the provision of assistance the coordinating doctor must…make a detailed record of the complications…make a declaration…and…make a report".

I am struggling to differentiate between having a conversation about it and it actually happening—it is still a complication, so why the resistance? Can the Minister agree that the Government will look at this and, perhaps in the wash-up, tidy it up—if that is the issue, and they agree in that instance?

Stephen Kinnock: Fundamentally, the role of the promoter of the Bill is to decide whether the Bill, as passed through this Committee, meets the policy intent that she wishes to achieve. Our job as Ministers is to work with her to deliver that objective. If the promoter of the Bill comes to the view that any of the amendments should be considered and added to the Bill, we will of course work with her to enable them to be delivered. My job at the moment is simply to say that there are concerns about these amendments due to the issue of ambiguity.

Kim Leadbeater: As a matter of clarity, although I appreciate the power that the Minister has just given me, which amendments we vote for is actually the job of the Bill Committee—rather than just my job, I would hope.

Stephen Kinnock: Absolutely, it is the job of the Committee to decide which amendments pass, but my hon. Friend's role as the promoter of the Bill is to define the policy intent of the Bill—its fundamental objectives, the fundamental safeguards issues and its architecture in that sense. It is absolutely the responsibility of the Bill Committee to decide whether to amend the Bill.

Sarah Olney: I hope the Minister can answer a question for me. I hear what he is saying about concerns with the amendments themselves, which makes a lot of sense, and the policy objectives of the hon. Member for Spen Valley. What I am concerned about is that in the Bill as drafted, notwithstanding that various amendments have been tabled, it is not clear what the doctor should do in the event of complications. There may well have been an earlier conversation with the patient, but the patient's request may still leave the doctor in the position of committing a criminal offence.

I would like to know whose responsibility it is to ensure that doctors are not left in that position, which could come about either because the Bill as drafted is not clear or the amendments do not make the appropriate clarification. The hon. Member for Spen Valley has done a marvellous job, but in terms of policy intention the Bill does not cover this aspect. The Minister is saying that it is his job only to ensure that the amendments are appropriate. I am still very concerned that there is a big gap here and that we are potentially leaving doctors in the very difficult position of not knowing whether or not carrying out the patient's intentions would leave them in the position of breaking the law. I would like to know whose responsibility it is to ensure that doctors are not left in that situation.

Stephen Kinnock: The hon. Lady will know that we rely on medical practitioners to make professional judgments all the time. My hon. Friend the Member for Stroud has set out the range of things that medical practitioners can do when they are dealing with end-of-life care. That happens all the time.

In these circumstances, it is the view of the Government that we should continue to rely on the skill, judgment and expertise of medical practitioners, underpinned by the various codes of practice—the GMC, or good medical practice, being probably the most obvious one. There is an understandable desire to use primary legislation to address issues of this kind, but it is important to point out that that could prove to be counterproductive and that we could end up with a Bill that becomes less workable and therefore potentially less safe—what one might call the law of unintended consequences.

Sarah Olney: The Minister is talking about somebody making a medical judgment, which would obviously be the right thing to do in the normal course of events, but we are talking about a doctor being left in a position of not knowing whether to take a further step that would end somebody's life or to take the step that would be natural for a doctor—to try to revive the patient. This is about what the legal position is in that case—it is not a matter for medical judgment.

Stephen Kinnock: My response would be to refer the hon. Lady to clause 30(1), which sets out that the Secretary of State will produce a code of practice. Amendment 430, which my hon. Friend the Member for Spen Valley has said she is minded to support, would also ensure that the code of practice includes guidance on the matter that the hon. Lady raises. I think there is a commitment to a code of practice, and if amendment 430 passes then it would be explicitly in the Bill that that code of practice should include the issue that she raises.

[Stephen Kinnock]

Amendment 533 places a duty on the Secretary of State to make regulations specifying where the provision of assistance under the Bill may take place. It sets out a requirement on the Secretary of State to consult such persons as the Secretary of State considers appropriate prior to making such regulations, including certain specified groups.

Amendment 430 would broaden the Secretary of State's power to issue codes of practice under clause 30. It would explicitly enable the Secretary of State to issue a code of practice in connection with responding to unexpected complications that arise in relation to the administration of the approved substance under section 18, including when the procedure fails.

I understand that amendment 255 is no longer relevant as it relates to schedule 6, which is going to be changed—I think that is right—so, in that sense, the amendment is null and void. I hope that those observations were helpful.

Kim Leadbeater: I thank colleagues for a thorough discussion of a group of interesting and important amendments. Amendment 429, tabled by my hon. Friend the Member for Bexleyheath and Crayford, would require the doctor to remain in the same room as the person. I respectfully disagree with my hon. Friend on that point. If a person is literally in the last few minutes and moments of their life, it should be up to them to decide who is in the room with them. In some cases, that might be the doctor, but I suspect that in many cases it would be loved ones and close family members.

We have had a thorough discussion of the range of amendments that look at how we deal with complications. My view is that amendment 430 would do what needs to be done. We need the Bill to show that this has been considered, and the logical place for that would be clause 30, on codes of practice. I am happy to support that amendment when the time comes to vote on it.

Danny Kruger: The Minister suggested that there will be a code of practice, but clause 30 says that there "may" be a code of practice. Does the hon. Member accept that there might not be one and that, even if there were, the only obligation on professionals would be to have regard to such a code? There is a big difference between that and a stipulation in the Bill.

Kim Leadbeater: I believe that amendment 447, tabled by my hon. Friend the Member for York Central, would change the "may" to a "must". I am minded to support it for that very reason.

Amendment 532, tabled by my hon. Friend the Member for Ipswich, comes from a good place as is meant to be a way of trying to help the doctor, but I worry, as medical colleagues have commented during our deliberations, that it could create more of a problem for the doctor in that it would remove flexibility and the use of their clinical judgment and expertise. It always worries me when we are considering putting that level of detail in the Bill.

Jack Abbott: I appreciate what my hon. Friend is getting at in terms of what might happen down the line, but the amendment would not restrict any doctor's flexibility at all or bind them in any way. All it would do is ask the Secretary of State to form a set of regulations.

Kim Leadbeater: The challenge would be in whether the co-ordinating doctor would be able to take actions that were not listed. I worry that a list would be quite restrictive. Amendment 430, which would look at the code of practice, would achieve something in a less restrictive way, which is why I am minded to support it.

We have had a really interesting discussion about amendment 533, and we will probably come further down the line to discuss where patients should have the choice to have an assisted death. I am not entirely sure how the amendment would work, which is why I am not minded to support it.

I am slightly concerned about the terminology and am not sure what the definition of "disadvantaged and marginalised communities" would be for the purposes of the amendment. I refer my hon. Friend the Member for Ipswich to new clause 8—the duty to consult—bearing in mind that there will be a long period of consultation before the Bill, if it passes, is enacted.

The Minister referred to amendment 255, which I think will fall as it refers to a schedule that has been removed from the Bill.

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

Amendment, by leave, withdrawn.

4.45 pm

Amendment proposed: 429, in clause 18, page 13, line 7, leave out subsection (10)—*(Daniel Francis.)*

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 52]

AYES

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

NOES

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

Question accordingly negatived.

Amendment proposed: 436, in clause 18, page 13, line 8, after "provided" insert—

"(10A) If complications occur as a result of the provision of assistance the coordinating doctor must—

(a) make a detailed record of the complications in the patient's medical records,

(b) make a declaration on the final statement issued under section 21, and

(c) make a report to the relevant Chief Medical Officer and the Voluntary Assisted Dying Commissioner."—*(Danny Kruger.)*

This amendment would require the coordinating doctor to record any complications in the patient's medical records, to make a declaration on the final statement issued under section 21, and make a report to the relevant Chief Medical Officer and the Voluntary Assisted Dying Commissioner.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 14.

Division No. 53]

AYES

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

NOES

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

Question accordingly negatived.

Amendment proposed: 464, in clause 18, page 13, line 8, at end insert—

"(10A) If the person loses consciousness and it appears to the coordinating doctor that the procedure is failing, the coordinating doctor—

(a) must not do anything with the intention of causing the person's death, and

(b) must seek to revive the person."—*(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 6, Noes 15.

Division No. 54]

AYES

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

NOES

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

Question accordingly negatived.

Amendments made: 497, in clause 18, page 13, line 9, leave out "decides" and insert

"informs the coordinating doctor that they have decided".

This amendment provides that the duty to remove the approved substance arises on the coordinating doctor being informed that the person has decided not to self-administer the substance.

Amendment 498, in clause 18, page 13, line 10, leave out

"that the substance is not"

and insert

"to believe that the substance will not be". —*(Kim Leadbeater.)*

This amendment clarifies the circumstances in which the coordinating doctor is under a duty to remove the approved substance from the person.

Amendment proposed: 532, in clause 18, page 13, line 12, at end insert—

"(12) The Secretary of State must by regulations make provision about what the coordinating doctor is legally permitted to do if it is determined by the coordinating doctor that the procedure has failed.

(13) The regulations under subsection (12) must include what specific actions can legally be taken by the coordinating doctor if—

(a) there is a greatly prolonged time to death,

(b) the person has been rendered unconscious, or rendered unfit to make a second attempt at self-administration, but has not died, or

(c) the person is otherwise undergoing complications." —*(Jack Abbott.)*

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 55]

AYES

Abbott, Jack	Paul, Rebecca
Francis, Daniel	Richards, Jake
Joseph, Sojan	Shah, Naz
Kruger, Danny	Woodcock, Sean
Olney, Sarah	

NOES

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

Question accordingly negatived.

Amendment proposed: 533, in clause 18, page 13, line 12, at end insert—

"(12) For the purposes of subsections (2) to (11), the Secretary of State must, by regulations, specify where the provision of assistance under this Act may take place.

(13) Before making regulations under subsection (12), the Secretary of State must consult such persons as the Secretary of State considers appropriate.

(14) The persons to be consulted under subsection (12A) may include—

(a) persons requesting or considering requesting assistance to end their own lives, and

(b) professionals working in palliative and end-of-life care, including hospice staff, and

(c) persons from disadvantaged and marginalised communities, and

(d) registered medical professionals and other healthcare professionals."—*(Jack Abbott.)*

Question put, That the amendment be made.

The Committee divided: Ayes 5, Noes 16.

Division No. 56]

AYES

Abbott, Jack	Shah, Naz
Francis, Daniel	
Joseph, Sojan	Woodcock, Sean

NOES

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

Question accordingly negatived.

The Chair: I am satisfied that the matters arising from clause 18 have been fully debated. I therefore do not propose to have a stand part debate.

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

The Committee divided: Ayes 17, Noes 4.

Division No. 57]

AYES

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

NOES

Francis, Daniel	Shah, Naz
Joseph, Sojan	Woodcock, Sean

Question accordingly agreed to.

Clause 18, as amended, ordered to stand part of the Bill.

Kit Malthouse: On a point of order, Sir Roger. Is there any chance somebody could attend to the heating? I do not know whether I am the only Member who is starting to feel a bit cold. As the evening wears on, we are likely to get colder. If we could have it turned up slightly, that might assist our proceedings.

The Chair: I was under the impression that cold concentrated the mind, but we will see what we can do. I speak as one who will not be in the room. The point has been taken.

Clause 19

Authorising another doctor to provide assistance

Sarah Olney: I beg to move amendment 408, in clause 19, page 13, line 18, after "provided" insert "has been consulted and".

The amendment ensures the person has been consulted before they have given consent for another medical practitioner to be authorised to provide assistance.

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

Amendment 210, in clause 19, page 13, line 22, at end insert—

"(2A) Regulations under subsection (2)(b) may in particular provide that the required training, qualifications or experience is to be determined by a person specified in the regulations.".

This amendment enables regulations under subsection (2)(b) to provide that the required training, qualifications or experience is to be determined by a person specified in the regulations.

Amendment 499, in clause 19, page 13, line 25, at end insert—

"(3A) Where a registered medical practitioner who is authorised under subsection (1) is not satisfied of all of the matters mentioned in section 18(4), they must notify the coordinating doctor immediately."

This amendment provides that where a practitioner authorised under clause 19(1) is not satisfied of all of the matters mentioned in clause 18(4), they must immediately notify the coordinating doctor.

Amendment 22, in clause 19, page 13, line 32, at end insert—

"(5A) Regulations under subsection (2)(b) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory."

This amendment would require that, in the event of the coordinating doctor authorising another registered medical practitioner to provide assistance under the Act, that other registered medical practitioner must also have undertaken training on domestic abuse, including coercive control and financial abuse.

Clause stand part.

Sarah Olney: Amendment 408 seeks clarity on a critical aspect of the legislation. Clause 19 allows a co-ordinating doctor to authorise another registered medical practitioner to carry out their functions, providing that the patient consents and that the replacement has completed training, qualifications and experience as specified by the Secretary of State. This is a facilitation clause to smooth the process, and in some cases it might seem like something that we should just nod through. If the co-ordinating doctor becomes unwell, takes leave or faces an emergency that prevents them from fulfilling their duties, they might delegate to ensure continuity of care for the patient. If the patient relocates, perhaps to be closer to family, or if the co-ordinating doctor cannot travel to the patient's location due to the distance or logistics, a local practitioner could be authorised to step in, provided they meet the specified requirements and the patient consents.

5 pm

There will also be cases where the patient's condition requires knowledge or skills beyond the co-ordinating doctor's expertise, such as how to adapt the administration of drugs to that particular patient's condition to try to limit complications. The co-ordinating doctor might delegate to a practitioner better equipped for that aspect of care, while still overseeing the process. In greyer territory, if a co-ordinating doctor managing multiple patients or facing scheduling clashes wants a colleague

to handle specific cases, the clause could be seen as ensuring that the patient's needs are met promptly without overburdening the primary doctor.

On the other hand, the patient might be placed under undue pressure to say yes so as not to inconvenience the doctor, and then find that they will go through their final moments, including the final check for capacity in the absence of coercion, with a complete stranger. We need to confront the fact that there may be unscrupulous private clinics where the highly paid co-ordinating doctor the patient meets at first is swapped for someone else.

In those scenarios, amendment 408 and the requirement that the patient be consulted could be a protection for the patient, because consultation goes beyond mere consent, implying a deeper involvement in the decision-making process. In cases of illness or unavailability, the co-ordinating doctor might need to act swiftly to delegate. Simply obtaining written consent could feel transactional, like ticking a box, and leave the patient uninformed about why the change is happening or who the new doctor is. Consultation would mean discussing the reasons for the switch, introducing the replacement's credentials, addressing any concerns and ensuring the patient feels heard.

In terms of geographical constraints, a patient might face a sudden shift in their care team due to relocation. Consent alone might suffice legally, but consulting them and explaining why a local doctor is needed and how that affects their care plan respects their agency, especially in a process as personal as an end-of-life decision. With workload or scheduling conflicts, delegation might prioritise efficiency. Asking for consent could be a formality, but consulting the patient about their comfort with the new doctor, or even offering options where feasible, would ensure that their preferences shape the outcome, making it not just about the doctor's convenience.

In cases requiring specialist input, the patient might not grasp why a new practitioner is involved. Consultation detailing the replacement's expertise and how it benefits their care turns consent into an informed partnership and not a rubber stamp. Even in cases of ethical discomfort, where a doctor steps back, consultation could reassure the patient that the change reflects the practitioner's limits and is not a judgment on their choice, fostering trust in the replacement.

The Bill's requirement for written consent is a start, but mandating consultation could ensure that patients are active participants in this critical transition, not passive recipients. Should their voice not carry more weight than a signature?

Naz Shah: I rise to speak to amendment 499, tabled by my hon. Friend the Member for Spen Valley. Let me outline what the amendment does and why I believe that it provides an inadequate safeguard. Under clause 19, the co-ordinating doctor may authorise another doctor to provide assistance—meaning that they will help the patient to take the lethal drugs. For clarity, I will refer throughout my speech to this other doctor who may step in to provide lethal drugs as the second doctor.

Under clause 18(4), the co-ordinating doctor must be satisfied of three conditions before they proceed to assist the person to take lethal drugs. Those three conditions are that the person has a clear, settled and informed desire to end their life, has capacity under the Mental Capacity Act 2005, and is not subject to coercion. Implicitly, the co-ordinating doctor can therefore end the procedure if they are not satisfied that those conditions apply. Under clause 19(3), the second doctor has the same duty as the co-ordinating doctor to be satisfied of those conditions before the assisted dying procedure can go ahead.

Amendment 499 would impose a new duty on the second doctor: if they suspected coercion, lack of capacity or lack of clear, settled and informed desire, they would have to inform the co-ordinating doctor. I suggest that the amendment does not take things far enough. It is a very serious matter if any doctor, be it the co-ordinating doctor or the second doctor, suspects coercion, lack of capacity or lack of desire. That means that a very serious mistake may well have been made, and that mistake could lead to someone having an assisted death who should not have qualified for it.

There should be several more safeguards in this part of the Bill. First, let us consider a situation where there was no previous suspicion that a patient had been coerced but where the doctor now suspects that they may have been. There should be a proper system of notification for such cases. It is true that doctors have a duty of care for patients, but it is also true that, given our overstressed, underfunded social care, health and policing systems, difficult cases sometimes fall through the cracks. The Bill should have a clear system for an authority to check back with the social care authorities and a person's GP to make sure that steps are being taken to protect them from potential coercion. Secondly, the report that the second doctor makes in those circumstances should go to not only the co-ordinating doctor, but the voluntary assisted dying commissioner. Thirdly, when that happens, the commissioner should investigate the incident.

To repeat: if a doctor originally assessed a patient as qualifying for an assisted death, but a second doctor could not support that assessment, that is a serious incident that could lead to the assisted death of someone who should not have qualified for it. That does not mean that the co-ordinating doctor was necessarily at fault—not at all. The co-ordinating doctor will have been taking very difficult decisions under considerable stress. However, it does mean that the proper authorities should investigate the initial assessment, whether it was wrong and, if so, why it was wrong.

We see something similar with the Air Accidents Investigation Branch, which investigates not only accidents, but near misses that could have caused serious accidents. It does not assume fault when it investigates near misses. Often, it finds that there has been no human error. However, it has a statutory duty to investigate serious near misses. That is because the law passed by this House recognises that we need to understand why they happened in order to prevent fatal accidents from ever happening in the future.

For that reason, I do not think that my hon. Friend's amendment is sufficient to fix the problems with this part of the Bill. I hope we can think about how better to address those problems, but I cannot support the amendment.

Rebecca Paul: I rise to speak in support of amendment 408, in the name of the hon. Member for Broxtowe. I also support amendments 499 and 210, in

[Rebecca Paul]

the name of the hon. Member for Spen Valley, and amendment 22, in the name of the hon. Member for Lowestoft (Jess Asato).

Clause 19 states that

"the coordinating doctor may authorise, in writing, a named registered medical practitioner to carry out the coordinating doctor's functions under section 18…A registered medical practitioner may be authorised under subsection (1) only if…the person to whom the assistance is being provided has consented, in writing, to the authorisation of that practitioner".

I support amendment 408, which adds that the person must also have been consulted.

I am sure the Committee recognises that, even where someone has basic training and the experience specified, delegating care at the end of life is something that must be done with great care, given the vulnerability of patients. If a co-ordinating doctor has guided someone through this profound and significant process, there are some intrinsic risks that come with delegating the administration of the final approved substance to someone else. I concede that there will be situations where a substitute may be required, but it will not be the doctor that the patient has trusted, confided in and relied on.

A new doctor will of course do the final checks for capacity and consent, but they do not necessarily have any specific detailed knowledge of the patient and may be unable to pick up less obvious cues that someone who knows the patient may be better able to. That gap matters, and history shows that it can lead to problems. The risks of delegation are well documented. If we take the Mid Staffordshire NHS foundation trust scandal in 2005 to 2009, detailed in the Francis report, consultants often delegated tasks to junior staff or nurses without adequate supervision, which contributed to poor care and an estimated 400 to 1,200 excess deaths. Patients suffered from neglect, untreated infections, dehydration and medication errors. That was partly because delegated staff lacked the training or authority to act decisively, and consultants failed to monitor effectively.

In surgical contexts, delegation can also falter. A 2006 *Daily Mail* report highlighted NHS payouts exceeding £1 million for wrong-site surgeries, where consultants delegated preparatory or operative tasks to trainees or assistants, who then misidentified sites—for example, operating on the wrong leg or tooth. Those errors often stemmed from inadequate briefing or supervision, pointing to a systemic delegation risk. We have to be really aware of this.

Those examples suggest that when consultants delegate, whether to junior doctors or other practitioners, including their peers, things can go wrong if communication breaks down, or if the replacement lacks equivalent expertise or is simply not aware of some of the detailed information. In order to manage some of the risks better, patients must be consulted about who takes over their care, and not just asked to consent after the co-ordinating doctor has decided what will happen.

Dr Shastri-Hurst: Given that valid consent requires a voluntary and informed decision, can my hon. Friend set out why that would not involve being consulted on the matter in any event?

Rebecca Paul: I would like to think that that would naturally happen, and we have had lots of conversations where we have said, "In reality, of course this conversation would happen." But I always like to be belt and braces, and I would like to have these things covered in the Bill. If Committee members are confident that these things would happen anyway, I am not sure there would be any detriment to accepting this amendment.

I want to finish with a question for the Ministers. I have been worried—perhaps unnecessarily—about the lack of photographic identification in this process, and I can see a situation where allowing another doctor to provide assistance could create a risk. Although it might be less of a risk in someone's home, because it would probably be clear who the person is, I am worried about a doctor in a hospital or clinic being substituted in at the final hour with no photographic verification of the person. At the point where they assist the patient to take the approved substance, how can the doctor be sure that it is the appropriate person if they have not had any involvement with the patient before? I accept, given some of the deep sighs I can hear, that that may be a rare occurrence, but it is worth thinking about. The simple inclusion of a photographic ID check would address some of that risk. I will not go over old ground, but I have been worrying about that.

Naz Shah: I rise to support amendment 22, in the name of my hon. Friend the Member for Lowestoft. Before I carry on, I am happy to give my hon. Friend the Member for Spen Valley the opportunity to say whether she will accept the amendment, because my hon. Friend the Member for Lowestoft has had a hat-trick of amendments being accepted around training on coercion.

Kim Leadbeater: I am very happy to accept amendment 22 from my hon. Friend the Member for Lowestoft, as it follows the theme of the previous amendments.

5.15 pm

Naz Shah: I am grateful for my hon. Friend's intervention, which will make my speech much shorter—I have repeated it at least three times on all the other amendments. While I welcome the amendment, I hope we can work towards something that strengthens the Bill even further.

Under the amendment, regulations would be made governing the doctors who could fill the role in the clause. Those doctors would have to undergo mandatory training in respect of domestic abuse, including coercive control and financial abuse. Giving doctors that training would not remove the danger that they will overlook evidence of abuse and coercion, but it should decrease it. The doctors we are talking about will spend less time talking to the person seeking assisted death than either the co-ordinating or the independent doctors. None the less, they will spend some time with that person, so I thank my hon. Friend the Member for Batley and Spen—sorry, Spen Valley; I keep going back to Batley and Spen, but we campaigned hard to get her elected there.

Stephen Kinnock: There are some amendments in this grouping—namely, amendments 210 and 49—that we worked on with my hon. Friend the Member for Spen Valley, and I will come to them later in my remarks.

If amendment 408 is passed, the person to whom assistance is being provided would have to be consulted before they consent in writing to another medical practitioner being authorised to carry out the co-ordinating doctor's functions. All registered medical practitioners must uphold the standards set out in the General Medical Council's "Good medical practice", which requires registered medical practitioners to support patients to make informed decisions prior to consenting. Therefore, the proposed amendment may have relatively minimal impact.

Turning to amendment 210, clause 19(2)(b) sets out that a registered medical practitioner may be authorised to carry out the co-ordinating doctor's functions only where they have

"completed such training, and gained such qualifications and experience, as the Secretary of State may specify by regulations."

The purpose of the amendment is to provide that the required training, qualifications or experience are to be determined by a person or organisation specified in the regulations. An example of such a specified organisation might be the General Medical Council. Allowing for that to be specified in regulations rather than on the face of the Bill ensures flexibility.

Amendment 499 provides that where a registered medical practitioner who is authorised to carry out the functions of the co-ordinating doctor is not satisfied that all matters have been met, they must notify the co-ordinating doctor immediately.

If amendment 22 is made, regulations made by the Secretary of State on the necessary training, qualifications and experience of the named registered medical practitioner who is authorised by the co-ordinating doctor to carry out the co-ordinating doctor's functions under clause 18 would need to include mandatory training relating to domestic abuse, including coercive control and financial abuse. The Committee has already made equivalent changes to requirements on training for the co-ordinating and independent doctors, so this amendment would bring the clause into line, should the co-ordinating doctor change, for the purposes of clause 18. Should this amendment be accepted, it would require setting up training mechanisms to equip registered medical practitioners with the knowledge and skills needed to identify domestic abuse, including coercive control and financial abuse.

On clause 19—sorry, I was going to refer to clause 19 stand part. That is the end of my observations.

Kim Leadbeater: Clause 19 applies when the co-ordinating doctor may not be available to provide assistance. They may be out of the country or unavailable due to other personal circumstances, as the hon. Member for Richmond Park articulated beautifully—I associate myself with her comments. Of course the doctor who steps in has to be trained appropriately, and if they are not satisfied of all the matters mentioned in clause 18(4), they must immediately notify the co-ordinating doctor. That is what my amendments 210 and 499 cover.

On amendment 408 in the name of my hon. Friend the Member for Broxtowe, who sadly is not with us today, it could be argued—and I take on board the comments by the hon. Member for Solihull West and Shirley—that it is unnecessary because it would be common practice by practitioners to consult. However, I also take on board the fact that the word "consultation" does some heavy lifting, and I think that is an important point, so I am happy to support amendment 408.

I have mentioned already in response to my hon. Friend the Member for Bradford West that I am happy to support amendment 22, for the reasons I have given previously in relation to similar amendments.

The Chair: Just before we move on to Sarah Olney to wind up the debate, I think I heard the Minister say, "No, that's stand part." Stand part is part of this grouping. Did the Minister wish to comment on stand part?

Stephen Kinnock: I did not wish to comment. That is why I sat down. I have said quite enough; I am sure everyone would agree.

The Chair: It was something else you were pre-empting yourself with—that is fine. I call Sarah Olney.

Sarah Olney: I have nothing to add.

Amendment 408 agreed to.

Amendments made: 210, in clause 19, page 13, line 22, at end insert—

"(2A) Regulations under subsection (2)(b) may in particular provide that the required training, qualifications or experience is to be determined by a person specified in the regulations."

This amendment enables regulations under subsection (2)(b) to provide that the required training, qualifications or experience is to be determined by a person specified in the regulations.

Amendment 499, in clause 19, page 13, line 25, at end insert—

"(3A) Where a registered medical practitioner who is authorised under subsection (1) is not satisfied of all of the matters mentioned in section 18(4), they must notify the coordinating doctor immediately."

This amendment provides that where a practitioner authorised under clause 19(1) is not satisfied of all of the matters mentioned in clause 18(4), they must immediately notify the coordinating doctor.

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

See the statement for Amendment 187.

Amendment made: 22, in clause 19, page 13, line 32, at end insert—

"(5A) Regulations under subsection (2)(b) must specify that training in respect of domestic abuse, including coercive control and financial abuse is mandatory."—*(Naz Shah.)*

This amendment would require that, in the event of the coordinating doctor authorising another registered medical practitioner to provide assistance under the Act, that other registered medical practitioner must also have undertaken training on domestic abuse, including coercive control and financial abuse.

Amendment made: 212, in clause 19, page 13, line 33, leave out subsection (6).—*(Kim Leadbeater.)*

See the statement for Amendment 188.

Clause 19, as amended, ordered to stand part of the Bill.

Clause 20

MEANING OF "APPROVED SUBSTANCE"

Danny Kruger: I beg to move amendment 409, in clause 20, page 13, line 35, leave out from "specify" to "for" and insert—

[Danny Kruger]

"two or more drugs or other substances with different techniques of administration".

The amendment requires that the Secretary of State specifies two or more drugs or other substances, which have different techniques of administration.

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

Amendment 465, in clause 20, page 13, line 36, at end insert—

"(1A) A drug may only be approved under this Act if it has been approved by the Medicines and Healthcare products Regulatory Agency for that purpose."

Amendment 466, in clause 20, page 13, line 36, at end insert—

"(1A) A drug may only be approved under this Act if the Secretary of State is reasonably of the opinion that there is a scientific consensus that this drug or combination of drugs, is effective at ending someone's life without causing pain."

Amendment 437, in clause 20, page 13, line 38, at end insert—

"(2A) The doses and types of lethal drugs specified in any regulations made under subsection (1) must be licensed by the Medicines and Healthcare products Regulatory Agency."

This amendment would require that any drugs and doses to bring an end to someone's life under the Act be licensed by the Medicines and Healthcare Products Regulatory Agency.

Amendment 438, in clause 20, page 13, line 38, at end insert—

"(2A) The doses and types of lethal drugs to bring about the person's death must be recommended by either the National Institute of Clinical Excellence or the All Wales Medicines Strategy Group in Wales' guidelines as appropriate prior to licensing."

This amendment will require the doses and types of lethal drugs must be recommended by either the National Institute of Clinical Excellence or the All Wales Medicines Strategy Group in Wales as appropriate.

Amendment 467, in clause 20, page 13, line 38, at end insert—

"(2A) Regulations under subsection (1) are subject to the affirmative procedure and when tabling the draft of the statutory instrument the Secretary of State must at the same time lay before both Houses of Parliament a report setting out all relevant information on the likely time to death, complications and likely side effect."

Amendment 482, in clause 20, page 13, line 39, leave out "negative" and insert "affirmative".

Clause stand part.

Danny Kruger: I rise to speak primarily to the amendments in my name and those in the name of the hon. Member for York Central with respect to the regulations for the approval of the approved substances—the drugs that will be used in the procedure of assisted death.

My amendment 465 states:

"A drug may only be approved under this Act if it has been approved by the Medicines and Healthcare products Regulatory Agency".

Amendment 437 in the name of the hon. Member for York Central would achieve a similar objective. My amendment 466 would require that the drugs "may only be approved under this Act if the Secretary of State is reasonably of the opinion that there is a scientific consensus that this drug or combination of drugs, is effective at ending someone's life without causing pain."

I also support amendment 482 in the name of the hon. Member for York Central, which would move the approval of the regulations to the affirmative procedure.

Those who support this Bill argue that death through the administration of lethal drugs offers dignity and the avoidance of suffering. If that is to be the case, the drugs used must be effectively regulated and life must be ended effectively and without pain. The amendments I have mentioned specify the role of the Medicines and Healthcare products Regulatory Agency; in my view, to leave this entirely in the hands of the Secretary of State, as clause 20 does, is quite an extraordinary step. It feels remarkable that the Bill as drafted leaves this enormous question to the Secretary of State.

[Peter Dowd *in the Chair*]

Good afternoon, Mr Dowd; it is a pleasure to serve under your chairmanship.

Throughout the Bill, important questions are left to regulations made subsequently by the Secretary of State. I think that is inappropriate here. When patients are prescribed medicines, in most cases the medicine will be licensed by the MHRA for use for the treatment of the particular condition. Patients can be assured that the medicine has been evaluated by the MHRA to ensure that it meets safety and efficacy standards. The MHRA reviews clinical trial data, inspects manufacturing facilities, monitors post-market safety and conducts independent quality testing so that there is regulation of medicine.

I have two concerns with my own amendments here; they might have occurred to other hon. Members, too, if they are paying attention. First, I do not accept that the procedure we are debating here is in fact healthcare. The question then arises, "Why are you proposing that the healthcare regulator would oversee the administration of the drugs?" My response to that is, "Well, somebody's got to do it." In fact, we are talking about substances that might be used in a medical setting, that would be appropriate in other medical settings, and that will have an effect on the body comparable to that for which they are licensed for medicine. Obviously, the intention is the direct opposite: they are licensed for genuine medicine and healthcare in order to preserve life and treat symptoms, but the intention here is to eliminate life without reference to symptoms.

Nevertheless, the only appropriate authority in our country is the MHRA—unless we were to conceive of another new body that would have that specific responsibility. However, that body would have the same obligations that the MHRA does to ensure that the substance is safe, paradoxically, in the sense of not causing unwanted side effects or distress to the patient.

The second objection—there is no reason why hon. Members present would know about it, but I have spoken in the main Chamber before about my concerns about the MHRA—is that, while I have just cited all the work that the MHRA is supposed to do in the regulation of medicines and healthcare products, I am afraid it does not do that job well. I do not want to give the Committee the impression that I think we have a perfect regulator; I think we have a very imperfect regulator in all sorts of ways.

In fact, the hon. Member for Stroud and I have participated in debates on the regulation of antidepressants and addiction-forming prescribed drugs, an important debate in which he and I are on the same side. There is genuine concern about the way the health regulator operates—we will not get into covid vaccines and other things at this moment; we have enough on our plate.

Nevertheless, despite the problems with the MHRA and the fact that I do not want to give the impression that I am concluding that assisted suicide is in fact healthcare, somebody has to do this. We cannot allow a situation in which the patient takes an overdose of a drug with no controls to ensure that the drug meets quality standards and does the job that it is meant to do. A tablet that is licensed for prescription or sale would need to have a minimum level of purity of the active substance, and to be free from other substances and contaminants that might cause unpleasant side effects or reactions. Without regulation, there is a risk that the drug may fail to work as intended or may induce unwanted side effects, such as those that we are all concerned about.

The question is: what safety standards should apply to an approved substance used for the purpose of assisted dying? A drug used to bring about death is not curing or preventing disease, or alleviating symptoms to improve death.

5.30 pm

Sojan Joseph: We had some discussion earlier about how we will potentially be assisting dying in people's own homes—that was not previously known to us; we thought it would be always in clinical settings—so medication will be transported from where it is stored as a controlled drug, in a hospital setting, to the patient's home. Does the hon. Gentleman think that it is important that we have clear guidance as to how we store this medication?

Danny Kruger: I entirely agree. The regulations need to specify not only what drugs may be approved, but, as the hon. Gentleman suggests, how they should be stored and transported. I would expect that to be part of the package of regulations under the Bill.

As I have stated, I do not accept that we are talking about healthcare here; nevertheless, we are using products that are comparable to health products. The MHRA would need to significantly adapt its work in order to identify the most effective drug to cause what we currently perceive as harm—namely, the death of a patient. I recognise that that would be a significant change of remit and work for the MHRA, but we need to do it. One of the reasons that we need regulation of approved substances is to help ensure that falsified versions of the drug—drugs that do not have a licence for use in assisted dying—cannot enter the market. Such drugs may not be effective and could cause distress to those ending their lives and their families. I would be grateful if the Minister could clarify whether, in his view, clause 20 is sufficient to establish the necessary regulatory regime, or whether further legislation will be needed.

We had evidence from Greg Lawton, and other pharmacists, who wrote to the Committee to suggest that the approved substances would not legally come within the definition of a "medicinal product", so medicines law, the protections associated with medicines and the MHRA licensing process might not apply. If that is the case, what do we do about it? We need a new licensing regime to ensure that the MHRA is able to properly regulate the substances, or, potentially, another regulatory agency would need to be established to do the job.

The Committee needs to make sure that there is a process that applies to approved substances used for assisted dying. It is not necessarily the case that a product licensed for treating a medical condition could not be used to bring about death—it is not the case that we cannot use any drug that is currently used for genuine health treatment—but it would not be being used as a medicine, so medicines law may not apply to its use for that purpose. There is an ambiguity, and I would be grateful for clarity on it.

The amendments that I am supporting would ensure that the MHRA had approved the drug for the specific purpose of ending someone's life, and that there was scientific consensus that the drug would be effective for that purpose. The MHRA, in the marketing authorisation for the approved substance, would define the dosage of the drug required to bring about death. It would also ensure that specific considerations and warnings were placed in the product licence.

For example, some patients have allergies to certain drugs. If they decide to end their own life, that should be brought about as a result of the effect of the drug, not an unintended allergic reaction to it. Some patients would not be able to take drugs orally and might need to have the drug administered through a tube into the stomach, so different formulations would need to be available. Some drugs may need to be administered by injection. Patients may be unable to do the injection themselves, as we have discussed. Even if the patient is physically capable, injection techniques require proper training, and that needs to be considered when licensing drugs for assisted dying if the patient is responsible for self-administration.

There will be further considerations when deciding what drugs can be used. Patients will have a right to know what to expect. If they take the drug orally, how long will they have to wait before they die? Will they lose consciousness first? If so, how long will that take? Could there be some side effects or reactions after taking the drug, such as seizures or choking, that the family or carers will have to deal with? Can the drug be taken at home—that relates to the point that the hon. Member for Ashford made—or must it be used in a clinical setting? We have suggested that it could be used at home, so questions about transportation arise. Is a combination of drugs required? If so, in what order should they be taken? What happens if the patient passes out before taking the entire concoction of drugs? Has the drug formulation been optimised for the purpose of assisted dying, so that it reaches maximum blood levels as quickly as possible?

All these sorts of questions are appropriate for medical regulators. The MHRA could ensure that the patient information leaflet, and the warnings associated with it, given with the drug when it is prescribed prompt doctors to think about what drugs are most suitable for the patient and to provide information to the patient about what to expect.

[Danny Kruger]

Parliament must have oversight. It must bear responsibility for the kinds of deaths that it approves. Both Houses of Parliament should approve the statutory instrument. To inform that decision, the Secretary of State should provide all relevant information on the likely time to death, and on complications and side effects. When the state is creating a regime that will end lives, there must be maximum transparency and accountability, yet the Bill provides that this will be done by a negative statutory instrument. In other words, Parliament will get a say on the regulations only if the Leader of the Opposition prays against them—that is the process for a negative SI. That is the only circumstance under which the Government would make time for a debate and a vote on a negative SI. Given that this is an issue of conscience, I find it inconceivable that the Leader of the Opposition would want to take a position on it and so pray against it to trigger a proper debate. I think it is highly likely that Parliament would never get a say on this crucial issue because of the use of the negative procedure.

That situation has been recognised repeatedly as being unacceptable. When Lord Falconer introduced his Assisted Dying Bill to the House of Lords in 2014, it too provided for a negative SI power on this matter. The highly respected House of Lords Delegated Powers and Regulatory Reform Committee—we do not have an equivalent Committee in the Commons, but it sits over Parliament—said that it did not consider either the power or the procedure in the Falconer Bill to be appropriate, yet that is the procedure that we are being presented with here.

In 2021, when Baroness Meacher introduced her Assisted Dying Bill to the House of Lords, the Delegated Powers and Regulatory Reform Committee again issued a report, in which it said:

"In the interests of clarity and transparency on such important issues of public policy, the matters that are in due course to be dealt with under clause 4(7) by negative regulations should in our view be spelled out in detail on the face of the Bill from the outset. Accordingly, the Bill should contain a definitive list of medicines, and details of the manner and conditions under which such medicines are to be dispensed, stored, transported, used and destroyed. The power to amend such matters should be a matter for regulations subject to the affirmative procedure."

We then come to Lord Falconer's 2024 Assisted Dying for Terminally Ill Adults Bill, which he withdrew following the introduction of this Bill by the hon. Member for Spen Valley. That Bill in part took on that feedback from the Lords Committee. Although it did not provide a list of medicines, it did at least provide that the power to specify the drugs would be through the affirmative procedure.

The Hansard Society, which is non-partisan and neutral on assisted dying, has issued a critical report on this power. It says:

"MPs may wish to enquire why Kim Leadbeater has chosen not to adopt the scrutiny procedure set out in the 2024 bill, but has preferred that proposed in the 2014 and 2021 incarnations of the bill, despite the advice to the contrary of the Delegated Powers Committee."

I would be grateful to learn from the hon. Lady why she has chosen this procedure.

It might be objected that the list that I am requesting might need to be modified quickly and that the affirmative procedure—having a parliamentary vote—would be an obstacle to doing that. The Hansard Society anticipated that objection. It said that

"this could be addressed by making provision for the use of the 'made affirmative' procedure in urgent cases where the Secretary of State wishes to remove a substance from the approved list and is of the opinion that it is necessary to do so immediately in order to prevent adverse medical events or failed assisted deaths. This would mean Ministers could act expeditiously but Parliament would have to debate and approve – albeit retrospectively – the change in the list. Whilst not perfect it would provide more opportunity for oversight than that offered by the negative scrutiny procedure."

It seems to me that there is no justification for this vital matter to be regulated under the negative procedure. Too much power and responsibility is being given to Ministers subsequent to the passage of the Bill—if that is what happens. My amendment 467 would ensure that Parliament has a meaningful say, through the affirmative procedure, and that a report is published as part of that process setting out the expected efficacy of the drugs that will be used. I hope that the Committee will support it.

Rebecca Paul: My hon. Friend the Member for East Wiltshire eloquently covered most of the things I would have said.

We have probably not spoken enough to date about the impact on pharmacists, but we are getting to the point in the Bill where it is really important that we take on board the written evidence and feedback that we are hearing from them. The Royal Pharmaceutical Society said:

"In dispensing a prescription, a pharmacist assumes a proportion of the responsibility for that prescription and therefore must be assured that all legal requirements are in place and that it is entirely appropriate for the patient. The link to the clinical assessment of eligibility criteria is essential and therefore the prescriber should always be one of the assessors. In addition to the usual practice of checking that the prescription fulfils the necessary legal requirement, pharmacists must have full access to the patient's diagnosis and assisted dying care plan."

That raises a few valid and interesting points that we need to take on board to ensure that pharmacists can do their jobs in line with the regulations and laws they are subject to, which are ultimately there to maintain patient safety.

I support amendment 466, tabled by my hon. Friend the Member for East Wiltshire, which would ensure that the Secretary of State must be of the opinion that there is scientific consensus that the drug is effective without causing pain. I am of the view that the Secretary of State is probably the right place for that responsibility to sit. One reason for that, which my hon. Friend spoke about, is that I am not sure that the MHRA is the right regulating body for that. I am no expert on this, and I am open to hearing the debate, but the MHRA's remit covers medicines and healthcare products, so there is a question about whether legally the responsibility falls to it. If it does not, do we set up another body, or do we adjust its remit so that it is covered? I have reservations about doing anything that would merge assisted dying into normal healthcare, but I have laid that out many times over the weeks, so I will not go over that.

My understanding is that, on top of all the things my hon. Friend set out, the MHRA's role is to give marketing authorisation for the promotion and advertising of medicine. Once that has been given, reams of regulations and compliance must be done, including in respect of the labelling of medicine. I believe it would have to be put on packaging that a medicine could be used for assisted dying. We need to get clarity on that from experts in the field, so that we fully understand it. If that is the case, how do we feel about making it clear that said medicines, potentially out in the market, could be used for assisted dying? I suggest there could be some significant downsides to such clear labelling. That is something for us all to think about. I wanted to raise those important points.

Naz Shah: I rise to speak in support of amendment 465, tabled by the hon. Member for East Wiltshire. It is a pleasure to follow the hon. Member for Reigate, who has made some powerful contributions. As we have heard, the amendment states that a drug may be approved under the Bill only if it has been approved by the Medicines and Healthcare products Regulatory Agency for that purpose.

5.45 pm

Making sure that the lethal drugs used have to be authorised by the MHRA—I hope this answers some of the questions the hon. Lady had—would help us to confront several problems with the Bill. We have considerable evidence that the lethal drugs administered in other countries cause complications to the people taking them. That means things like pain, discomfort, bitter taste, burning sensations in the mouth and death taking a very lengthy time. Unfortunately, although we know that complications occur in countries with assisted dying laws, we do not know what proportion of people are affected. We also do not have the data that might allow researchers to investigate which medicines and methods are more or less likely to cause complications—I will return to that point.

I refer the Committee to the written evidence that we received from a group of 17 experts in the field, headed by Máire Stapleton, a member of the British Pharmacological Society. The evidence number is TIAB 255. The pharmacological experts say:

"The public may understandably assume that drugs for Assisted Suicide (AS) work reliably and that nothing can go wrong. They may not realize that when used for AS their safety and efficacy haven't been studied, they are being used experimentally, and they are unlicensed. To protect the public from potential risks from unlicensed drugs, prescribers and pharmacists must comply with professional standards that form part of requirements to maintain their professional registration. They must:

(1) assess the risks and benefits to the patient of taking an unlicensed drug and be satisfied that there is sufficient evidence or experience of use to demonstrate safety and efficacy.

(2) give patients sufficient information about the unlicensed drug to allow them to make an informed decision."

The experts say that the preliminary review of evidence on drugs used for assisted dying identified

"little evidence on safety and efficacy of drugs used to assist a person to end their life".

They say this is a "low evidence zone" and argue that a comprehensive review is required before the Bill is finalised. My hon. Friend the Minister for Care has repeatedly said that the Government will publish an impact assessment for the Bill once Committee stage is over; will he tell us whether the Government are carrying out a comprehensive review of the evidence on drugs used for assisted dying? If the Government do not currently plan to do so, will he please assure the Committee that this will change and a review of assisted dying drugs will take place? I look forward to hearing his response.

As well as data on complications, we need data on efficacy—that is, whether the lethal drugs will work to end life within a reasonably short period of time. The data on that is also limited. I am not the only hon. Member to have noted that there is very limited data on drug complications and efficacy from Australia. That is because the majority of assisted deaths in all the Australian states are the result of self-administration. Since no doctor has to be present for the majority of assisted deaths in Australia, we simply do not know how many people suffer complications or how long they take to die.

As other Members have noted, Western Australia does publish data on the complications suffered by people who were assisted by healthcare professionals. The Western Australia official annual report 2023-24 said that 4.3% of those people suffered complications during death. The same report explicitly said that the Government there have no data on the complication rate for the majority of people who self-administer drugs.

The pharmacological experts I referred to presented some evidence on complications and efficacy from other countries. They say:

"In Oregon between 2001 and 2023, data on complications is only reported for 1093 of 2847 deaths. Of the 1093 deaths, complications were experienced in 7.7% of patients and included oral mucosal burning, nausea, vomiting, regurgitation and regained consciousness following coma induction."

Their source was the state of Oregon data summary for the Dying with Dignity Act. The experts also cited an academic study of assisted dying in the Netherlands that was published in 2016:

"In the Netherlands between 2013 and 2015, of 165 cases, 17 patients (10.3%) reported complications including retching, falling asleep before finishing the full lethal dose, muscular contractions, bad taste, throat pain and stomach pain."

Let me sum up the problems with using drugs to bring about assisted dying. We know that these drugs will cause pain and distress to some people who take them. We know that they will cause a quick death for other people, but a longer one for some people and an even longer one for others, but we do not have the evidence to be able to say which combinations of drugs are better than others. Nor do we have the evidence to be able to say what the probability of having a reasonably swift and painless death is.

If we made the MHRA the regulator for lethal drugs, that would not solve those very difficult problems, but it would make them easier to address. The MHRA would examine evidence from other countries before any assisted dying scheme began. It would be able to build an evidence base as England and Wales implemented this law. That information would allow us to do several things. It could inform patients about the risks of complications and prolonged death from using assisted dying drugs, which would give people the information they deserve if they are to make an informed choice. That information could and should be used to research

how to reduce the chance of complications and prolonged deaths. It should also be used to inform the decisions that the House makes if we have to amend this law or approve regulations under the positive procedure.

This country has one of the best reputations in the world for high standards of drug regulation. That reputation is something we all benefit from. It increases the quality of treatment for patients in the NHS, and it is one of the reasons why we are one of the world's leading centres for pharmaceutical research. That is not something we should risk throwing away. We must avoid a situation where assisted dying becomes a second-rate service that accepts lower standards than exist for medical treatment. That would be a very dangerous road to go down.

The MHRA is undoubtedly the best qualified agency in this country to undertake such a task. We could create another quango to specifically monitor the efficacy of and complications around lethal drugs, but that organisation would be starting from scratch, and it would almost certainly have to recruit its staff from the MHRA. We could give the task of monitoring drug efficacy and complications to the newly created commissioner, but I have warned before that we are giving the commissioner—one person—too much power to mark their own homework and, again, the commissioner would have to recruit experts in pharmacology, whereas the MHRA already has some of the best in the world.

Danny Kruger: The hon. Lady puts her finger on the tension—my hon. Friend the Member for Reigate and I expressed it as well—about whether it is appropriate to give the health regulator responsibility for regulating a product that is about not health, but death. Does the hon. Lady agree that no other agency would be appropriate, given the skills she has set out? The purpose of these lethal drugs is to kill the patient; nevertheless, it is appropriate that we consider them in terms of not only that objective but their potential side effects. The purpose is not one of healthcare, but the product is very close to a healthcare intervention. Therefore, despite all our anxieties, it feels appropriate for the healthcare regulator to oversee this.

Naz Shah: I absolutely agree and share those concerns. This is important. I appreciate that we have had this debate for many days now. Is this a healthcare intervention? Is it a treatment? What words should we apply? In this instance, when it comes to drugs, there are potential side effects. We have seen that they do not work everywhere and that they create complications. We have just debated whether a doctor should be in the room, outside the room or round the corner, as well as whether they should be visible or able to see what is going on. Ultimately, this is about the drugs. Having looked at the issue, I genuinely cannot imagine anything but the MHRA in this role. Are we really going to set up something completely new, outside our health service, that regulates drugs, their side effects and the potential implications?

Dr Opher: The matter of unlicensed drugs sounds very alarming, but we cannot regulate a drug through the MHRA if it unlicensed, and we would be looking for therapeutic effect, which would not apply in this case. More importantly, many other regulatory bodies, like the pharmacy framework and the General Pharmaceutical Council—

The Chair: Order. Remember that an intervention should be a sketch, not an oil painting. It should be a question or should seek clarification; it should not be a mini-speech.

Dr Opher: Does my hon. Friend accept that there are ways of regulating drugs other than through the MHRA?

Naz Shah: My hon. Friend clearly speaks with expertise. There are other regulators, but the reason why I support amendment 465 is that the MHRA is an institution that we trust and that has the expertise. My understanding—my hon. Friend might be able to tell me differently—is that, of the regulators, the MHRA is the body that does the ultimate rubber-stamping and gives our country confidence in the national health service.

Danny Kruger: The hon. Lady is right that there is no other agency that is appropriate. The difficulty is that the MHRA is itself highly conflicted—we will come in due course to discuss the role of the profit motive in this mooted procedure—and the big problem is that it is overwhelmingly funded by the pharmaceutical companies. We have to ensure that there is no hint of corruption in the system, but I agree with the hon. Lady that the only way to do this is through that agency, but perhaps after reform.

Naz Shah: I thank the hon. Member for his intervention.

We should be using the world-class pharmaceutical regulator we already have to oversee the drugs that will be used for assisted dying, and I urge all Committee members to support the amendment, which is a very important safeguard.

Stephen Kinnock: It is a pleasure to serve under your chairship, Mr Dowd.

The Government's assessment of amendment 465 is that it would significantly impact the legal and operational delivery of the Bill. The Government anticipate that all substances used for assisted dying will have existing licences from the Medicines and Healthcare products Regulatory Agency for other indications, but the amendment would require the approved substances to be licensed by the MHRA specifically for the purpose of assisted dying. That would require additional powers or provisions to ensure consistency with the current legal framework. The Bill does not currently provide for that, so the amendment would create significant issues for the Bill's operability.

Amendment 466 would require there to be scientific consensus regarding the efficacy of the substances to be used in assisted dying under the Bill. The availability of scientific evidence related to the substances used for assisted dying is limited and varied across international jurisdictions. Although expert advice from clinicians and scientists will be fundamental to agreeing a list of approved substances for this purpose, in any area of medicine it would be challenging to achieve consensus on the medicines or substances to be used. The amendment may therefore open up the regulation-making process

to legal challenge on the basis that there is not unanimity, and that might extend the implementation process. In addition, there may be variations in product availability and in clinical practice among countries, and that may require different substances or combinations of substances to be used.

Secondly, the amendment would narrow the scope of the duty, focusing on the drug's efficacy in eliminating pain as a priority impact over other factors that may be considered. Our assessment is that the experience of pain is subjective. The amendment may limit the ability of a doctor to make an appropriate clinical decision on which approved substances to prescribe for their patient. The decision on an appropriate approved substance would be a clinical decision between the doctor and the person seeking assisted dying, having regard to the needs of the relevant person, including that person's experience of pain.

6 pm

Amendment 437 would require the dosage and type of approved substances specified in secondary legislation to be included in the licence from the Medicines and Healthcare products Regulatory Agency. Specifying the dosage of the approved substances in secondary legislation may limit the ability of the co-ordinating doctor to decide dosages for individual patients based on their unique medical situation, body weight and so on. This may also limit patient and clinician choice.

A further impact of the amendment may be to require that the approved substances are licensed by the MHRA specifically for the purpose of assisted dying. This would require additional powers or provisions to ensure consistency with the current legal framework. These are not provided for in the Bill as it is currently drafted.

I turn to amendment 438. The National Institute for Health and Care Excellence in England and the All Wales Medicines Strategy Group in Wales play a key role in providing evidence-based best practice guidance for the NHS, including on whether medicines should be routinely funded by the NHS. NICE's recommendations are typically based on clinical and cost effectiveness considerations. It typically makes recommendations only on medicines that have already been proven safe and efficacious. The amendment requires treatments to be recommended as best practice by these bodies as a condition of receiving a marketing authorisation or other approval. This would alter the usual order for licensing and might pre-empt the decision of the regulators.

Amendment 467 would change the regulation-making procedure for specifying approved substances from the negative procedure to the affirmative procedure, meaning that the provision would require a higher level of scrutiny in Parliament before becoming law. This would increase the timeline for legal and operational delivery of the approved list of substances and might impact the two-year commencement period set out in clause 42. Our assessment of the requirement for a report containing all relevant information to be laid at the time of laying the regulations is that it may raise legal and operational difficulties, as there is a lack of specificity about what the report should entail.

Amendment 482 would mean that regulations specifying one or more drugs or other substances as approved substances would be subject to the affirmative procedure instead of the negative procedure. The affirmative procedure would require approval by both Houses of Parliament, which may extend the timeline to make or change regulations and could extend the overall timeline for delivery. I hope that those observations have been helpful to the Committee.

Kim Leadbeater: My view is that this is very clearly a matter for the Secretary of State, but with expert clinical and medical guidance. These are the people who should be making the decisions about such drugs. The evidence about this type of medication exists. As part of the commencement period and the consultation period, I anticipate there will be wide consultation about the drugs that are available. I think it is best left with the Secretary of State, so I would leave the clause unamended.

Danny Kruger: I will press amendments 465 to 467, but not amendment 409. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

The Chair: Before we continue, let me make a point about the process for tonight. We are not far off a vote in the main Chamber: it may happen in the next half-hour. There may be four or five votes, including a potential Division on Third Reading of the Children's Wellbeing and Schools Bill. No doubt people will need a comfort break, so my intention is that when the Division bell rings, we will suspend for an hour and 15 minutes. I am not saying that that will absolutely the right period, but it is as good as we can judge at this stage.

Amendment proposed: 465, in clause 20, page 13, line 36, at end insert—

"(1A) A drug may only be approved under this Act if it has been approved by the Medicines and Healthcare products Regulatory Agency for that purpose."—*(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 6, Noes 16.

Division No. 58]

AYES

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

NOES

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

Question accordingly negatived.

Amendment proposed: 466, in clause 20, page 13, line 36, at end insert—

"(1A) A drug may only be approved under this Act if the Secretary of State is reasonably of the opinion that there is a scientific consensus that this drug or combination of drugs, is effective at ending someone's life without causing pain."
—*(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 15.

Division No. 59]

AYES

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

NOES

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

Question accordingly negatived.

Amendment proposed: 467, in clause 20, page 13, line 38, at end insert—

"(2A) Regulations under subsection (1) are subject to the affirmative procedure and when tabling the draft of the statutory instrument the Secretary of State must at the same time lay before both Houses of Parliament a report setting out all relevant information on the likely time to death, complications and likely side effect."—*(Danny Kruger.)*

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 15.

Division No. 60]

AYES

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

NOES

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

Question accordingly negatived.

Amendment made: 213, in clause 20, page 13, line 39, leave out subsection (3).—*(Kim Leadbeater.)*

See the statement for Amendment 188.

Clause 20, as amended, ordered to stand part of the Bill.

Clause 21

FINAL STATEMENT

Amendment made: 214, in clause 21, page 14, line 9, leave out "Schedule 6" and insert

"regulations made by the Secretary of State".—*(Kim Leadbeater.)*

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

Kim Leadbeater: I beg to move amendment 379, in clause 21, page 14, line 10, at end insert—

"(3A) The coordinating doctor must, as soon as practicable, give a copy of the final statement to the Commissioner."

This amendment requires the coordinating doctor to give the Commissioner a copy of a final statement.

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

Amendment 500, in clause 21, page 14, line 10, at end insert—

"(3A) Regulations under subsection (3)(a) must provide that a final statement contains the following information—

(a) the person's full name and last permanent address;

(b) the person's NHS number;

(c) the name and address of the person's GP practice (at the time of death);

(d) the coordinating doctor's full name and work address;

(e) the date of each of the following—

(i) the first declaration;

(ii) the report about the first assessment of the person;

(iii) the report about the second assessment of the person;

(iv) the certificate of eligibility;

(v) the second declaration;

(vi) the statement under section 13(5);

(f) details of the illness or disease which caused the person to be terminally ill (within the meaning of this Act);

(g) the approved substance provided;

(h) the date and time of death;

(i) the time between use of the approved substance and death."

This amendment provides that regulations about the form of a final statement must make the provision mentioned in paragraphs (a) to (i).

Amendment 439, in clause 21, page 14, line 20, at end insert—

"(7) The relevant body must supply—

(a) full medical records,

(b) court records, and

(c) all documentation relating to the assessments and procedures,

relating to bringing about the death of the person in accordance with this act must be made available to the Chief Medical Officer and the Assisted Dying Commissioner.

(8) For the purposes of subsection 7 the 'relevant body' is—

(a) the coordinating doctor, if they are a practitioner with the person's GP Practice;

(b) in any other case, the person's GP practice."

This amendment would require full medical records, court records and all documentation relating to assessments and procedures to be supplied to the Chief Medical Office and Assisted Dying Commissioner.

Clause stand part.

Kim Leadbeater: Amendment 379 would ensure that the co-ordinating doctor provides the commissioner with a copy of their final statement in cases in which the person has successfully been provided with assistance to end their life in accordance with the Bill. That is an important part of the reporting procedures and of the role of the commissioner. If agreed to, the amendment will ensure a robust recording and monitoring process for assisted dying.

Amendment 500 provides that regulations about the form of the final statement must make the provision mentioned in paragraphs (a) to (i) of proposed new

subsection (3A). It builds on my amendment 214, which would amend subsection (3)(a) to require that the form of the final statement must be set out in

"regulations made by the Secretary of State".

This is another way of ensuring robust and thorough reporting.

Danny Kruger: I thank the hon. Lady for explaining the purpose of the amendments. Amendment 500 specifies the information that a final statement must contain. Will she clarify why there is no requirement to record any details of what happened once the drugs were administered, other than the time between the use of the approved substance and death?

In this debate, we have acknowledged the importance of record keeping. If the intention is to maintain public confidence in the system, should there not be some provision to record whether complications happen and what complications there were? This skirting of the issue of complications is concerning. We have ruled out explicitly informing patients of the risk of complications.

6.15 pm

Kim Leadbeater: I do not think that anyone has ruled out discussing complications. Clause 9 makes it clear that the doctor has a very clear discussion with the patient about what will happen if they proceed with an assisted death.

Danny Kruger: I am sorry; I mis-spoke. I should have said that we have ruled out clarifying the expectations of what doctors should do in the event of an assisted death, and whether or not that is specified by the patient.

Earlier today, the Committee again ruled out specifying what the obligations on doctors are if complications arise, whatever the patient has discussed earlier. With this amendment, we now seem to be ruling out gathering any information about what happened, which is surely vital not just for safeguarding but to develop good practice in the operation of the Bill, a point that the hon. Member for Ashford made earlier. There is too much silence in the Bill, between the taking of the substance and death, on what happens if there are complications, what is permitted and, now, what is recorded. Amendment 439, in the name of the hon. Member for York Central, attempts to address that point. I hope that the Committee will accept it.

Naz Shah: I rise to speak to amendment 439, tabled by my hon. Friend the Member for York Central, which would amend clause 21 such that the relevant body would provide the chief medical officer and the commissioner with the full set of documents relating to a person who had undergone assisted dying. The relevant body would be the co-ordinating doctor if that person were a practitioner with the person's GP practice. If the co-ordinating doctor did not meet that condition, the person's GP practice would have the responsibility of sending those documents.

Those documents would be the person's full medical records, court records and all documentation relating to assessments and procedures relating to the person's assisted death. I note that "court record" refers to the Bill before we agreed to the amendments and new clauses that replace the High Court procedure with a panel system. We should be able to slightly tweak the wording to reflect that when we tidy up the Bill. That is what the amendment does. Let me say a little about why it does so and how it would make the Bill stronger.

The key aim is to ensure proper public oversight of any assisted dying scheme. The Bill creates the role of the voluntary assisted dying commissioner, who will look at and report on the workings of the system, appoint panel members and be the final court of appeal, so to speak. Those are far too many powers to give to one person, but if we are giving the commissioner a duty to report on how the system works, they should have the best possible information. It is only right that the information also be sent to the chief medical officer for England or for Wales, as appropriate; they are both very senior public officials and experienced doctors.

My hon. Friend the Member for Spen Valley has tabled amendment 382, which, to quote the explanatory statement,

"provides for monitoring, investigation and reporting functions under Clause 34 to be carried out by the Voluntary Assisted Dying Commissioner (instead of the Chief Medical Officers for England and for Wales)."

I will have more to say on that amendment when we come to it, but removing the chief medical officer from the monitoring, investigation and reporting functions is not a good idea.

What use could the commissioner and the chief medical officers make of the data provided under amendment 439? Let me give some practical examples. If there were reported instances of a person experiencing discomfort or pain as a result of taking the medication, that would be of interest to the CMO and the assisted dying commissioner. It could trigger a further exploration of the titration of medication used in the procedure. As another example, let us think about what could happen if a family raised concerns about a person receiving assisted dying despite lacking capacity or being coerced. The CMO and assisted dying commissioner could use the information provided to investigate those allegations.

The amendment will ensure that the assisted dying commissioner and the chief medical officer receive detailed qualitative as well as quantitative data on people who have received assisted deaths. It is an important step towards making sure that the assisted dying scheme receives proper, well-informed scrutiny. In turn, that scrutiny will make it less likely that the scheme will allow abuses or ignore serious problems. I urge hon. Members to support the amendment.

Rebecca Paul: I will be very brief. I rise to ask a few questions about clause 21 as a whole. Following our debates on various amendments, I am aware that family and those close to the patient could not be involved in the process, although potentially for understandable reasons. I appreciate that we are not here to deal with the whole operational piece, but we should think about it. For example, what happens with notifying next of kin after death, bearing in mind that "next of kin" has a different meaning after death? That is when we start to get into legal considerations, such as who the executor is—and this could be the first time that they are hearing about it. What would be the process for that, given that the person has potentially died on their own at home with the doctor?

[Rebecca Paul]

What is the process for handling the next stage? Is there anything that we need to include in the Bill to make it a clearer, simpler and easier process? Who will the medical certificate of cause of death be given to for registration of the death? While all that is going on, what will happen to the body? At that point, we may not have family members to take care of that. Those are some questions arising from clause 21 that are worth reflecting on.

Stephen Kinnock: The amendments relate to clause 21, which applies where the person has been provided with assistance to end their own life in accordance with the Bill and has died as a result. Throughout this process, we have worked with my hon. Friend the Member for Spen Valley. Amendments 379 and 500 have been mutually agreed on by her and the Government, so I will offer a few technical and factual comments.

Amendment 379 would require that, where a person has been provided with assistance to end their life and has died as a result, the co-ordinating doctor must provide the voluntary assisted dying commissioner with a copy of the final statement under clause 21 as soon as practicable. That links to the commissioner's role in monitoring the operation of the Bill, as set out in new clause 14. Amendment 500 sets out the information that must be included in the form of a final statement, which is to be set out in regulations in accordance with amendment 214.

The effect of amendment 439 would be to introduce a new requirement for the relevant body, defined as either the co-ordinating doctor or the person's GP practice, to provide full medical records, court records and all documentation related to assessments and procedures relating to bringing about the death of the person in accordance with the Bill to the chief medical officer and the voluntary assisted dying commissioner. The amendment is broad, and it is not clear whether doctors would be able to comply with the duties fully.

For example, GPs do not normally have access to court records, and would need to request them to provide them to the chief medical officer and the commissioner. Currently, a decision to share court records is made at the discretion of the judiciary in most cases. As such, any statutory burden to disclose court records agreed by both Houses would require consultation with the independent judiciary. Depending on the type of record, there could also be data protection considerations.

Kim Leadbeater: I have nothing to add other than to respond to the fair point made by the hon. Member for East Wiltshire about complications. The doctor does have to record the final statement in the medical records, and I am confident that they would also record any complications in the medical records. Similarly, we have talked about the code of practice with regard to complications, so there is scope to include what would happen in those instances there. It is, however, a fair point, and it could be something to look at amending on Report, if the hon. Gentleman wants it to be in the Bill.

Amendment 379 agreed to.

Amendment made: 500, in clause 21, page 14, line 10, at end insert—

"(3A) Regulations under subsection (3)(a) must provide that a final statement contains the following information—

(a) the person's full name and last permanent address;

(b) the person's NHS number;

(c) the name and address of the person's GP practice (at the time of death);

(d) the coordinating doctor's full name and work address;

(e) the date of each of the following—

(i) the first declaration;

(ii) the report about the first assessment of the person;

(iii) the report about the second assessment of the person;

(iv) the certificate of eligibility;

(v) the second declaration;

(vi) the statement under section 13(5);

(f) details of the illness or disease which caused the person to be terminally ill (within the meaning of this Act);

(g) the approved substance provided;

(h) the date and time of death;

(i) the time between use of the approved substance and death."—*(Kim Leadbeater.)*

This amendment provides that regulations about the form of a final statement must make the provision mentioned in paragraphs (a) to (i).

Clause 21, as amended, ordered to stand part of the Bill.

Clause 22

Other matters to be recorded in medical records

Kim Leadbeater: I beg to move amendment 380, in clause 22, page 14, line 25, at end insert—

"(1A) The coordinating doctor must, as soon as practicable, notify the Commissioner that this has happened."

This amendment requires the coordinating doctor to notify the Commissioner of a matter mentioned in subsection (1).

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

Amendment 440, in clause 22, page 14, line 34, at end insert—

"(4) For the purposes of subsections (2) and (3)(b), the information recorded must include—

(a) any interventions made by a medical practitioner in response to the procedure failing, and

(b) the timing of those interventions."

This amendment would specify certain information to be recorded under section 22 when the procedure fails.

Clause stand part.

Kim Leadbeater: The amendment would require that if a person has decided not to take the substance or the procedure has failed, the co-ordinating doctor must, as soon as is practicable, notify the commissioner of that. It is fairly straightforward.

Sean Woodcock: I rise to speak to amendment 440, which stands in the name of my hon. Friend the Member for York Central. It concerns what the doctor must do when they are supervising an assisted dying procedure. It would add a requirement for the medical records to include

"(a) any interventions made by a medical practitioner in response to the procedure failing, and

(b) the timing of those interventions."

Should the procedure fail and the person start to suffer complications, record keeping will be vital. That is particularly true because the Bill does not provide clear guidance on what doctors should do if a person starts to suffer complications during the assisted dying process; it states that a doctor and the applicant should discuss before the procedure what the applicant's wishes would be if they suffer complications. We have heard from the Minister that doctors should use their clinical judgment when that happens to a person undergoing assisted dying. Some doctors may commence lifesaving treatment; others may decide to wait and watch while the patient suffers complications in the hope that those complications do not last too long.

Collecting accurate records will enable the authorities, including the Secretary of State for Health and Social Care, to compile information on people suffering complications during assisted dying procedures, however few they are. That in turn would allow for several things. It might allow doctors to compile data on which drug combinations and methods are most likely to bring about complications. It could help doctors and medical authorities to write procedures for responding to patients who suffer such complications. That information could also be used to inform patients about the likelihood of suffering complications if they go ahead with assisted dying.

We have heard from several hon. Members that good record taking is essential to monitoring and safeguarding assisted dying. Unfortunately, in other jurisdictions there are significant gaps in the data on when patients have suffered complications. In Oregon, records are destroyed the year after each annual report, and physicians are not required to be present when lethal drugs are taken, so the reports of complications depend on information provided by whoever was present at the time. Complications are recorded via a form, but in 2023, 72% of complications in cases were listed as unknown.

Simply recording the fact of a procedure failing will not provide enough information for monitoring, review and improvement. We should aim to do considerably better in the data we collect on patients who suffer complications, and that is why I urge Members to support the amendment.

6.30 pm

Danny Kruger: I rise to speak to amendment 440, which stands in the name of the hon. Member for York Central. I echo the points made by the hon. Member for Banbury. Surely it is the case that the interventions made by a medical practitioner in response to the procedure failing, and the timing of those interventions, must be properly recorded. Should the procedure fail, the need for record keeping is of significant importance, as with all medical record keeping.

The doctor with the patient should write up the notes, including the times at which they reacted negatively to the procedure, the amount of medication that they consumed, any side effects and any action taken. That is good practice. In other jurisdictions there has been poor record keeping, as I mentioned, when things have not gone according to plan. We do not fully understand what happened in those instances or, more generally, the prevalence of complications in those jurisdictions. That information will be vital if further interventions are required, including emergency care.

Clause 22 deals with two situations: if the person decides not to take the substance or if the procedure fails—the phrase "Other matters to be recorded in medical records" seems a rather innocuous title for a clause that deals with such situations. In fact, I think that is the only mention of the procedure failing in the whole Bill. However, the clause, and amendment 380, simply require the co-ordinating doctor to notify the commissioner that it has happened as soon as practicable. Do we have any sense of when the doctor should judge the procedure to have failed? I would be grateful if the Minister or the promoter could offer a definition of procedural failure. What does that actually mean?

That question arises in other jurisdictions that have assisted dying laws. A 2019 paper by the Canadian Association of MAiD Assessors and Providers said:

"There is no clear cut-off for what constitutes 'delayed time to death' or 'failed oral MAID'."

At what point does a delayed time to death yield to failure? That question is not just abstract for us; it is a philosophical question in other contexts, but we are required to answer it. That paper goes on to suggest that

"clinicians should decide with patients in advance at what point they will consider inserting an IV and completing the provision",

which is a rather euphemistic term but we know what it means. That is legal in Canada, but it would not be here, so what happens?

In written evidence, Dr Alexandra Mullock, who is a senior lecturer in medical law and co-director of the Centre for Social Ethics and Policy at the University of Manchester, pointed out:

"The Bill is silent on the precise obligations of the doctor if the procedure fails."

Clause 18(9)(a)(ii) states that the doctor must remain with the person, but what the doctor should be permitted to do, either in relation to aiding recovery or supporting the person to die after the initial attempt has failed, is unclear. She said:

"During my work with the Nuffield Citizen's Jury, the issue of what happens if the drugs do not end the person's life was raised within the evidence presented to the jury, and this became a point of concern for several jurors."

She also said:

"By not addressing this question within the Bill, it allows doctors to exercise clinical discretion, however, it is arguably legally and ethically preferable to clarify the position and address public concern by including a clause that covers this problem."

I hope that is helpful.

I will end by referencing the hon. Member for York Central, who tabled amendment 440 and made the case very powerfully. She said that should the procedure fail, the need for record keeping is of significant importance,

[Danny Kruger]

as with all medical record keeping. I have already said that, but we cannot have too much of the hon. Member for York Central.

Stephen Kinnock: Amendment 380 is one that the Government have worked on with my hon. Friend the Member for Spen Valley. As the Bill currently stands, clause 22 sets out that where a person decides not to take an approved substance provided under clause 18 or where the procedure fails, the co-ordinating doctor must record that that has happened in the person's medical record or inform a registered medical practitioner with the person's GP practice. The amendment would require that in those circumstances, the voluntary assisted dying commissioner must also be notified.

I turn to amendment 440. As I have just mentioned, clause 22 provides that the co-ordinating doctor is required either to record in the person's medical records or inform a medical practitioner registered at that person's GP practice if the person has decided not to take the substance or the procedure has failed.

The amendment increases the requirements on the co-ordinating doctor to document in such cases any interventions made by a medical practitioner and the timing of those interventions. The requirement on the co-ordinating doctor to record interventions following a failed procedure is open-ended in time, which could lead to operational challenges. For example, the co-ordinating doctor would remain obliged to record the medical interventions made by others in response to the procedure failing, even if those interventions took place weeks or months after the event itself. I hope that those observations have been helpful to the Committee.

Kim Leadbeater: I have nothing to add, other than to say that the complications that have been referred to many times today would be covered by the code of practice that we will introduce by agreeing to amendment 430.

Amendment 380 agreed to.

Amendment proposed: 440, in clause 22, page 14, line 34, at end insert—

"(4) For the purposes of subsections (2) and (3)(b), the information recorded must include—

(a) any interventions made by a medical practitioner in response to the procedure failing, and

(b) the timing of those interventions."

—(Sean Woodcock.)

This amendment would specify certain information to be recorded under section 22 when the procedure fails.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 15.

Division No. 61]

AYES

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

NOES

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

Question accordingly negatived.

The Chair: The sitting is suspended until 7.55 pm.

6.37 pm

Sitting suspended for Divisions in the House.

7.55 pm

On resuming—

Clause 22, as amended, ordered to stand part of the Bill.

Naz Shah: On a point of order, Mr Dowd. I wish to apologise to you and to Committee members, as I now have to leave. This is not something I want to do, but I have to leave because my hearing aids will need recharging. Without them, I cannot hear. If I cannot hear, I cannot contribute to the scrutiny and the debate, as I would like to and as the Bill deserves. I have raised this issue repeatedly with the promoter of the Bill, my hon. Friend the Member for Spen Valley, and with the Committee, and it saddens me that I am unable to continue today. As Members know, I have chosen to give up a lot to make sure that I can contribute, especially during Ramadan, but hearing is not a choice for me. I want to be here for these hugely important discussions, and it is frustrating that I cannot because of my disability.

The Chair: Thank you for that point of order.

Clause 23

NO OBLIGATION TO PROVIDE ASSISTANCE ETC

Danny Kruger: I beg to move amendment 480, in clause 23, page 15, line 3, leave out subsection (1) and insert—

"(1) No individual is under any duty (whether arising from any contract, statute or otherwise) to be involved, directly or indirectly, in the provision of assistance in accordance with this Act.

(1A) In particular, no individual is under any duty (whether arising from any contract, statute or otherwise) to—

(a) provide information about assisted dying;

(b) participate in an initial discussion;

(c) participate in the request and assessment process;

(d) supply, prescribe or administer an approved substance;

(e) be present at the time of administration of an approved substance; or

(f) dispense a prescription of an approved substance.

(1B) Nothing in subsections (1) or (1A) of this section shall affect any duty to—

(a) signpost someone to where they can obtain information about assisted dying (under section 4(5) or otherwise);

(b) perform acts of a clerical, secretarial, or ancillary nature; or

(c) perform any acts necessary to save the life of or to prevent grave injury to a person."

This amendment would expand the provision of Clause 23(1) to all individuals and clarify the activities in which they are not obliged to participate.

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

Amendment 483, in clause 23, page 15, line 5, after "assistance" insert

", or in any activity closely related to the provision of assistance,"

This amendment would widen the range of activities which medical practitioners and other healthcare providers are not under an obligation to provide to include activities closely related to the provision of assistance under the Act.

Amendment 484, in clause 23, page 15, line 8, after "Act" insert

", or in any activity closely related to the provision of assistance under this Act,"

Amendment 441, in clause 23, page 15, line 9, at end insert—

"(3) There is no obligation on any care home or hospice regulated by the Care Quality Commission or the Care Inspectorate Wales to permit the provision of assistance under this Act on their premises."

This amendment prevents there being any obligation on a care home or hospice which is regulated in England or Wales to permit the provision of assistance under the Act on their premises.

Amendment 481, in clause 23, page 15, line 9, at end insert—

"(3) Nothing in subsection (2)—

(a) prevents an employer who has chosen not to participate in the provision of assistance in accordance with this Act from prohibiting their employees from providing such assistance in the course of their employment with that employer, or

(b) prevents an employer from specifying occupational requirements in relation to the provision of assistance in accordance with this Act in accordance with Schedule 9 of the Equality Act when hiring employees."

This amendment ensures that employees cannot provide assisted dying against the wishes of their employers and that employers can still rely, in appropriate cases, on the occupational requirements of the Equality Act to either require employees to provide or not to provide assisted dying.

New clause 22—*No obligation for occupiers and operators of premises*—

"(1) Any individual, business, organisation, or association who occupies or operates premises has the right to refuse to permit the self-administration of an approved substance on their premises.

(2) Nothing in subsection (1) confers any right on anyone with an interest in the land but who is not occupying or operating those premises."

This new clause would mean that the owners or occupiers of premises — but not landlords not currently in occupation — are not obliged to permit the self-administration of approved substances on their premises.

New clause 23—*No detriment for care home or hospice not providing assistance*—

"(1) No regulated care home or hospice shall be subject to any detriment by a public authority as a result of not—

(a) providing assistance in accordance with this Act, or

(b) permitting such assistance to take place on their premises.

(2) No funding given by a public authority to a regulated care home or hospice can be conditional on that care home or hospice—

(a) providing assistance in accordance with this Act, or

(b) permitting such assistance to take place on their premises."

This new clause would mean that regulated care homes and hospices cannot be subject to any detriment for not providing or permitting assistance in accordance with this Act, and that their funding cannot be conditional on them providing or permitting such assistance.

Clause stand part.

Danny Kruger: I rise to speak in support of my amendments 480 and new clause 22, and amendments 483, 484 and 441, tabled by the hon. Member for York Central. The conscience clause that is provided for in clause 23 is too narrow in two respects: first, in who it covers, and secondly, in what it protects. I will start with the issue of what it protects.

As drafted, the conscience clause protects against any duty to

"participate in the provision of assistance in accordance with this Act."

My concern is that, as written, and especially in the light of the amendments tabled by the hon. Member for Spen Valley to clauses 24 and 25, it is very likely to be interpreted as limited to the final act of assistance. The Committee does not need to take my word for it, because the British Medical Association said in its written evidence to us:

"we are concerned that using the word 'assistance' in the titles of Clauses 18 + 19 could be interpreted (by a court, for example) as narrowing the right to refuse in Clause 23(1). We would be very concerned if doctors only had the right to refuse to carry out the activities detailed in Clauses 18 + 19 which are the process of providing the approved substance for the individual to self-administer and remaining with the patient until they have died."

It goes on to say:

"We urge the committee to review the use of the word 'assistance' throughout the Bill; Clauses 18 + 19 might be better titled as 'Providing assisted dying' and 'Authorising another doctor to provide assisted dying', or similar, to avoid confusion over multiple uses of (and meanings associated with) 'assistance' in the Bill. It is essential that the right to refuse is not (unintentionally) narrowed in any way."

The BMA makes a powerful point and is clear that the conscience clause must cover not just the final act but the entire process, with the exception of the signposting duty in clause 4(5).

As Members will recall, the BMA opposed clause 4(5) as originally formulated, as it imposed a duty to refer if the original doctor did not want to participate in the assisted death procedure. The Royal Pharmaceutical Society makes a similar point in its further written evidence to us:

"We would urge the Bill Committee to make it clear that clauses on conscientious objection (23) and criminal liability (24) extend to all activities associated with assisted dying, and are not limited to a narrower interpretation of the 'provision of assistance'. Pharmacists, other health professionals , and indeed wider staff, should not unknowingly be involved in supporting an assisted dying procedure, directly or indirectly, without their consent."

I note that the promoter has tabled amendments to clauses 24 and 25 to make it clear that the exemption from both criminal and civil liability covers the provision of assistance under the Bill. Clause 23 also refers to assistance. Additionally, there is reference to a person "performing" any other function under the Bill. Clauses 24 and 25 cover liability, and refer to the provision of assistance and performing any other function under the Bill, but clause 23—the conscience clause—refers only

[Danny Kruger]

to the former: the provision of assistance. That will likely be interpreted by the courts as Parliament having intended a narrow construction of clause 23. As the expert medical bodies are telling us, that is not acceptable. Health professionals and indeed anyone else must be able to opt out of any functions under the Bill.

The Royal College of Psychiatrists found that 58% of its members would not be willing to participate as a medical professional in an assisted dying service, including determinations of capacity or assessments of mental disorder, if it became law in the UK. That is well away from the provision of assistance as we understand it from the Bill.

The Royal College of Nursing told us in written evidence that the protection of the conscience clause

"should extend to indirect involvement, such as administrative tasks or referrals, to ensure all professionals are supported in line with their personal and professional values."

There is widespread support among our medical institutions for a wide conscience clause that covers everything under the Bill and is not limited to the final act: the administration of the drugs.

The second issue is who benefits from the conscience clause. Clause 23 limits it to registered medical practitioners and other health professionals. A "health professional" is defined in clause 40 as:

"a) a registered medical practitioner;

(b) a registered nurse;

(c) a registered pharmacist or a registered pharmacy technician".

One set of professionals is omitted from that list: social workers. Under amendments 422 and 423 to clause 9, which we passed, social care professionals have a role in the process. The British Association of Social Workers, in its written evidence, said:

"social workers have duties in relation to both mental capacity and adult safeguarding, so it is concerning that legal protection in Section 23 of the Bill is given to healthcare professionals but not to social workers. All professionals that could potentially be involved with assisted dying, such as social workers, should be able to conscientiously object to participating in work that could reasonably be argued would be contributing to an assisted death."

I am sure that other professionals who may be called upon to give an opinion on matters pertaining to the processes in the Bill would feel the same way.

Members may be interested to know that the conscience clause in the Abortion Act 1967 simply says:

"no person shall be under any duty"

to be involved, rather than no registered medical practitioner, so there is a difference. The same goes for the conscience clauses under the Human Fertilisation and Embryology Act 2008. Baroness Meacher's 2021 Assisted Dying Bill also referred to a person rather than a registered medical practitioner, as did Lord Falconer's 2024 Assisted Dying for Terminally Ill Adults Bill, so I am not sure that the limitation to registered medical practitioners and health professionals can be justified. It is not the precedent from similar legislation.

My amendment addresses all those mischiefs and provides that the benefit of the conscience clause be for all individuals and not limited to health professionals. That accommodates the request of the Royal Pharmaceutical Society on the importance of protecting wider staff and the British Association of Social Workers. It also fits with the precedents that I have described in the Abortion Act and the Human Fertilisation and Embryology Act.

Kim Leadbeater: The hon. Member is making an important point. I would like to get it on the record that I agree with him: there should be no duty on any person to take part in the Bill's provisions if they choose not to, for whatever reason. I will struggle to support his amendment because there are other issues with it, but on that principle I wholeheartedly agree, and I would be happy to work with him in sorting it out, before Report, to that effect.

Danny Kruger: I am very pleased to hear it. I thank the hon. Lady for that. That helps me because I was perplexed about the difference. It is good to hear from her that there is no particular group of professionals who she thinks should not be included in the conscience clause. It is good to hear that she agrees with that. I would be interested to hear what her objections to the amendments are because, as I say, they simply bring this Bill into line with previous attempts to introduce assisted dying and with the Abortion Act and the Human Fertilisation and Embryology Act.

My amendments provide a non-exhaustive list of activities that would be protected. The list was roughly adapted from the legislation in Victoria, Australia, so I hope Members can see that I am following precedents from elsewhere. If amendment 480 is passed and the list is in need of refinement or drafting changes, I would of course be happy to work with the Government on a tidying-up amendment at a later stage. The amendment would ensure that all professionals—indeed, all individuals—are properly protected and would not become involved in assisted dying if they did not want to. None the less, it contains three exceptions, which I will briefly explain.

The first exception is to ensure consistency with clause 4(5), as amended. Members will recall that that clause imposed a duty on a doctor who did not want to have a preliminary discussion to refer the person to another doctor. We have amended the clause to now say that the doctor

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

The exception makes it clear that clause 23 cannot allow one to avoid that signposting duty. A person cannot say, "I am protected by this amendment from fulfilling the obligations under clause 4 to signpost somebody to where they can get the information they require."

The second exception concerns tasks of a clerical, secretarial or ancillary nature. The presence of that exception means that the Royal College of Nursing's demand for clause 23 also to cover administrative tasks is not fully met. I regret that I was not able to go that far, but I will explain why. In a 1989 case, Janaway *vs.* Salford Health Authority, a medical secretary claimed that the conscience clause under the Abortion Act meant that she was not required to type out a letter on behalf of the doctor she was working for, referring a patient for abortion. Both the Court of Appeal and the House of Lords, albeit for different reasons, concluded that such types of secretarial tasks were not protected by the conscience clause in the Abortion Act.

That decision was applied about 10 years ago in the Supreme Court case of Greater Glasgow Health Board *vs.* Doogan and another, in which it was held that the conscience clause did not protect an individual from having to carry out ancillary tasks such as managing the rota of a labour ward where abortions were performed. Interestingly, I note that in the Doogan case, the Royal College of Nursing took the view that the conscience clause should be narrowly interpreted, whereas for this Bill it seems to be asking for a wider exception that covers all administrative tasks.

Given that assisted dying is far more controversial than abortion among health professionals, I can see a case for a wider conscience clause in this Bill, but to maximise the chances that my amendments are accepted I have compromised and tried to match the precedent of the Abortion Act and the case law in Janaway. That is why the second exception is as it is. Again, if the drafting is not perfect and we can make improvements through a tidying-up amendment, I would be happy to work with the Government or the hon. Member for Spen Valley.

The third and final exception is for acts necessary to save someone's life or health. The need for that exception arises because no one is under any duty to be present when self-administration happens but, if things go wrong, emergency services or other help might be required. It is important that that help is provided; there should not be a conscience exception to it. I hope that exception is uncontroversial. Obviously, if somebody requires emergency help, we expect all medical professionals—all people—to jump to it. For the sake of clarity, there can be no exception under the amendment in those circumstances.

I sincerely hope that this amendment to the conscience clause, which reflects the requests we have had from the professionals who will have to deliver this service, will be accepted by the Committee. If it is not, I wish to indicate my support for amendment 483.

New clause 22, unlike my amendment to the conscience clause, is only about the final act. It makes it clear that the occupier or operator of a premise has the right to refuse its use for the final act of self-administration. That applies regardless of who the occupier or operator is; it is not limited to hospices, but it certainly includes them. So anybody occupying or operating premises should be able to determine that they may not be used for assisted dying services.

However, the new clause does not grant landlords or freeholders any right to insist that their property not be used. For example, the Church estates commissioners could not use it to prevent assisted dying from happening on land for which they own the freehold or land that they rent out. The same would be true of any other landlord, so if somebody lived in a rented property and wanted to die at home, this provision would not give their landlord any right to prevent that. It is instead focused on protecting the rights of those who occupy or operate premises. I hope I have explained the value of the new clause and the amendments.

Lewis Atkinson: Could the hon. Gentleman help us by giving some more examples of when the new clause would apply? For example, would it apply to supported housing schemes or nursing homes that are a person's normal place of residence and, indeed, home?

Danny Kruger: Those are the sorts of circumstances in which I envisage an occupier—namely, the manager or the organisation that provides the home—being entitled to state that assisted dying does not take place on their premises. I recognise that that is a challenge for individuals living there, but it is explicitly because they are living in a community of others, supported by members of staff, that it is important to acknowledge the rights of the community as a whole, and particularly the organisation or individuals responsible for overseeing the service. I am thinking explicitly of hospices or care homes, where many people end their days; it is imperative that we give the operators of care homes and hospices the explicit opportunity in law to state that they do not facilitate assisted dying on their premises.

I hope I have helped the hon. Gentleman to understand the circumstances in which this provision would apply.

Kit Malthouse: Are there other personal characteristics, beliefs or behaviours that my hon. Friend thinks those groups should be allowed to exclude?

Danny Kruger: Not really. It is within the rights of managers—particularly hotel managers or people who host a bed and breakfast—not to admit prostitution on their premises, even if it is legal. Although it is illegal to discriminate against particular groups, it is legal for the occupiers of premises, in certain circumstances, to determine that some activities will not take place on their premises. That reflects the rights of property, which are appropriate. Given that we are creating an entirely new legal event—something that has never been legal in our country before, namely the deliberate administration of death—it is appropriate to consider the impact on certain places where people live or will end their days, and to give those places a specific protection.

Kim Leadbeater: I am just trying to imagine what this would look like in reality. My own grandparents, for example, ended their days in a care home, and that was their home—that was where they lived, that was their address, and they paid to live there. If they had had a terminal diagnosis and had wanted to end their days in their home, having lived there for however long it was—four or five years—it would have felt incredibly cruel to expect them to go somewhere else to do something that was legal.

Danny Kruger: I am afraid that is right—I am not going to pretend otherwise. I recognise that, in those circumstances, it would be distressing for the individual who lives in the care home either not to have this new treatment—this service—or to go elsewhere to have it. I recognise that that would be an imposition on and an inconvenience for them, and possibly quite distressing. Nevertheless, I proposed the new clause to protect everybody else who lives in that community and the staff who work there. I did that specifically from the point of view of the conscience of staff; if an assisted death takes place in a premises, everybody is involved. The facilitation, the admission of the doctors involved and the support of the process is the responsibility of the occupiers of the premises—the management of the care home.

8.15 pm

The fact is that an assisted death would take place in everybody else's home. Think of all the other people who live in homes with the patients receiving an assisted death; they are also affected. This goes to the point that has run through our debates, which is the extent to which assisted dying does not just affect the individuals who receive it. There is a wider social context in which assisted death happens, and in which all death happens. Particularly when we are authorising professionals to play a role in the facilitation of this service, and when we are also obliging neighbours—in fact, housemates—to have the service provided in their home, we are right to suggest that the operator of the home should appropriately have a veto on that.

On the hon. Member for Spen Valley's suggestion about people who have made a particular care home their home in the last years of their lives, I would suggest that care homes that refuse assisted dying would make it very clear that they do not want to participate in it, and people who would like, or would consider that they might one day want, to have an assisted death would not choose those care homes. I recognise that this is difficult.

Tom Gordon: I completely understand where the hon. Member is coming from, but the reality is that although that may well be the case in urban areas, where there are lots of care homes and people can make that choice, in rural areas in particular terminally ill people might have to move to access an assisted death. Does he acknowledge the problem with that?

Danny Kruger: Yes, I do acknowledge the problem with that. My expectation would be—thinking about this in real human terms—that if somebody wanted an assisted death, and they wanted to do it in a particular care home, that would be a conversation they would have with the care home operator. The care home operator might have an absolute blanket objection, for lots of reasons we can imagine, but they might in certain circumstances recognise that Mrs Smith has lived here for some years and wants to have an assisted death, and that would be perfectly acceptable to the care home operator, other residents and staff—in which case, that is fine. To challenge the hon. Gentleman, he suggests that because one resident of the care home wants to have the service, the people who live with, and the staff who support, him or her should be obliged either to facilitate or to co-exist with this enormously impactful event that takes place in their space.

Kit Malthouse *rose—*

Danny Kruger: I will give way to my right hon. Friend, but I want to invite Committee members to recognise or consider evidence that I have heard, from the settings where assisted deaths take place in other countries, of the genuinely disturbing impact that an assisted death has on everybody involved, even those people who support the principle and support the act itself. It is not nothing when someone participates in the assistance of someone else's suicide, and I can well imagine that care home operators would be very wary of inviting assisted suicides to take place in their premises, not least because of the disturbing signal it sends to residents about the end that might occur for them.

Rachel Hopkins (Luton South and South Bedfordshire) (Lab) *rose—*

Danny Kruger: I am sorry; I was going to give way to my right hon. Friend.

Kit Malthouse: I am sure my hon. Friend did not mean to equate assisted dying with prostitution—I would not want anybody on social media to misinterpret what he said. I have been subject to that myself, and I want him to be clear of that.

I am intrigued by this notion. I fully appreciate and support the idea that individuals should be able to opt out from the process and not participate, but by what means would the view of these institutions be ascertained? Would it be the view of the management? My hon. Friend said that other residents might be disturbed, so will there be a residents' vote? How will these organisations come to a collective view? Practically, the Bill refers to individuals—it is an easy one for us that people do not have to participate; we have talked about the wider application of that and the hon. Member for Spen Valley says she is willing—but I do not understand how the collective view of the organisation would be reached.

Danny Kruger: I am grateful for my right hon. Friend's concern about my experience on social media. I referenced prostitution because he, or another Member, asked me in what circumstances it might be acceptable for an owner or occupier of a premises to specify activity that may or may not—

Kit Malthouse: A legal activity.

Danny Kruger: Well, I think prostitution is actually legal; it is the soliciting of it that is illegal—but others can correct me. The only thing that an owner or occupier of a premises is not allowed to forbid is activity that is covered by the Equality Act 2010 or other equality laws. There is nothing in the Equality Act or other laws to prevent an operator from exercising their right to deny assisted dying. My amendment would clarify that right.

My right hon. Friend asks how the collective will of the community would be ascertained. It would not be. I am proposing that the operator of the premises would have the right to determine whether assisted dying could take place there or not. I am suggesting that the likelihood with a care home is that the operator would, on behalf of residents and staff, say, "We're not doing that here." If they wanted to—if there was a pro-assisted dying care home—it would then be a question for residents and staff whether they wanted to live or work there.

I am simply attempting to insist on the right of property—or the right of occupation, I should say, because it is a question not just for the freeholder but for the occupier of the premises. In the case of a house or a business premises, that would be the tenant. Whoever operates the business or the activity of the premises should have the right to conclude that they are not going to have assisted dying in their premises.

Sojan Joseph: Does the hon. Member think it might be even harder for faith-based organisations, such as the Institute of Our Lady of Mercy, which submitted

written evidence? It is an organisation run by the Sisters of Mercy, a Roman Catholic religious group. Would those organisations find what the hon. Member is talking about even harder?

Danny Kruger: I thank the hon. Gentleman for that intervention, because that is exactly the sort of organisation that I would expect to have an objection to assisted dying taking place in its premises. He invites us to consider the alternative to the amendment, which is that there should be an obligation on a care home provider to facilitate an assisted death if somebody wants one. That would mean, in the case of a care home run by the Sisters of Mercy, that a resident could insist on their right to have an assisted death in a care home that is staffed by people who have strong moral objections to that treatment and that is inhabited by other residents who are also deeply uncomfortable with it taking place in their home.

I implore Committee members to expand their scope beyond the single individual who would be the subject of the application, and to consider the community they live in.

Sarah Olney: Would it not be easier for workers in care homes and other institutions who have a conscientious objection to assisted dying to apply to work in a place where they know it is not going to happen, as opposed to needing to exercise their right to conscientiously object every time it comes up? Is that not a reason to support the amendment?

Danny Kruger: The hon. Lady is absolutely right. We have heard so many professionals convey their concerns about the Bill. The majority of medical professionals who work with the dying—care workers, palliative care specialists and hospice staff— oppose assisted dying, and it is not right to ask them to take a job knowing that they might be called on to witness, if not directly facilitate, assisted death. My other amendment speaks to the whole range of activities that can lead to an assisted death, not just the provision of assistance at the end. It is important that that amendment is accepted too. The hon. Lady is absolutely right: it is important for staff to have that protection. The amendment tabled by my hon. Friend the Member for Reigate speaks to that as well, and would address that concern. I think we are going to hear from her as well, so that is enough from me.

Rachel Hopkins: It is a pleasure to serve under your chairship, Mr Dowd.

I am very sympathetic to the views put forward by my hon. Friend the Member for Spen Valley about people being able to conscientiously object in principle, but the way amendment 480 is written is difficult. For me, it is about the word "indirectly". That could lead to even more ambiguity that would make it more tricky to facilitate the provision. For example, trying to list some activities but not all of them has potentially left some gaps. A gardener in a care home might be "indirectly" linked—will they be able to say that they are not going to mow the lawn? We will get ourselves in a difficult place, and I would welcome further work being done to recognise the point the hon. Member for East Wiltshire is trying to make, because of that ambiguity.

Trying to establish a point of principle in new clause 22 could lead to some difficulties. It reads:

> "Any individual, business, organisation, or association who occupies or operates premises has the right to refuse to permit the self-administration of an approved substance on their premises."

Perhaps it is about the interpretation of that and how we read it, but any individual who occupies a premises could refuse permission. Does that mean that a husband could deny a wife the opportunity to die at home when that is where she has been treated for a terminal illness, where all her help has been administered and where she would like to die? Again, it is about whether the drafting might have unintended consequences when we want to have compassion and choice for the individual at the heart of the Bill.

Similarly, could an organisation or association with shared ownership of a property—a form of tenure that many people now have—object to this route for someone who is after all in their own home, as they own part of it? There are some difficulties in the new clause, and by trying to establish one principle, it is making things more difficult and open to challenge. We are trying to make law that is good, even if we do not agree with it.

Danny Kruger: On the hon. Lady's first point, about the gardener refusing to mow the lawn, the activities that an individual will be allowed to opt out of are clearly specified in the amendment and they are the activities covered under the Bill. It is not about unrelated activities connected with the premises but the provision of assistance—not just at the end but all the way along. I hope that is clear.

On her second point, again we have—

The Chair: Order. Perhaps the hon. Gentleman might wish to pick up these points when he winds up later on.

Rachel Hopkins: I—

Kim Leadbeater: If my hon. Friend will give way, in response to the point made by the hon. Gentleman, the drafting of "directly or indirectly" does worry me—

The Chair: Order. This is an intervention on the hon. Lady, not on the hon. Gentleman. Who are you referring to?

Kim Leadbeater: I am speaking to my hon. Friend. The point she raised about "directly" and "indirectly" is a very good one, and subsection (1A) says "In particular", which is not exclusive. That lack of clarity and certainty concerns me; does she agree?

Rachel Hopkins: I appreciate the interventions, because we are trying to get the best clarity we can for dying people. Are we debating the other amendments in this group, Mr Dowd?

The Chair: It is a debate on the whole group, yes.

8.30 pm

Rachel Hopkins: Okay. I will carry on.

[Rachel Hopkins]

Some of the amendments were tabled by the hon. Member for Reigate, and I want to speak to amendment 481, which is of a similar ilk. There is no obligation on an employer to provide assistance, and we are all absolutely bought into that, so that is not a bad thing. Amendment 481 would avoid preventing

"an employer who has chosen not to participate in the provision of assistance…from prohibiting their…employees from providing such assistance in the course of their employment with that employer".

I have some questions on that. People's working lives are varied and often they may not have just one employer, so there is a slight ambiguity—I hope the Committee will bear with me—if employer A exercises a right to prohibit under the amendment, and someone works for employer A but also for employer B, which is okay with people participating in a legal act under this legislation. Let me provide a bit of clarity with the example of a locum doctor. If a doctor is employed by employer A, but also does some locum work for employer B, does that mean that employer A could say the doctor was not permitted to carry out legitimate employment for employer B?

Rebecca Paul: I thank the hon. Lady for raising that question. No, that would not be the case, because the amendment specifically says "with that employer", so it links only to employer A. I think the wording is very clear that the situation that the hon. Lady is concerned about should not arise.

Rachel Hopkins: I thank the hon. Lady for her response, but I think it made my point: I interpreted it slightly differently from the way the hon. Lady intended. I would welcome some clarity on that from the Ministers and lawyers in the room.

Similarly, I was interested in the point regarding the genuine "occupational requirements", and how that is written and interpreted. There are reasons for

"specifying occupational requirements in relation to the provision of assistance in accordance with this Act in accordance with Schedule 9 of the Equality Act when hiring employees"

but that occupational requirement means that an employer could discriminate on the basis of a protected characteristic, if that requirement is essential for the job and

"a proportionate means of achieving a legitimate aim".

I am a little concerned as to the interpretation. In respect of which protected characteristic would they or would they not be recruiting? We need some legal input to clarify that, because we cannot make assumptions about people's protected characteristics, particularly in recruitment.

Rebecca Paul: It is really helpful to have these questions. I would, of course, defer to the Ministers, as they will be best placed to answer that. However, I suspect the characteristic would be belief. We are trying to ensure that if a hospice has a policy of not providing assisted dying, it is not in a situation where it has employees who are not aware of that at the outset and then want to provide it—or conversely, the opposite situation. All we are trying to do is make sure we match the right employees with the right hospices, clinics and services provided, so that we avoid these issues as they come down. It is a well-intended amendment.

The Chair: Order. It is getting late, and I completely accept that we need to explore these areas, but if Members want to intervene, I exhort them, yet again, to keep their interventions very brief. If, on the other hand, Members want to pick these points up when they make a speech, they should feel free to do that. But please keep interventions short and to the point or question.

Rachel Hopkins: I thank the hon. Member for Reigate for her intervention. In the light of her comments, it seems the amendment may be trying to put on the face of the Bill some nuances that should be picked up through employment law. I understand the principle of what she is trying to achieve, but there are protections in those areas.

Sean Woodcock: Will my hon. Friend give way?

Rachel Hopkins: I am conscious of the Chair's comments, so I am going to proceed, because I want to make a final point about new clause 23. I am sympathetic to its principles, as I recognise that some institutions may not want to provide assistance. This new clause, however, relates solely to no detriment for care homes or hospices for not providing assistance. As my hon. Friend the Member for Sunderland Central pointed out, there are a variety of settings, such as sheltered accommodation, warden-controlled accommodation, hospitals or other regulated premises, to which this would apply. We might therefore, in this new clause, be putting some institutions on the face of the Bill but leaving a whole bunch of others to fall through the gaps. So again, there are difficulties with the new clause, even though there is an element of it to which we might want to be responsive.

Rebecca Paul: Before I get into my speech, I thank the hon. Lady for her useful questions, as it is important to explore these issues. I will talk in more detail about new clause 23, but I would happily expand its provision, if that would make her happy.

I wish to speak to amendment 481 and new clause 23 in my name. I welcome clause 23, which makes it clear that no registered practitioner or other health professional is under any duty to participate in the provision of an assisted death. I believe, however, that it can be further bolstered by the amendments that my hon. Friend the Member for East Wiltshire has spoken to, including my amendment 481 and new clause 23.

The amendments concern a practical issue that would face hospices and care homes from day one of the legislation coming into force—namely, how they can continue to operate effectively with a huge diversity of views among staff members. We will all remember Sarah Cox's oral evidence to the Committee. She cited a 2023 Royal College of Physicians survey in which 43% of Association for Palliative Medicine members said that

"if assisted dying were implemented within their organisation, they would have to leave."

Dr Cox said that if this Bill became law, it would have

"a massive impact on palliative care, in terms of its potential to develop both our funding and our workforce, who are really concerned about this."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 70, Q83.]

In written evidence, the Association for Palliative Medicine said:

"The APM recognises the importance of organisations also being able to conscientiously object to involvement in assisted dying. This is essential for the organisation and also for healthcare professionals choosing where to work with their conscience. By not having robust conscientious objection at all levels, the Bill risks imposing harm on health or social care practitioners, violating their autonomy and risking an exodus of skilled and valuable health and social care practitioners."

There will be many people in the sector who support and want to participate in assisted dying, but it is likely that some institutions and organisations will want to have a clear policy of not providing assisted dying. Some nurses, doctors and other professionals will want to work only in that kind of organisation. Either we carve out a space for them, or we risk losing some very dedicated people from end-of-life care.

I am trying, through amendment 481, to carve out that space. It allows an employer—a hospice, for instance—that has a blanket policy of not offering or supporting assisted dying to require their employees to adhere to their policy. My amendment clarifies that clause 23(2) does not make blanket policies impossible to enforce: a care home or hospice can prohibit its employees from participating in the provision of assisted dying. They can still believe whatever they want to believe, but it sets out clearly what is expected if they are employed in those premises.

Kit Malthouse: I have just two quick questions. First, I am intrigued to know how my hon. Friend imagines these organisations would reach this collective view. Secondly, if they could reach a collective view, should they still be able to deny what is a legal service, if they are in receipt of public funds?

Rebecca Paul: I am slightly confused about the collective view. That will be done in the same way that any policy is come to. When a company is making a decision about their policies, vision and values, that normally involves directors around a table deciding what that will be. I do not really see any difference in how the decision is made. It is not a vote. It is not about going around and surveying everyone who uses the service—although some of that might feed into what they take into account—but they will make the same decision about this policy as they would about any other policy. Obviously, it will be quite an important conversation for them to have. For some groups, it will be very obvious and fairly easy to identify the groups that may have an issue with it. Equally, there will be other groups where it is known that they are going to be comfortable with it.

I think my right hon. Friend asked me another question. I do not know if he wants to intervene in relation to public funds—

Kit Malthouse: In receipt of public funds—

The Chair: Order. If Members wish to stand up and intervene, feel free, but this is not a dialogue across the Committee between two or three Members.

Kit Malthouse: Let me remind my hon. Friend—first, she is saying that the views of, say, the residents count for little compared with the views of the directors, but my second question was whether she believes these organisations should be able to discriminate in that way, even if they are in receipt of public funds.

Rebecca Paul: Yes, I believe that they should be able to discriminate in that way, and I believe their public funds for palliative care should remain consistent and unchanged in spite of whatever decision they make on that front.

Danny Kruger: Does my hon. Friend agree that just as we are specifying that an individual who is in receipt of public funds—a public employee, a medical professional—is allowed to decline to participate in this service, institutions in receipt of public funds should be able to do likewise? Many institutions receive public funds for specific purposes and they are perfectly entitled to decline to take part in other activities. Just because they are in receipt of public funds does not mean they should do anything that any member of the public requests of them.

Rebecca Paul: I completely agree. We are giving the same courtesy and rights at organisation level as we do to individuals. I know that the Committee is very supportive of that position for individuals, so I question why it would not be the same for organisations.

Sean Woodcock: I understand where the hon. Lady is trying to come from with this, but I am not convinced that management of employee behaviour, such as going against policy set out by a hospice or an institution, should be in the Bill. I am struggling to get my head around the idea that that is what we should be policing. Will she explain why that should be included compared with the standard way a hospice would manage staff who had gone against their policy on any other aspect of their daily duties?

Rebecca Paul: We are just giving clarity; we are making it clear that it is reasonable and legal for an organisation to have a policy to not provide assisted dying and therefore to require its employees to respect that. All we are doing is protecting that employer from cases of discrimination, and so on, and it is really important to give that clarity. Again, I am looking forward to hearing the views of Ministers on the technicalities of this. The aim and the intention of the proposals is to avoid the problems that we will inevitably see if we do not make this clear up front. We are trying to ensure that we match the right people to the right clinics and hospices to avoid these difficulties where an employee wants to provide it but the hospice does not, and vice versa.

Kit Malthouse: In the interest of symmetry, if I work for one of these organisations and it takes that decision, can I conscientiously support it? We are saying that at an organisation that allows it, staff can conscientiously object. If there is an organisation that conscientiously will not allow it, can I conscientiously support it as an employee, or am I automatically fired?

Rebecca Paul: We are saying that when an employee is employed by the hospice or the clinic, they are employed to deliver services as directed by the employer. I think the answer is that if an employer is really clear that they do not want to offer a service, an employee should not have a right to then offer the service that the employer

[Rebecca Paul]

does not want to offer. It is like saying, "We are a shop that sells sofas, but I have this employee who wants to sell an oven. I'm worried I will end up in court if I do not allow them to sell an oven." It is a perfectly reasonable ask for employees to respect what the employer wants to do on this matter, and I am trying to put that clarity in the Bill. As I say, we will save no end of issues down the line if we are really clear on this now.

8.45 pm

Kim Leadbeater: This is a very interesting point. I am slightly concerned about the equality and human rights issues in terms of the patients and terminally ill people, as well as the staff—that relates to the point that the right hon. Member for North West Hampshire just made. I do not know whether the hon. Member has done any research into gay marriage and whether there were similar issues there, because I imagine that when that was brought into law, there may have been similar issues. Does the hon. Member know how that was addressed?

Rebecca Paul: The answer is no, I have not done any research on that, so I cannot comment. Following this sitting, I will look into it, because the hon. Lady raises a very interesting point. This comes back to the eloquent explanation from my hon. Friend the Member for East Wiltshire that, on the one hand, there is the autonomy—we want to make sure the patient has what they need, and we are all sympathetic to that—but we must also recognise that there is an impact on others. It is about trying to weigh that up and get the balance right. I do not think it is reasonable that patients' autonomy overrides everyone else. We have to think about the impact on everyone else too, and that is what these proposals try to do. I am trying to get the balance right. That is why I welcome the debate, because it is never quite clear where the line should be, so it is good for us to have this conversation.

Amendment 481 is intended to answer the BMA's request for such a carve-out. In written evidence, the BMA says of clause 23 that

"there would need to be scope for some exceptions to allow, for example, an assisted dying service to only employ people willing to actively participate in the provision of assisted dying, without falling foul of this provision."

Presumably this freedom would apply in both directions.

My amendment allows any institution or organisation, whatever its stance, the scope to set its policy and bind its employees accordingly. This also works in favour of those institutions or organisations that want to offer assisted dying. It ensures that they can make sure that they do not employ a load of people who are against assisted dying. Would you want Danny Kruger working in one of those organisations? Sorry, Mr Dowd—I meant my hon. Friend the Member for East Wiltshire. I am just saying that it benefits both sides.

Danny Kruger: I am not objecting to that suggestion. No one would want me working in any sort of clinical setting. I just wanted to emphasise my hon. Friend's point, and that speaks to the point from my right hon. Friend the Member for North West Hampshire about the symmetry. Her amendment would enable a service like Dignitas, or the equivalent to be set up in the UK, to ensure that it only employed workers who supported the work that they were doing, and there would not be some sort of fifth column of objectors coming in to cause trouble. That could happen. We worry about all sorts of things happening in the context of this Bill in future. It would at least ensure that people who worked in an assisted suicide clinic would actually support the procedure.

Rebecca Paul: I apologise to my hon. Friend; I probably should not have used him as an example in that way—it is getting late. I actually think that this clause would benefit more those organisations that support assisted dying. It would ensure that they have the right people who support it working in there. We want patients to get the support and everything that they need.

Rachel Hopkins: The hon. Member is referring to the genuine occupational requirement, but I go back to my point: which protected characteristic is she talking about? Support for assisted dying is not a protected characteristic. I am intrigued to know how that would operate in practice.

Rebecca Paul: I go back to my previous comment: I suggest that belief would be the protected characteristic.

Rachel Hopkins: I respect that. I have been very clear about my beliefs, but I know people who share my beliefs and do not support assisted dying, and vice versa; I have friends who are religious and do support assisted dying. Again, we cannot make assumptions about people's protected characteristics.

Rebecca Paul: I do not think we should make the mistake of thinking belief is necessarily religious. I do not adhere to any faith, but I have beliefs about certain things that are protected—those beliefs are protected, and they do not necessarily have to relate to a religion. We are getting philosophical now!

Kit Malthouse: Technically, as we established earlier, cancer is a disability and therefore a protected characteristic, so under the law, anybody who has cancer cannot be discriminated against by an organisation that is offering services to the public.

I want to make a wider point. The point we are trying to make about the amendments is that very few people will move into these organisations and live in them in the expectation that they will get a terminal disease. They will move in in their twilight years, whether it is an almshouse or a care home, for retirement purposes or other reasons—

The Chair: Order. I have asked Members several times today to make their interventions short. They are not mini speeches. If Members want to make a speech, they should indicate that by bobbing.

Rebecca Paul: I thank my right hon. Friend and am sure I will come to his point.

I echo what my hon. Friend the Member for East Wiltshire said about the definition of "assistance" in clause 23. If this legislation is to genuinely respect the

preferences of doctors and other professionals, it is essential that "assistance" is read as including the matters in amendment 480 covering non-medical practitioners, too. I support that amendment, and what I am going to say is based on its definition of "assistance".

My amendment, it is important to say, works both ways. A care home or hospice can state that all employees must be willing to assist. We agreed to amendment 341, which allows individuals to opt out on conscience grounds. My amendment 481 gives institutions and organisations the same latitude. It opens the way to three kinds of institution: those that provide assisted dying as a matter of policy, those that will not provide it as a matter of policy, and those with no fixed policy, where some employees will assist and some will not. All those different approaches should be respected and supported.

The legal basis for this is found in schedule 9 to the Equality Act 2010, which allows an employer to specify a "genuine occupational requirement". A company can require a particular protected characteristic, as long as it is a work-related requirement and the requirement is a proportionate means of achieving a legitimate aim. The Equality and Human Rights Commission gives an example: a humanist organisation that promotes humanist philosophy and principles would probably be able to apply an occupational requirement for its chief executive to be a humanist. In this case, an organisation providing end-of-life care and with a blanket policy in either direction would not be found in breach of the Equality Act's protection of beliefs. In healthcare, there is the obvious precedent of abortion. The British Pregnancy Advisory Service, as an abortion provider, is allowed to specify that employees must support its position.

Without this amendment, we are looking at a legal and ethical minefield. If a hospice has a policy of helping with assisted dying requests and a staff member refuses to refer a patient to a doctor, can that staff member be sacked, or are they protected by clause 23? Surely we want to avoid the situation arising in the first place, by ensuring that employers can make clear their requirements on this front at the hiring stage.

Conversely, what if a hospice has a policy of not participating in assisted dying? Many hospices may want to have such a policy, to reassure their patients on this front and provide a safe space for those who need it. In written evidence, Rowcroft hospice says:

> "Some patients may fear discussing pain and suffering in case assisted dying is suggested as an option."

According to an article in *Annals of Palliative Medicine*, this is a major concern in Oregon. One nurse is quoted as saying:

> "there's all this advice about how to get information on Death with Dignity…already there is an attitude among many of our clients that 'if I go into hospice, they're going to kill me because that's what a hospice does'".

Likewise, a healthcare professional in Australia is cited in one study as saying:

> "It's affecting us in palliative medicine, more than we would like and more than it should because of the assumption that because we specialise in end-of-life care therefore, this is for us. And so, the general perception amongst medical practitioners, the health community and the general public is that this is our thing. And so, for a lot of us, we're saying, no, this is not our thing."

Clearly, some hospices will want to have an explicit policy that assisted dying is not their thing, and they should have the right to do that. But what if an employee at that kind of hospice wants to help a patient with the assisted dying process? What if, for instance, a hospice doctor volunteers to do one of the assessments? That will obviously compromise the hospice's policy, but are they in breach of the Equality Act 2010 if they only hire doctors who share that institution's view of assisted dying? Again, without my amendment, it is not clear what the law allows. Amendment 441, in the name of the hon. Member for York Central, has a similar aim and would further clarify the legal position for institutions, so I am glad to support that, too.

This kind of institutional opt-out is, I believe, standard practice in US states that have adopted assisted dying. California's law includes the following provision:

> "a health care entity may prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating under"

this legislation

> "while on premises owned or under the management or direct control of that health care entity or while acting within the course and scope of any employment by, or contract with, the entity."

There is also a good model in New Zealand, where the High Court has ruled that institutions can opt out. Hospice New Zealand, the organisation representing all hospice services in the country, sought a declaratory judgment because of exactly the kind of confusions that I have described. In its judgment, the High Court of New Zealand agreed that the ambiguity about institutional opt-outs was

> "causing confusion amongst those involved in palliative care and more generally."

The Court found that New Zealand's assisted dying law

> "does not require hospices or other organisations to provide assisted dying services. They are entitled to choose not to provide these services. This does not depend on a hospice or other organisation having a conscientious objection, although that may often be the reason…Hospices or other organisations that choose not to offer assisted dying services may employ or engage health practitioners on the basis that these services are not provided by the hospices or organisations".

As a result, New Zealand hospices can set their own policy on whether to provide assisted dying. Sinéad Donnelly, professor of palliative care at the University of Otago, says that this judgment has proved very helpful to the hospice sector:

> "this has proven pivotal in retaining staff at hospices, many of whom would no longer be willing to work there if the assisted dying doctor or nurse practitioners were given access to the hospice to end a patient's life."

Dr Siwan Seaman, a hospice doctor, says in written evidence:

> "I have liaised with a Medical Director of a hospice in New Zealand…The Medical Director in New Zealand believed that without the organisation-level conscientious objection that the hospice movement in New Zealand would have been under even more strain and look very different now."

Dr Seaman says that if we want the quality of palliative care provision across England and Wales to continue to improve,

> "the bill has to be amended to allow specialist palliative care services such as hospices to be separated from assisted dying processes."

Kim Leadbeater: I think it is fair to say that the evidence from New Zealand is mixed. One family said that the final few precious hours of their mum's life

[Kim Leadbeater]

were mostly filled with stress and distress, as they had to scurry around to move her out of her so-called home. Does the hon. Lady agree that there are different views and opinions about the New Zealand model?

9 pm

Rebecca Paul: I have real sympathy for that situation, because no one wants to see that. That is why it is really important to be clear up front. I would like care homes and hospices to be clear with their policy, so that when people make decisions about where to have their care or where to live, they can take it into account. I totally recognise that in the situation we have, if the Bill went through in two years' time, there would be some people who were already settled in care homes where they did not know the policy, because it was not relevant at the time they moved in. I totally take the point that there are downsides to the provision, but it is important to include it to get this right in the long run.

I hope Members will agree that amendment 481 seeks to make it easier for hospices and other institutions to deliver on their policy, whatever it may be, by ensuring that they can require their employees to comply. It would also leave space for palliative care to flourish by not imposing burdens on people who work in the sector.

Let me turn to new clause 23. I have talked about one challenge for the hospice sector, but it is not the only challenge. The past few years have been a challenging time, given the rising cost of living and rising demand for hospice services. Hospices play a vital role in local communities by providing high-quality, compassionate care at the end of life, and I pay tribute to their work. They face huge financial pressures that put their essential work in jeopardy and could lead to unprecedented closures.

In oral evidence, Dr Cox said:

"The first thing to say is that palliative care is currently inadequate. Not only do we need to ensure that it does not decline, but we need to massively improve it so that this Bill offers patients a real choice. We know that effective palliative care can change a terminally ill person's point of view from wanting to die to wanting to live.

We also know that 25% of people who die in this country do not have the palliative care they need. That is more than 100,000 people a year. Providing palliative care, which might make their lives better, reduce their suffering and even change their perspective on whether they would want assisted dying, should be our priority in reducing suffering in this group."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 70, Q84.]

I also remind the Committee of what Dr Clarke said:

"There are hospitals, and mine is one currently, where we do not even have a 24/7 palliative care service face to face. Every night in my hospital, and every weekend from Friday to Monday, you cannot see a palliative care nurse or doctor, despite the fact that for a number of years that has been an NHS standard. That is an absolute disgrace and it shows how little people who are dying are truly cared for in a civilised society.

It does not necessarily have anything to do with assisted dying, except that if we do not address that simultaneously, some of those people will "choose" to end their life, because we as a society do not care about them enough to give them the care that might make life worth living. Surely that is a travesty for Britain."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 76-77, Q94.]

I remember being quite moved when she said that.

Although we are limited in what can be done through the Bill to rectify funding for palliative care, we can ensure that it is not further impacted detrimentally by the introduction of assisted dying. New clause 23 seeks to protect hospices from further funding pressures arising specifically from the Bill, because there is a risk that public funding becomes dependent on offering assisted dying. The new clause would ensure that public authorities could not make funding conditional on the provision of assisted dying, and could not subject care homes or hospices to any other detriment merely on the grounds that they do not permit such assistance to take place on their premises.

The new clause reflects a serious concern in the hospice sector. St Gemma's hospice in Leeds warns in written evidence:

"If compliance with assisted dying provision becomes a condition for NHS funding, institutions like St. Gemma's may have no alternative but to cease operations entirely given its reliance on NHS funding for its financial sustainability. Such closures would have devastating consequences for the communities we serve, eliminating high-quality palliative and hospice care options for thousands of terminally ill patients annually. If patients in our catchment area could not be cared for by St Gemma's, this would, at a minimum, reduce the degree of choice for many and put at risk the availability of palliative care across large parts of the city. Patients would be admitted to hospital or would die at home in a way that is difficult to reconcile with the palliative care ethos of choice, quality of life and quality of dying. This would increase demand on a health and care system that is already under unprecedented pressure, leading to devastating outcomes."

That is a real possibility, as shown by the fate of the Irene Thomas hospice in British Columbia. It was known as a sanctuary for dying people who did not want to be in a setting offering assisted dying, but the province adopted a policy that required hospices to provide assisted dying if they had over 50% funded beds. After the hospice board voted not to offer assisted dying, its 1.5 million Canadian dollars of public funding was cut, its clinical staff were laid off and it was taken over by the regional health authority.

We should be honest about the possible threat to palliative care. This is a much-debated subject, so I will lay out in some detail the evidence that assisted dying may be detrimental to palliative care. It is true that the Health and Social Care Committee concluded that palliative care did not deteriorate where assisted dying was introduced, but a recent report by Professor David Jones looked at the issue more forensically and found:

"This conclusion, however, was based on the selective evidence that the Committee received from respondents, much of which was irrelevant, outdated, or speculative. In contrast, a more complete review of better and more recent evidence shows 'clear indications in several jurisdictions of palliative and end-of-life care deteriorating in quality and provision following the introduction of AD / AS, and a negative impact on some healthcare professionals.'"

In his study, Professor Jones found that some of the evidence on which that Committee based its conclusions was highly unreliable. For instance, it was partly based on Canada committing to spend 6 billion Canadian dollars on palliative care and home care over 10 years at the time that assisted dying was legalised. The money was not ringfenced, however, so five years later, only 184 million Canadian dollars could be shown to have been allocated to palliative care. Other evidence was also out of date. For instance, Belgium's spending on palliative care was cited, but that covered only 2002 to 2011, and that spending appears not to have been sustained.

In his lengthy analysis, Professor Jones cites a wealth of evidence for his conclusion. He examines the data and finds that, between 2012 and 2019, European countries without assisted dying increased palliative care provision more than three times more than countries with assisted dying. Between 2015 and 2022, Belgium, Canada and the United States fell out of the top quartile in the world ranking for quality of death and dying, while the United Kingdom remains in first place. Between 2015 and 2019, the number of palliative care teams in hospitals increased by 3.2% in US states with assisted dying, but by 9.4% in non-assisted dying states.

Clearly, there is a competition for resources between palliative care and assisted dying. In 2023, for instance, New South Wales cut spending plans by 249 million Australian dollars after increasing palliative care spending.

Kim Leadbeater: The hon. Lady is making some interesting points, but I am not entirely sure that they are within the scope of the amendments.

Rebecca Paul: I thank the hon. Lady for keeping me on track. These points are important because I am setting out the importance of protecting the hospice sector, which is what these amendments seek to do. I am setting out the context that hospices currently face, and the challenges that they will potentially face if assisted dying is implemented, so that the importance of the amendments is clear—I am nearly there, Mr Dowd.

When there was an outcry, the Premier of New South Wales told the press that one reason for that cut in spending was assisted dying. His Government had to find 98 million Australian dollars to pay for the voluntary assisted dying regime, because the previous Government had introduced it without funding. In oral evidence, Dr Cox said that

"although palliative care services have improved in those countries where assisted dying has been implemented, they have improved three times more in countries where assisted dying has not been implemented. The evidence from that study shows that the implementation of assisted dying is impeding the development of palliative care services."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 70, Q83.]

Jack Abbott: This issue came up in the oral evidence sessions. Assisted dying has not been introduced in this country, but very few people would say that palliative care has improved in the 10 years since the House last voted on assisted dying. As I said in the oral evidence sessions, I am not sure that that comparison is directly relevant to what we are debating.

Rebecca Paul: Technically, our palliative care can be described as world leading, but we would all agree that much more is needed.

Jack Abbott: Only technically.

Rebecca Paul: It is in the top quartile. That does not mean it is good enough—not by any stretch—but I would prefer not to see it fall down.

Jack Abbott: I think the point that the hon. Lady is trying to make with her statistics is that palliative care has improved in the countries that have not had assisted dying, but I do not think anybody can quantifiably say that palliative care has improved in this country even since the last such debate we had in 2015. I am not quite sure how that comparison holds water in relation to what we are debating.

Rebecca Paul: I am just making the point that palliative care has deteriorated in jurisdictions that have introduced assisted dying. Therefore, we need to bear that in mind for this country if assisted dying is introduced.

This is also about competition for time and resources. One palliative care provider in Ontario has been cited as saying that

"when a patient is requesting MAID [Medical Assistance in Dying], most of the resources have been sucked up by that one case and it's all everyone's talking about and they're rushing to get stuff done…everyone from admin down to the bedside nurse is focusing on MAID…And all of the high-quality palliative care that we do falls by the wayside for the other patients."

One academic study found that

"in Ontario, some palliative care nurses were tasked with administration and co-ordination of MAiD which has been taking up an increasing proportion of their roles—to the point that nurses have left their jobs because they were not able to provide palliative care."

In oral evidence, Dr Cox also said:

"It is unclear how this is going to be funded. It looks as if it is going to be within healthcare, and if so, there will inevitably be competition with other aspects of healthcare, including palliative care, for those limited resources. There are finite numbers of doctors, nurses and side rooms in hospitals. If palliative care and assisted dying were funded from the same pot, I think there would be a massive detrimental effect on palliative care because we would be in competition for a limited resource."—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee,* 28 January 2025; c. 70, Q83.]

I have outlined this at length—I thank Members for their patience—because how we vote on these amendments could have enormous consequences for the palliative care sector. At the moment, it is world-leading, but that does not mean there is not huge room for improvement or that it will not be affected by the same pressures as in other jurisdictions. Amendment 481 would institute a common-sense change that the British Medical Association has suggested. New clause 23 would protect the sector from unintended consequences and unfair funding cuts. I urge Members to support both.

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

9.12 pm

Adjourned till Wednesday 19 March at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

TIAB 424 Steven Illingworth

TIAB 425 Dignitas

TIAB 426 Michael Romberg

TIAB 427 Peter Scott

TIAB 428 Institute of Our Lady of Mercy (Sisters of Mercy)

TIAB 429 Dr Amanda Harlow MBChB, specialist doctor in substance misuse

TIAB 430 Professor Emyr Lewis, Emeritus Professor, Aberystwyth University (supplementary)