

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

TERMINALLY ILL ADULTS (END OF LIFE) BILL

Twenty-fourth Sitting

Tuesday 18 March 2025

(Morning)

CONTENTS

CLAUSES 13 TO 17 agreed to, with amendments.

CLAUSE 18 under consideration when the Committee adjourned till this day at Two o'clock.

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

not later than

Saturday 22 March 2025

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The Committee consisted of the following Members:

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

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

Public Bill Committee

Tuesday 18 March 2025

(Morning)

[ESTHER McVEY *in the Chair*]

Terminally Ill Adults (End of Life) Bill

9.25 am

The Chair: Will everyone ensure that all electronic devices are turned off or switched to silent? Tea and coffee are not allowed in the Committee Room.

We are continuing line-by-line consideration of the Bill. I remind Members that interventions should be short and raise points of clarification or questions; they should not be speeches in themselves. Members who wish to make a speech should bob and continue to do so through the whole debate in which they wish to speak, until they are called. When Members say “you”, they are referring to the Chair. “You” should not be used to refer to one another; the debate should be through the Chair.

Clause 13

CONFIRMATION OF REQUEST FOR ASSISTANCE: SECOND DECLARATION

Amendment proposed (12 March): 457, in clause 13, page 9, line 17, after “made,” insert “and have not voluntarily stopped eating and drinking”.—(*Sarah Olney.*)

Question again proposed, That the amendment be made.

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

Amendment 471, in clause 13, page 9, line 27, leave out from “if” to “that” in line 28 and insert “the coordinating doctor is satisfied (immediately before witnessing it)”.

This amendment removes wording which would suggest that a second declaration is made before it is witnessed.

Amendment 316, in clause 13, page 9, line 36, at end insert—

“(5A) If, when making the statement under subsection (5), the definition of “second period of reflection” under subsection (2)(b) applies, the coordinating doctor must make refer the person for urgent specialist palliative care.”

This amendment will ensure that there is an immediate referral to a specialist in palliative care due if the patient is likely to die within a month of the declaration from the Court.

Amendment 374, in clause 13, page 10, line 2, at end insert—

“(8) Where the coordinating doctor has—
 (a) witnessed a second declaration, or
 (b) made or refused to make a statement under subsection (5),
 the doctor must notify the Commissioner and give them a copy of the second declaration or (as the case may be) any statement under subsection (5).”

This amendment requires the coordinating doctor to notify the Commissioner of witnessing a second declaration, and of having made or refused to make a statement under clause 13(5).

Naz Shah (Bradford West) (Lab): As we heard from the hon. Member for Richmond Park, her amendment concerns the second period for reflection under the Bill as drafted. The second period of reflection would take place after the panel had approved a person’s application for assisted death. The Bill states that that period would be 14 days, unless

“the coordinating doctor reasonably believes that the person’s death is likely to occur before the end of the period of one month beginning with the day that declaration was made”;

in that case, the second period is shortened to 48 hours.

Some people who have a strong desire to hasten death might wish to avoid the second period for reflection. If they refused food, there would be a strong possibility that their physical condition would deteriorate, so that a doctor would indeed believe that they were likely to die within one month. That is not a hypothetical possibility. We know that there are people who do refuse food to the point where they become gravely ill with malnutrition.

The right hon. Member for North West Hampshire said something that I think is relevant here. He was asking questions of a witness before this Committee, Professor Nicola Ranger of the Royal College of Nursing, on 28 January. To quote *Hansard*, the right hon. Gentleman said:

“At the moment, within palliative care and palliative nursing generally, you are already dealing with patients who are electing to refuse treatment, food and water, or are supporting patients following an advance directive.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 59, Q70.]

On the same day, the right hon. Gentleman said something similar to another witness, Dr Sarah Cox:

“I want to pursue that point a little with you, Dr Cox. My understanding is that your profession is already taking these decisions, or supporting patients to take these decisions—for example, the withdrawal of ventilation for an MND patient towards the end, or if I decide to decline treatment or food and water to end my life as quickly as I can.”—[*Official Report, Terminally Ill Adults (End of Life) Public Bill Committee*, 28 January 2025; c. 74, Q91.]

In other words, it is not some remote possibility that patients who are already ill may decide to refuse food. That is one thing I hope that the right hon. Gentleman and I can agree on. We also know from the survey undertaken by a group of specialists in eating disorders that, in countries that have assisted dying laws, at least 60 people have qualified for assisted death because they suffered advanced malnutrition.

Some people who are seriously ill and who wish, in the words of a psychiatric witness, to “hasten death”, may see the 14-day period as intolerable. An alarming possibility is that they might stop eating in order to worsen their physical condition and qualify for the 48-hour period. Amendment 457 would remove that possibility. I strongly recommend that hon. Members support it.

People would qualify for a shortened period for reflection only if they

“have not voluntarily stopped eating and drinking”.

That word “voluntarily” is important. I understand the reason that the Bill’s drafters included a provision for a shorter, second period of reflection, but as with much of the rest of the Bill, I am sorry to say that I do not think that they have provided strong enough safeguards. This is a well drafted amendment that would tighten those safeguards. I urge Members to support it.

Danny Kruger (East Wiltshire) (Con): I will speak briefly to amendment 316 in the name of the hon. Member for York Central (Rachael Maskell). She has tabled a sensible suggestion that if a patient makes a statement after the second period of reflection, there should be an automatic referral to palliative care. We have heard how expected and usual that is anyway, and the hon. Member for Spen Valley has frequently made the point that people who are having an assisted death, or going through the process, are likely to be in palliative care anyway—it is not an either/or. It is important that we clarify that expectation.

It will obviously be the case that the patient is not required to take up the referral, and if the referral already exists, that case is dealt with, but let us be absolutely clear that the decision to take an assisted death is not a fork in the road, as would be my concern. If that is not the case and that, in fact, palliative care and the assisted death process go hand in hand and will be seen as part of an integrated package of support for patients, my view is that we should specify clearly that in the event of a decision to proceed down the road to an assisted death, a palliative care referral should be made.

Bluntly, I want to make this as clear as we can, although I am not sure that we will ever be able to do that fully. It really has to be very plain to healthcare commissioners and managers that there is to be no cost saving as a result of an assisted death referral. I very much doubt that a single commissioner or manager would have that at the forefront of their mind; nevertheless, incentives apply in healthcare decisions. Ultimately, we have a ration system, and resource allocation necessarily is the job of commissioners.

If, as we are saying, a decision to proceed with an assisted death will be in parallel with palliative care, let us make that plain, so that if indeed it is the case that the patient requires the investment of palliative care services—hospice treatment or otherwise, even though, as we know, hospice care is inadequately funded through public money—nevertheless, there is a resource requirement. It is important that we specify to everybody in the system that an assisted death is not a way of avoiding the expense of proper end-of-life care.

I hope that Members will recognise that amendment 316 is consistent with the arguments that have been made consistently by advocates of the Bill, which is that there is not an either/or between palliative care and assisted death, and that, in fact, it is appropriate for patients to be on both tracks simultaneously.

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

The purpose of amendment 457 is to exclude a person who has less than one month to live from being eligible for the shorter second period of reflection of 48 hours if that person has voluntarily stopped eating and drinking. That person would instead be required to comply with a second period of reflection of 14 days under clause 13(2)(a). The amendment could create uncertainty as to the required length of the period of reflection. It is unclear, for example, if “voluntarily” would include where someone’s appetite has naturally declined as they approach the end of life, and therefore whose decision to stop eating or drinking may not be deliberate.

As I have said previously, the Government have worked with my hon. Friend the Member for Spen Valley on certain amendments to bolster the legal and workability sides of the Bill, and the purpose of amendment 471 is to clarify that the co-ordinating doctor needs to be satisfied that, immediately before witnessing the second declaration, the criteria set out at subsection (4) are met, and not at any time before. That also ensures consistency with the duty on the co-ordinating doctor in respect of the first declaration.

Amendment 316 would require that where the co-ordinating doctor reasonably believes that the person seeking assistance has less than one month to live from the court declaration, they must refer that person for urgent specialist palliative care. As the referral must be made whether the patient wants that referral or not, this may result in unwanted referrals. The effect of this amendment is unclear.

As drafted, clause 13(2)(b) sets out that where the person’s death is likely to occur within one month, the period of reflection is then 48 hours. Amendment 316 sets out that the referral to urgent palliative care must be made alongside the co-ordinating doctor making the statement, which is the last step to be completed before the provision of assistance under clause 18. That would mean that in some circumstances, there may be insufficient time to make a referral before the person is provided with assistance to end their life.

Kit Malthouse (North West Hampshire) (Con): I want to emphasise that at the moment the patient reaches that point, they will have had their palliative care options explained to them extensively, under the Bill, and it is highly unlikely at that point, as my hon. Friend the Member for East Wiltshire said, that anyone would not be in receipt of palliative care, given the very late stage of their disease.

Stephen Kinnock: I happened to be at a hospice in Stafford yesterday on a ministerial visit and was extremely impressed by the work that the hospice staff were doing on family counselling, and advice and engagement both with the patient and family and loved ones, so the right hon. Gentleman is right that the hospice sector, among others, plays a vital role in that holistic engagement with patients throughout the process.

Amendment 374 requires that the co-ordinating doctor must notify the voluntary assisted dying commissioner where they witness a second declaration and where they make or refuse to make the supporting statement under clause 13(5), and that the commissioner must be provided with a copy of the second declaration and any statement. I hope that those observations were helpful to the Committee.

Kim Leadbeater (Spen Valley) (Lab): It is a pleasure to serve under you this morning, Ms McVey. My amendments 374 and 471 serve to clarify that the second declaration must be made before it is witnessed—it is a drafting amendment—and to bring clause 13 in line with the reporting requirements elsewhere in the Bill. For the functions of the commissioner to be carried out effectively, including supervising the assisted dying panels and making annual reports on the legislation’s operation, it is essential that all relevant details and reports are made available.

[Kim Leadbeater]

I am unable to support amendment 457, in the name of the hon. Member for Richmond Park. As I said when we started discussing the amendment, I do not fully understand why it has been positioned at this stage in the process. The shorter period of reflection is a recognition that a person's death is expected within a month, so they literally have a few weeks left of life.

Sarah Olney (Richmond Park) (LD): That was the hon. Member's response when I made my speech on the amendment in the previous sitting. I have reflected on that over the weekend. I still think that the issue of the voluntary stopping of eating and drinking is a very serious one that ought to be reflected somewhere in the legislation, but she is correct that, at this particular point, we are talking about the second period of reflection already being at an end, so it cannot be hastened in any way by such a measure. Therefore, I will be withdrawing the amendment.

Kim Leadbeater: I appreciate that; that is helpful and I thank the hon. Member. As the Minister said, a person whose death is approaching may have stopped eating and drinking for a number of reasons. They may simply be too ill. They may be unable to digest food. It may be that they have lost their appetite, or that they will be even more ill if they eat and drink, so it would seem particularly cruel to intervene on that basis at that point, but I appreciate her comments.

Amendment 316 in the name of my hon. Friend the Member for York Central seeks to mandate the action a doctor must take if a patient is likely to die within one month. Like other amendments, it goes against the basic principles that underlie the Bill—that the wishes of the person seeking assistance should be respected. Surely that is even more important than ever as they face their final weeks. As the right hon. Member for North West Hampshire said, palliative care will have been discussed at length throughout the assisted dying process. It is also worth noting, as the hon. Member for East Wiltshire said, that evidence from other jurisdictions with similar laws—Australia and America—shows that between 80% and 90% of people who have gone through the assisted dying process are already receiving palliative care, so I am not minded to support the amendment.

Sarah Olney: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendments made: 207, in clause 13, page 9, line 20, leave out “Schedule 4” and insert

“regulations made by the Secretary of State”.

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

Amendment 470, in clause 13, page 9, line 26, at end insert—

“(3A) Regulations under subsection (3)(a) must provide that a second declaration contains—

- (a) the following information—
 - (i) the person's full name and address;
 - (ii) the person's NHS number;
 - (iii) contact details for the person's GP practice;
 - (iv) specified information about the certificate of eligibility;

- (b) the following further declarations by the person—
 - (i) a declaration that they have made a first declaration and have not cancelled it;
 - (ii) a declaration that they understand that they must make a second declaration in order for assistance to be provided under this Act;
 - (iii) a declaration that they are making the second declaration voluntarily and have not been coerced or pressured by any other person into making it;
 - (iv) a declaration that they understand that they may cancel the second declaration at any time.

In this subsection “specified” means specified in the regulations.”

This amendment provides that regulations about the form of a second declaration must make the provision mentioned in paragraphs (a) and (b).

Amendment 471, in clause 13, page 9, line 27, leave out from “if” to “that” in line 28 and insert

“the coordinating doctor is satisfied (immediately before witnessing it)”.

This amendment removes wording which would suggest that a second declaration is made before it is witnessed.

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

“regulations made by the Secretary of State”.

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

Amendment 472, in clause 13, page 9, line 41, at end insert—

“(6A) Regulations under subsection (6)(a) must provide that a statement under subsection (5) contains—

- (a) the following information—
 - (i) the person's full name and address;
 - (ii) the person's NHS number;
 - (iii) the coordinating doctor's full name and work address;
 - (iv) specified information about the certificate of eligibility;
- (b) the following declarations by the coordinating doctor (in addition to a declaration that they are satisfied of all of the matters mentioned in subsection (4)(a) to (d))—
 - (i) a declaration that they are satisfied that a certificate of eligibility has been granted in respect of the person;
 - (ii) a declaration that the second declaration was made after the end of the second period for reflection;
 - (iii) if the second declaration was made before the end of the period mentioned in subsection (2)(a), a declaration that they have the belief mentioned in subsection (2)(b);
 - (iv) a declaration that they are satisfied that neither the first declaration nor the second declaration has been cancelled.

In this subsection “specified” means specified in the regulations.”

This amendment provides that regulations about the form of a statement under subsection (5) must make the provision mentioned in paragraphs (a) and (b).

Amendment 374, in clause 13, page 10, line 2, at end insert—

- “(8) Where the coordinating doctor has—
- (a) witnessed a second declaration, or

(b) made or refused to make a statement under subsection (5),

the doctor must notify the Commissioner and give them a copy of the second declaration or (as the case may be) any statement under subsection (5).”—(*Kim Leadbeater.*)

This amendment requires the coordinating doctor to notify the Commissioner of witnessing a second declaration, and of having made or refused to make a statement under clause 13(5).

Clause 13, as amended, ordered to stand part of the Bill.

Clause 14

CANCELLATION OF DECLARATIONS

Kim Leadbeater: I beg to move amendment 375, in clause 14, page 10, line 9, at end insert—

“(1A) Where notice or an indication is given to the coordinating doctor under subsection (1)(a), the doctor must as soon as practicable notify the Commissioner of the cancellation.”

This amendment requires the coordinating doctor to notify the Commissioner of a cancellation of a first or second declaration.

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

Amendment 376, in clause 14, page 10, line 12, after “doctor” insert “and the Commissioner”.

This amendment requires a practitioner other than the coordinating doctor to notify the Commissioner (as well as the coordinating doctor) of a cancellation of a first or second declaration.

Clause stand part.

Kim Leadbeater: I hope that these are a couple of nice, simple amendments. The right of the patient to cancel at any time is obviously really important. It is also important that, for the purpose of monitoring and reporting the process, the commissioner, as proposed, is kept informed at every stage. I hope that the whole Committee can see the necessity of these amendments.

Danny Kruger: The hon. Lady is quite right that there is nothing to object to in these amendments or the clause. It is worth stating at this point, though, that in the context of the debate we are having in this Committee, we are moving at some pace. The likelihood is that there will be opportunity for only a five-hour debate on Report—maybe more, but possibly not. This Committee is the time we have to consider in detail the content of the Bill. My concern is that moving too quickly and trying to do too much too soon means that we will miss the opportunity to debate very important aspects of the Bill.

The hon. Lady says that these are “nice, simple” amendments, as if the only thing being discussed here is the paperwork around the declaration. What should we say to patients who decide to cancel their declaration? My concern—I am unaware of any other point when we could appropriately discuss this question—is what happens in the event of a cancellation. What duty of care do doctors have to patients who have decided not to proceed with an assisted death? The Bill does not currently address that question: it imposes no obligation on doctors to follow up in any way after a declaration has been cancelled.

9.45 am

As ever, I absolutely agree that, as hon. Members will no doubt be thinking in response, doctors have a duty of care to patients. Nevertheless, we are talking about a new procedure that sits in an uncomfortable hybrid state between healthcare and non-healthcare. We have special rules and procedures around the particular intervention being designed here. We are still ignorant of the precise mechanisms by which healthcare professionals, and potentially others, will be involved in the administration of this process. What exactly happens in the event of a cancellation? Perhaps the promoter could explain her understanding of what the expectation should be on the providers who have been responsible for supporting the patient up to that point. If amendment 316, which would have made a palliative care referral automatic, had been accepted, we could have had some reassurance that other doctors were there to pick the patient up.

Kit Malthouse *rose*—

Danny Kruger: Before I give way to my right hon. Friend, I want to posit the hypothesis of a private provider that has been established explicitly for the purpose of facilitating the assisted death procedure for patients. If that provider steps back when the patient decides to cancel their declaration, the provider is required to notify the GP as soon as practicable, whatever that means—the timeframe there is clearly at the convenience of the provider, not the patient. My concern is what happens when the patient’s GP is not quickly informed that they have decided not to proceed with the assisted death and they are sitting in limbo. Obviously, there are significant concerns about their wellbeing, given their decision and the state they are in. It is not yet fully clear to me what the obligations on the doctors would be at that stage.

Kit Malthouse: I am not entirely certain that my hon. Friend’s remarks are germane to the amendments, but nevertheless. As we discussed when debating clause 13, at the stage he is talking about, the patient will have had all their options—“all appropriate”, as I think we have amended the Bill to say, services that will be available to them—explained to them. If they are cancelling, the presumption has to be, in respecting their autonomy, that they are choosing one of the alternative paths that has been laid out to them. It is quite hard to legislate for a negative.

Danny Kruger: I am speaking to the group as a whole, which includes clause stand part. I have no objection to the amendments. My right hon. Friend is absolutely right. As I said, the expectation is that the medical professionals involved in the person’s care will have laid out their options clearly. We are to a certain degree trusting in that because amendments to insist on it have been rejected, although I recognise that it will be the clear expectation. He is right that it is hard, as it were, to prove a negative.

Nevertheless, the purpose of my speech at this point is to tease out from the advocates of the Bill what their expectation is. My right hon. Friend has clearly explained his expectation, which is that we are dealing with somebody whose mind is clear, rational, uncluttered by other concerns and entirely free of any undue influences or

[*Danny Kruger*]

anxieties about the different choices they might make. Having previously decided in the fullness of their autonomy that they wanted to go through the procedure, they have now decided in the fullness of their autonomy that they want to do the opposite, and we should say, “Fine. We have no further interest in your decision making. It is your choice—you’re on your own.” I am very concerned about the implication of my right hon. Friend’s comments about the sorts of patients who might be involved in the process of assisted dying.

Kim Leadbeater: To allay those fears, perhaps the fundamental answer to the question is that those people do not stop being patients—sadly, they do not stop being terminally ill patients. They have just chosen to cancel the declaration, and they will already have wraparound care. To some degree, the hon. Gentleman answered his own question when he said that doctors have a duty of care. That duty of care does not stop because the person has chosen to take this course of action. They will still be cared for by the professionals looking after them.

Danny Kruger: Well, we certainly hope so. Nevertheless, that is inconsistent with the doctrine of absolute patient autonomy, which in this circumstance allows a patient to withdraw from the medical treatment, or at least from the support of the medics who had been facilitating their assisted death. They are rightly under no obligation to receive any other sort of care.

Of course, one would assume that in most cases medics will be closely involved in looking after these patients, because they are likely to be very ill. Nevertheless, the Bill has nothing more to say about patients who have just stepped back from the brink of suicide; the medics will have no further obligation to ensure that they will be looked after—except by the GP, as soon as it is practicable for the provider who has just been denied the business of looking after the assisted death to get round to emailing them. If that is seen as sufficient to ensure that those patients will be properly looked after, I beg to differ.

Kit Malthouse: I am not sure what compulsion there is in wider legislation for there to be a duty of care to patients who do not choose assisted dying in the first place. For thousands and thousands of patients who die, there is no legislation that imposes certain duties on medics or others to look after them; we rely on the professional standards and overall atmosphere of the healthcare system, as we would in the case of these patients.

As my hon. Friend knows, overseas experience shows that a large proportion of the people who obtain the right to an assisted death—up to a third—do not cancel but do not exercise it. As we have said before, for many people assisted dying is an insurance card that they may choose to use if and when they think their life becomes intolerable.

Danny Kruger: I recognise that, but that is not germane to the debate that we are having, which is about the actual cancellation. There is a question about why there would have been a cancellation. My right hon. Friend is right that there is no obligation to proceed once a

patient passes a particular hurdle. Many will not, but when someone decides actively to renounce their decision, a big question should be asked: what is going on, and what further help is needed?

My right hon. Friend suggests that we do not step in and ensure that care is provided—that, in other circumstances, there is no additional obligation in relation to patients. I am afraid to say that he has, as ever, a coldly rationalistic vision of healthcare and of the sorts of patients we are dealing with. As I have said to him, these patients will be acting much as I imagine he would imagine—I think from a position of health and self-confidence—himself acting in that circumstance. In fact, we are dealing with people who have decided to renounce their decision to proceed, and so are by definition in some turmoil.

I crave the indulgence of the Committee, because I am talking at length about a set of amendments that I do not intend to oppose, and I recognise the value and necessity of the clause. However, I draw to the Committee’s attention that we are dealing not simply with a bit of paperwork, but with a human being who, having made one enormous decision—to die—is now making an enormous decision to live, and we are treating it as if it is only a bureaucratic question.

I finish with a question to the hon. Member for Spen Valley or to the Minister, to help me understand something that confuses me in the clause.

Naz Shah: I have not given this matter as much thought as the hon. Member has. My interest is very much in the issue of domestic violence. Does he agree that this could be somebody who has experienced domestic violence? Or children could be at risk. This person may then decide not to take the option, even though they wanted to, because of obligations elsewhere.

Danny Kruger: The hon. Lady is right, and her point goes to the question that runs through all of these clauses: why? As a Committee, we rejected the obligation on the doctors to ask, “Why are you doing this?” It was suggested by one hon. Member that it was nobody’s business why somebody was trying to take their own life and that if that person qualified, they should be able to summon the agents of the state to provide them with lethal drugs without any question about their motivation.

I agree with the hon. Lady. There is an equal expectation in my mind that doctors should ask the question, “Why are you changing your mind?” I would expect that. The clause could clarify what further referrals would need to be made, if they had not already been; as we have acknowledged, we would expect appropriate care to be provided by doctors anyway.

I conclude with a factual question. Clause 14(1) lets a patient cancel a first or second declaration, but subsection (4) says only that the duties of the doctor stop when a first declaration is cancelled. I would be grateful if the hon. Member for Spen Valley would explain what happens if the patient cancels a second declaration. It strikes me that there would be a need for urgency because if a patient decides to change their mind at that point, that is arguably a more dangerous situation. What would be the obligations on the doctor at that point? Should we read across from subsection (4) that their duties stop in the same way? Perhaps that could be clarified in later drafting, if necessary.

To conclude, my general point is that the issue of a cancelled declaration is about more than the paperwork. Although, of course, we respect the autonomy of a patient to make their own decision to cancel a declaration—obviously, I would insist that that right should be in the Bill—it nevertheless raises a question in my mind: why is that happening, and what should we expect the patient’s medical team, or others, to do in that circumstance?

Stephen Kinnock: The Government have worked with my hon. Friend the Member for Spen Valley on amendments 375 and 376. The amendments require that where the co-ordinating doctor, or any registered practitioner from the person’s GP practice, receives a notification or indication from the person seeking assistance under the Bill that the person wishes to cancel their first or second declaration, the doctor or practitioner must inform the voluntary assisted dying commissioner as soon as practicable. Where a registered practitioner from the person’s GP practice has received a notification or indication from the person to cancel their first or second declaration, they must also inform the co-ordinating doctor. I hope those observations are helpful to the Committee.

Kim Leadbeater: I repeat what I said earlier about what will happen to the patient if they choose to cancel: their care will continue. From a medical practitioner perspective, it is inconceivable that those patients would be abandoned, as the hon. Member for East Wiltshire is suggesting. That would not happen.

I understand that cancellation of the second declaration does not need to be included in clause 14(4) because of when in the process it would happen. The first declaration comes much earlier, so clauses 7 to 9 would be applicable; the second declaration comes further down the process, so does not need to be included. However, I am happy to look at that in further detail and come back to the hon. Member on that, if necessary.

Amendment 375 agreed to.

Amendment made: 376, in clause 14, page 10, line 12, after “doctor” insert “and the Commissioner”.—(*Kim Leadbeater.*)

This amendment requires a practitioner other than the coordinating doctor to notify the Commissioner (as well as the coordinating doctor) of a cancellation of a first or second declaration.

Clause 14, as amended, ordered to stand part of the Bill.

Clause 15

SIGNING BY PROXY

Daniel Francis (Bexleyheath and Crayford) (Lab): I beg to move amendment 321, in clause 15, page 10, line 33, at end insert—

“(d) the reason why the person was unable to sign their name.”

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

Amendment 431, in clause 15, page 11, line 1, leave out paragraphs (a) and (b) and insert

“the donee of Lasting Power of Attorney for Health and Welfare decisions, who has the ability to give or refuse consent to life-sustaining treatment, as registered with the Office of the Public Guardian.”

This amendment would restrict proxies to donees of Lasting Power of Attorney for Health and Welfare decisions, including to give or refuse consent to life-sustaining treatment.

Amendment 473, in clause 15, page 11, line 3, leave out from “person” to end of line and insert

“of a description specified in regulations made by the Secretary of State.”

This amendment provides that persons of a description specified in regulations (rather than persons “of good standing in the community”) may be proxies.

Amendment 253, in clause 15, page 11, line 3, at end insert—

“(6) For the purposes of this section “declaration” includes the cancellation of a declaration.”

This would allow a cancellation of the first or second declaration to be signed by a proxy.

Clause stand part.

10 am

Daniel Francis: It is a pleasure to serve under your chairship, Ms McVey. Amendment 321 will mean that the proxy’s declaration must also include the reason why the person was unable to sign their name. That would add a vital safeguard for the person and for the proxy.

In this Committee, we have consistently discussed the need to safeguard vulnerable people from being coerced into choosing assisted dying; for those who need a proxy, the risk of coercion might be higher. As the Bill currently stands, the person needs to tell only their proxy the reason why they are needed. I would like to make it clear why the amendment is important. The Bill does not currently specify that the patient’s declaration of the reason for needing a proxy has to be heard by anyone other than the proxy themselves.

I am conscious that, since my amendment was tabled, my hon. Friend the Member for Spen Valley has also tabled amendments about the relationship and who the proxy could be, but I do not believe that amendment 321 would be a burden or cause any unnecessary complication. As the Bill currently stands, when a proxy signs the declaration they already have to include their full name and address, the capacity in which they qualify, and a statement that they have signed in the capacity of a proxy.

As we have said before, it is vital to safeguard vulnerable people at every stage of the process; adding the reason why the proxy was required allows other people during the process, including if there were allegations later, to understand why that was required. If the first declaration is signed by a proxy, then the co-ordinating doctor—the independent doctor—would be able to examine that reason, so including the reason for someone being unable to sign their own declaration would improve transparency around the process. I hope that hon. Members will agree that we need to be able to monitor how those requests are made and the reasons that people are giving.

In written evidence, several experts raised the importance of collecting good data to ensure that the assisted dying process is properly monitored, and amendment 321 would assist that; I believe that it would protect both vulnerable patients and proxies. I absolutely appreciate and understand that people may have a very good reason for requiring a proxy—if they are very ill during the process, for example. The amendment would simply mean that, if there were to be concerns or allegations at a later stage, the reason why the proxy was required would be written down.

Kim Leadbeater: My hon. Friend is making a really sensible point and a fair argument, and I am very happy to support the amendment.

Daniel Francis: I welcome my hon. Friend's acceptance of the amendment, and I think she sees the point behind it. It was meant not to be awkward—I do not think I have been at all awkward during this process—but simply to state that, if there were concerns later, the reason why the proxy was required should be there in a transparent way. I commend amendment 321 to the Committee.

Danny Kruger: I am grateful to the hon. Gentleman and I very much support his amendment; it is good to hear that the Bill's promoter, the hon. Member for Spen Valley, will as well. The hon. Member for Bexleyheath and Crayford has made his points very powerfully, and it is good that we are in agreement.

I also support amendment 431, tabled by the hon. Member for York Central, which would restrict proxies to donees of lasting power of attorney. The point is that somebody who has been through the process of taking on power of attorney has been properly vetted and approved; they are required to demonstrate their fitness for the role and undertake a meaningful duty of care to the person for whom they are a proxy. That strikes me as an appropriate suggestion from the hon. Lady.

Amendment 411, tabled by the hon. Member for Broxtowe, suggests that the phrase "a person who is of good standing in the community" should be deleted. I think she is absolutely right to suggest that. I made the point on Second Reading that—

Kim Leadbeater: Will the hon. Member give way?

Danny Kruger: I think the hon. Lady is about to say that her own amendment addresses that point.

Kim Leadbeater: My point was that I think amendment 411 has been withdrawn.

Danny Kruger: Is that the case? I apologise.

The Chair: I will double check.

Danny Kruger: Okay. I am grateful to the hon. Member for Spen Valley, if so. I regret it, because I think amendment 411 had a good suggestion. It would have been my preference if we were just amending the provision, although removing the whole question of a proxy might be the safest thing. Nevertheless, if we are proceeding with the proxy arrangement, it strikes me as dangerous to include a person of good standing in the community. While it sounds like an old-fashioned and sonorous expression, as if it has genuine meaning and recognition, I do not think it is an acknowledged concept and does not appear in English law much, if at all. It obviously begs the question of what on earth it means, and who is to determine who is of good standing.

I labour the point even though the amendment might have been withdrawn, because amendment 473 in the name of the hon. Member for Spen Valley proposes to delete that phrase and give the responsibility for who the proxies could be to the Secretary of State. That is another important instance of a running flaw in the Bill, and particularly the amendments tabled in Committee,

which is the transferring of important decisions beyond the Committee and Parliament to the Government and the Minister of the day.

That matters, because we are trying to ensure that when the Bill passes—if it passes—it is safe, but a blank space is being left on the important question of who can determine who the proxies are. The proxies have enormous power to do the paperwork and to answer the questions—to essentially act on behalf of the patient who, in the scenario envisaged, would be silent. It matters who the proxy is.

The decision of the hon. Member for Spen Valley is not to resolve that question here in Committee but to pass it on to a future Minister. My concern is that the same ambiguity or openness that is currently in the Bill about this person of good standing—a serious-sounding but actually vacuous concept—could be replicated in the regulations specified by the Secretary of State.

I am worried about where we are going here. Instead, I wish that we could restrict the proxy to somebody known to the patient, without the inclusion of the person of good standing or, if we are to do without that phrase and imagine that there will be other criteria and other individuals judged appropriate to be the proxy, that we had the will to determine that now. The hon. Member for Spen Valley, working with the Government, may well have concluded that they did not have enough time to come up with such a list or to think through the various complications involved in deciding who the proxy should be. Again, if that was the case, I regret the pace at which we are moving. I do not see why the decision has to be delayed until the Secretary of State comes up with a plan in a couple of years' time and why it is not being resolved in the Bill now.

The Chair: I confirm that amendment 411 has been withdrawn. I see no other Members bobbing; I call the Minister.

Stephen Kinnock: Amendment 321 would require a proxy to record, when signing the declaration on behalf of the person, the reason why the person they are acting as a proxy for is unable to sign their own name. The recording of the reason may make the use of a proxy more transparent. It may also assist others involved in the scrutiny of the process to understand why a proxy was used.

Amendment 431 seeks to restrict who can be a proxy under the Bill to attorneys with a lasting power of attorney, or LPA, for health and welfare decisions—that is, those people who are able to consent to or refuse life-sustaining treatment. The amendment raises significant practical issues. First, not everyone has an LPA. Secondly, where a person has made an LPA, they will have decided whether to give the attorney the authority to refuse or consent to life-sustaining treatment. That is not automatic and means that not all attorneys would be able to meet the eligibility requirement of the amendment. Thirdly, the Mental Capacity Act 2005 enables an attorney to exercise power under an LPA only if and when someone has lost capacity.

Kit Malthouse: Does the Minister agree that, unfortunately, my hon. Friend the Member for East Wiltshire seems to be labouring under the misapprehension that there is some reputational test in becoming an attorney? In truth, I can appoint anybody I want to be

my attorney. There is no verification or otherwise until there is some form of dispute around the exercise of the power of attorney. In fact, the regulations may mean that we have stronger verification of the bona fides of the person who is a proxy than we would have through the LPA route.

Does the Minister not also find it slightly sad that, given the type of Conservative I know my hon. Friend the Member for East Wiltshire is, he thinks the concept of being of good standing in society is somehow meaningless?

Stephen Kinnock: I am not a lawyer, but thankfully I am sitting next to a very eminent and distinguished one—my hon. and learned Friend the Member for Finchley and Golders Green—who has confirmed that everything the hon. Member for East Wiltshire said was correct from a legal standpoint, so I shall leave it at that.

Clause 15(5) of the Bill defines a proxy as

“(a) a person who has known the person making the declaration personally for at least 2 years, or

(b) a person who is of good standing in the community.”

Amendment 473 would remove subsection (b) from the definition of proxy, instead introducing a regulation-making power to specify the persons who may act as proxy. That would avoid any ambiguity around the meaning of a person who is of good standing in the community and retain flexibility to amend the specified list in regulations.

Danny Kruger: Will the Minister confirm that the Secretary of State could simply reintroduce that ambiguous term at their own discretion? If they are being given the freedom to decide who can be a proxy, they might decide that it should be a term of equal ambiguity. My right hon. Friend the Member for North West Hampshire is absolutely right that I have great respect for the concept of “standing”; nevertheless, I do not believe that the Government have yet been able to define exactly what that means. Does the Minister agree that there is still the opportunity for ambiguity? We are just leaving it completely blank at this stage and hoping that some future Secretary of State will have more clarity than we do.

Stephen Kinnock: I would not want to pre-empt the regulations, because clearly that is the point of the process. If this Bill gets Royal Assent, we then move on to making regulations, and I have confidence in the good offices of parliamentary counsel, legal advice and the drafting process. I absolutely agree with the hon. Gentleman, however, that the purpose of those regulations must be to remove ambiguity, not to increase it. I am confident that the system will produce regulations that address his concern.

Kim Leadbeater: Does the Minister agree that it will be on the record that we have had this conversation, and that many of us—including myself—have expressed our concerns about the concept of good standing in the community? I would like to think that that will be taken into consideration.

Stephen Kinnock: I am acutely conscious that every word we say in this Committee is on the record. My hon. Friend makes a valid point in that context.

The purpose of amendment 253 is to clarify that a person acting as a proxy can both sign and revoke a declaration on behalf of a person seeking assistance under the Bill. This amendment would extend the provisions under clause 15 to a person who is acting as proxy to the person seeking assistance under the Bill, enabling the proxy to act on behalf of the person to cancel their first or second declaration if they are unable to sign their own name by reason of physical impairment, being unable to read or for any other reason. I note that the cancellation of a declaration is governed by clause 14, and the cancellation may be given orally, via writing, or “in a manner of communication known to be used by the person”. It does not require the signature of the person seeking assistance under the Bill, so a proxy may not be required for some people in relation to revoking a declaration, even if they have been required under clause 15.

Naz Shah: On the point made by the Bill’s promoter, my hon. Friend the Member for Spen Valley, should the issue of proxy end up before a court, what will be relied on—the conversation that we are having here and the intentions stated in Committee, or a future statutory instrument and what the Secretary of State puts in the guidance?

Stephen Kinnock: The regulations will have primacy, and will be shaped by a range of inputs, including the conversation we have just had in Committee. The process is that the Bill gets Royal Assent, then the regulations are drawn up based on a range of consultations and inputs—including the *Hansard*. The regulations then become the basis on which this proxy process is managed, enforced and executed.

Naz Shah: I genuinely want to understand this issue. Even though we have had this conversation in Committee, what if the Secretary of State, following those consultations, decides otherwise? What recourse do we as a Committee have to challenge that?

Stephen Kinnock: The Bill, once it becomes an Act, places a legal duty on the Secretary of State to produce those regulations. The Secretary of State would be in breach of the law if he were not to enforce the conclusions of the Act.

10.15 am

Kim Leadbeater: I will speak first to my amendment 473. It is important to be clear that the role of the proxy is very specific and would be used only in a very limited number of cases, where the patient is not able to sign their own name. That is, however, important when we are talking about terminally ill people who may be physically impaired, as my hon. Friend the Member for Bexleyheath and Crayford alluded to.

Danny Kruger: I am sorry to interrupt the hon. Lady so soon into her speech. Nevertheless, the clause says that someone can use a proxy when they are unable to sign their name

“by reason of physical impairment, being unable to read or for any other reason”.

Does the hon. Lady acknowledge that that is tantamount to saying that somebody can have a proxy for any reason at all? There is literally no restriction in the clause on the reason for why somebody could have a proxy—anybody could have one.

Kim Leadbeater: That is why amendment 321 in the name of my hon. Friend the Member for Bexleyheath and Crayford is really important. We have to put the reason down for why there is a proxy. It depends on personal circumstances and what that patient is going through, so we have to have a bit of flexibility, but they have to be unable to sign their name and they have to explain why they are unable to sign their name.

Danny Kruger: I hope that this does not appear pedantic, but we are talking about life and death after all. The patient's inability to sign their name could be psychological; it is not as if they will have to do a writing test. They simply have to say that they are unable to sign their name, unless the hon. Lady is proposing that there could be some sort of test for that.

I entirely support amendment 321 in the name of the hon. Member for Bexleyheath and Crayford about the proxy being obliged to state the reason why—it is good to finally have the question “Why?” being asked in the Bill. Nevertheless, there is no obligation for anything to be done about that reason; someone could give a reason that would be regarded as irrelevant. I respect the intention behind the amendment, but it does not clarify the point that literally anybody could effectively get a proxy to sign their name, having said to the assessing doctor, “I want my friend to sign for me.”

Kim Leadbeater: That is the sort of thing that the doctor would explore with the patient. It would happen in a very limited set of circumstances. We have to accommodate people who are physically impaired as a result of their terminal illness, and we have to include that there are a range of circumstances where this might apply. The proxy is being asked not to make any kind of judgment or assessment, but merely to act as an intermediary for the patient if they are unable to sign for themselves. They would have to explain why they are unable to sign for themselves, and the proxy has to be satisfied that the person understands the nature and effect of the making of the declaration.

I thought long and hard about who should and should not be accepted as a proxy. As always, I try to imagine how it would be seen by someone with a terminal illness. As we know, no two people are the same, nor are their circumstances. The hon. Member for East Wiltshire said that surely it should be done by someone the patient knows. The clause defines a proxy as someone the patient has known for two years, which is an important inclusion, but not everyone might have known for two years a person who they are comfortable asking to undertake that role.

I also appreciate the challenges with the wording “of good standing in the community”.

I will let the hon. Member for East Wiltshire and the right hon. Member for North West Hampshire fight that out among themselves. I am sure we all have our own version of what that means.

I have explored various options and, contrary to the suggestion of the hon. Member for East Wiltshire, I have spent a huge amount of time on this question, because it is very important. Looking at different lists, there is the list of people who can sign the back of someone's passport. I do not think that would be appropriate, so I moved away from that. I have also looked at much shorter lists. I do think that this question

would be part of a consultation; it is really important to get it right, which is why we must have it as part of a consultation. I am content that having the Secretary of State put it in regulations is the right thing to do.

As I said, I am happy to support amendment 321 in the name of my hon. Friend the Member for Bexleyheath and Crayford. It is a sensible amendment that makes the reasons for the use of the proxy more transparent. If amendment 253 in the name of my hon. Friend the Member for Filton and Bradley Stoke (Claire Hazelgrove) is moved, I am happy to support that too. As the Minister said, a cancellation need not be in writing; it can be made orally or through any other form of communication.

Amendment 321 agreed to.

Amendment made: 473, in clause 15, page 11, line 3, leave out from “person” to end of line and insert “of a description specified in regulations made by the Secretary of State.”—(*Kim Leadbeater.*)

This amendment provides that persons of a description specified in regulations (rather than persons “of good standing in the community”) may be proxies.

Amendment made: 253, in clause 15, page 11, line 3, at end insert—

“(6) For the purposes of this section “declaration” includes the cancellation of a declaration.”—(*Sean Woodcock.*)

This would allow a cancellation of the first or second declaration to be signed by a proxy.

Clause 15, as amended, ordered to stand part of the Bill.

Clause 16

RECORDING OF DECLARATIONS AND STATEMENTS ETC

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

“(b) a report about the first assessment of a person is made under section 7;

(c) a report about the second assessment of a person is made under section 8;”.

This amendment is consequential on Amendments 420 and 421.

Amendment 377, in clause 16, page 11, line 12, leave out paragraph (d) and insert—

“(d) a certificate of eligibility has been granted in respect of a person;

(da) a panel has refused to grant such a certificate;”.—(*Kim Leadbeater.*)

This amendment is consequential on NC21.

Kim Leadbeater: I beg to move amendment 474, in clause 16, page 11, line 17, at end insert—

“(1A) In this section ‘recordable event’ means an event mentioned in a paragraph of subsection (1).”

This amendment is consequential on amendments 209 and 377.

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

Amendment 475, in clause 16, page 11, line 19, leave out from second “the” to “in” in line 21 and insert “occurrence of the recordable event”.

This amendment is consequential on amendments 209 and 377.

Amendment 476, in clause 16, page 11, line 24, leave out from “the” to “, and” in line 26 and insert “occurrence of the recordable event”.

This amendment is consequential on amendments 209 and 377.

Amendment 477, in clause 16, page 11, line 27, leave out from “the” to “in” in line 29 and insert “occurrence of the recordable event”.

This amendment is consequential on amendments 209 and 377.

Amendment 478, in clause 16, page 11, line 30, leave out from second “a” to end of line 32 and insert “declaration, report or statement within subsection (1) must include the original declaration, report or statement.”

This amendment is consequential on amendments 209 and 377.

Clause stand part.

Kim Leadbeater: The amendments are designed to streamline the drafting of the Bill. Taken together, they create a new definition of a recordable event, namely those events set out in clause 16(1), where declarations and statements are required at any stage of the process. We can all agree that record keeping is essential, so it is necessary to define the events that should be recorded. I commend the amendments to the Committee.

Danny Kruger: I very much respect the hon. Lady’s intention, and I support the amendments. On clause 16, however, I must take the opportunity to express a certain concern. The clause applies if, under subsection (1)(b), the co-ordinating doctor “refuses to make...a statement”

to be entered into the person’s medical records. That is good but, as I understand it, a statement could be made that complies with the Bill but does not put on record, in relation to subsection (2), which requirements the co-ordinating doctor did not believe were satisfied. We have missed an opportunity to have more clarity about which exact requirements have not been met. There is also the eternal question about the co-ordinating doctor’s reasons for reaching that conclusion. I just note the missed opportunity to be a little safer with the drafting.

My more general point is about the importance of effective record keeping and declaration. I thank the hon. Member for Spen Valley, who throughout the whole Bill process has stressed the importance of good data collection and record keeping, which will be vital so that in later years, if the Bill passes, we can judge whether it is working as intended.

I am concerned about going on the evidence of other countries, which is frequently adduced in support of the Bill, particularly in respect of the absence of evidence of coercion, questions around capacity, proper administration of drugs or the support that patients receive. It is often said that concerns are exaggerated or inappropriate, “because look at what happens in other countries”, but let me briefly run through some evidence from abroad.

The fact is that no other country does adequate record keeping. One ambition of the hon. Member for Spen Valley that I really do share is to have a better system of keeping data than in other countries. In Oregon, the most recent annual report demonstrates a whole series of failures in record keeping. Ingestion status was unknown for 25% of the patients prescribed the drugs, so we do not know whether they took the drugs or what the process was. In 72% of cases, it was unknown whether there were complications; we have been talking about how exaggerated my concerns and those of other Members are about complications, but in 72% of cases in Oregon we do not know. In 30% of cases, it was unknown whether a healthcare provider was present. In 44% of cases, the duration between ingestion and death was unknown.

I very much recognise that the intention of the Bill is not to have those sorts of mistake. Indeed, the intention is to ensure that some of them should be impossible, because a doctor should be present and so on. Nevertheless, there is evidence that in other countries that have inspired the Bill, the data is inadequate. I will give a few more examples.

British Columbia has poor documentation, incomplete assessments, recurrent and excessive delays in reporting. In the debate on the last group of amendments, we spoke about the necessity that a doctor be informed if a declaration is cancelled; I am very concerned that that will not happen quickly and that people could fall through the gaps. That is what happens abroad. We have seen evidence from the former Attorney-General of Victoria, Australia, of all sorts of irregularities, with doctors falsely certifying that patients had signed statements and so on.

Kim Leadbeater: I do not know the details of the individual cases that the hon. Member speaks about, but he makes a powerful point and we absolutely agree on the importance of recording and monitoring. I know that he voted against the changes at clause 12, but I hope he gets some reassurance from the changes that the commission would bring in. Having the commission and the panels would ensure robust monitoring and reporting. I hope he agrees that that is a positive step.

Danny Kruger: I absolutely recognise that the hon. Lady has every intention of insisting that the system works well, that doctors do their job and that good record keeping happens. My concern throughout has been that we have not been robust enough in ensuring that all of that happens.

A huge amount of faith is being placed in the good professional conduct of doctors. Patient autonomy has been stressed, but it often translates into doctor autonomy. We are relying enormously on doctors doing their job well, and we are giving them significant latitude to do their job properly. As we see in other jurisdictions, particularly when assisted suicide becomes normalised and services are established explicitly to provide assisted suicide, we get into a dangerous area in which adequate documentation and reporting might not happen.

I will conclude with evidence from Canada, which is a very comparable country; it has a slightly different mechanism for delivering assisted suicide, but its legal framework is very similar to ours. The Health and Social Care Committee in our last Parliament received evidence from an academic in Canada, Dr Kotalik, who stated that federal regulations had been

“mandating a collection of data from MAID providers”,

just as the Bill will do. However, he noted that

“those legal and regulatory efforts have yet to produce evidence that the program operates as intended. We have no publicly accessible evidence that the eligibility criteria and safeguards prescribed by law were respected and that the Criminal Code has not been transgressed.”

It is fine for us, in this Committee and in Parliament, to specify that all doctors should do their job properly and that all data should be appropriately collected, transmitted and recorded. Nevertheless, as we all know from our casework, the reality is often one of bureaucratic mistakes being made, albeit not with any ill will. Given the volumes that we may well be dealing with, I think it

[*Danny Kruger*]

is appropriate to raise significant concerns about the operation of the Bill and the data collection that we seek.

10.30 am

Sojan Joseph (Ashford) (Lab): Record keeping is a huge issue in our healthcare system. A huge number of coroners' reviews have identified that record keeping has been an issue. By specifying only that clinicians need record a "recordable event", we are leaving it as the responsibility of individual clinicians to decide what a recordable event is.

It is important that a good record be available to prevent future incidents and learn good practice. Leaving it open to a clinician to decide whether something is a recordable event could lead to most issues not getting recorded. For example, if a clinician has identified that there was coercion, it will be for the clinician to decide how much documentation to do. In my view, if they have identified a coercion, that should be recorded as an incident and further investigation should be done, but the Bill leaves it up to the clinician to decide. There is no standard for record keeping across the healthcare system, so a care home's may be different from an NHS ward's. I think it is for the Committee to look into what "recordable event" actually means.

Stephen Kinnock: The purpose of amendments 474 to 478 is to improve the drafting of the Bill by creating a new definition of "recordable event". Recordable events are the events set out in clause 16(1) related to the recording of declarations and statements.

The amendments would also make consequential changes to clause 16, which refer to the occurrence of the recordable event, as per the new definition, and include reference to a report in addition to a statement or declaration. The reference to a report is consequential on the amendments already agreed by the Committee to clauses 7 and 8.

Kim Leadbeater: I have nothing further to add.

Amendment 474 agreed to.

Amendments made: 475, clause 16, page 11, line 19, leave out from second "the" to "in" in line 21 and insert "occurrence of the recordable event".

This amendment is consequential on amendments 209 and 377.

Amendment 476, in clause 16, page 11, line 24, leave out from "the" to ", and" in line 26 and insert "occurrence of the recordable event".

This amendment is consequential on amendments 209 and 377.

Amendment 477, in clause 16, page 11, line 27, leave out from "the" to "in" in line 29 and insert "occurrence of the recordable event".

This amendment is consequential on amendments 209 and 377.

Amendment 478, in clause 16, page 11, line 30, leave out from second "a" to end of line 32 and insert "declaration, report or statement within subsection (1) must include the original declaration, report or statement."—(*Kim Leadbeater.*)

This amendment is consequential on amendments 209 and 377.

Clause 16, as amended, ordered to stand part of the Bill.

Clause 17

RECORDING OF CANCELLATIONS

Kim Leadbeater: I beg to move amendment 479, in clause 17, page 11, line 37, leave out "at" and insert "with".

This amendment clarifies that a cancellation may be given to a practitioner with the person's GP practice.

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

Kim Leadbeater: The amendment, which would clarify the drafting, speaks for itself. The important point is that the record of cancellation be with the GP practice as soon as is practicable. It is not necessary for that to take place physically at the practice, as that could potentially delay its delivery.

Stephen Kinnock: Clause 17(2) provides that where a notice or indication regarding a cancellation of a first or second declaration is given to a registered medical practitioner "at" the person's GP practice, that practitioner must record the cancellation in the person's medical records as soon as possible. Amendment 479 seeks to clarify that the requirement to record the cancellation applies not just where the cancellation is given to a registered medical practitioner physically at the GP practice, but where the cancellation is given to a registered medical practitioner "with" the person's GP practice, irrespective of whether the notice was given at the GP practice. I hope that that explanation is helpful.

Kim Leadbeater: I commend the amendment to the Committee.

Amendment 479 agreed to.

Clause 17, as amended, ordered to stand part of the Bill.

Clause 18

PROVISION OF ASSISTANCE

Amendment made: 378, in clause 18, page 12, line 9, leave out paragraph (a) and insert—

"(a) a certificate of eligibility has been granted in respect of a person."—(*Kim Leadbeater.*)

This amendment is consequential on NC21.

Danny Kruger: I beg to move amendment 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."

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

Danny Kruger: This group of amendments contains two sub-groups that I shall deal with separately. Amendment 462, in my name, and amendments 497 and 498, in the name of the hon. Member for Spenn Valley, concern the information given at the provision of assistance and decisions around that. My amendment 463 concerns the question of assistance in the final act.

This is a rather sombre moment in the Bill, because it is somewhere in clause 18, between subsection (9)(a) and subsection (9)(a)(i)—between the self-administration and “the person has died”—that the death happens. The amendments are about making sure that we understand what is happening here and whether it is safe.

Amendment 462 would require the doctor to make it clear to the patient at the final moment that they do not have to proceed. Of course, this is clearly the implication of the Bill. We have stressed autonomy all along. Everybody who is helping us to draft the Bill, all colleagues in the House and all doctors understand that of course the patient is not obliged to proceed at this point. The reason for the amendment is to think about the patient: to put ourselves in the mind of the person who has gone a long way down the road, who has summoned multiple professionals to endorse a decision that they have made and who has, we hope, involved their family and other people in their life, all of whom will be aware of what is about to happen and will, we also hope, be supportive of that decision or at least neutral about it.

That person finds themselves suddenly at the moment when the drugs are due to be set up for self-administration, a point that we will come on to. That is the final opportunity that they have to decline to proceed. Throughout the Bill, hurdles and gateways have been introduced through which a patient must proceed. In many respects I do not think them adequate, but it is acknowledged by the framers of the Bill that it is necessary to pass through certain hurdles and, in what might appear to be quite a formulaic way, require the patient to confirm and reconfirm that they have a clear, settled and informed wish.

What we do not have at this vital moment—in a sense, the only moment that matters, because everything up to this point has been preliminary; it is at this point that they step through the final gateway—is an obligation, expectation or requirement for any conversation to take place. The doctor is expected to satisfy himself or herself that the patient

“has a clear, settled and informed wish to end their own life”

and must be prepared to swear to that. Nevertheless, there is no expectation that they will have a conversation. We can pretend, imagine, hope or surmise that some kind of conversation would happen at that point—“Do you want to proceed?” “Yes, I do”—but we are not requiring it.

I raise this point in the clear and certain knowledge that many people do, at that moment, have second thoughts. We know that from the number of people

who contemplate and get very close to the act of unassisted suicide and step back, literally, from the brink. I want to insist that there is an opportunity here to step back from the brink, just as our suicide prevention strategy seeks to ensure that at the moment when and in the places where many people tragically do take their own life, on bridges or on Beachy Head, there are signs saying, “Call the Samaritans” or “You are not alone”. I want to specify clearly that this is that moment, rather than it being assumed that the train has left the station and the person is just on it now. I think it would be a helpful amendment.

I cite written evidence from Dr Philippa Youd, writing in a personal capacity:

“I have witnessed ‘post-euthanasia regret’. I was 18 when my mother took her own life due to ‘interminable suffering’. She knew what she was doing—she had tried before. Just before she slipped into a coma, she told me she was sorry and that she regretted it. The inquest therefore deemed her death an ‘open verdict’. It was suicide, but it was suicide that was regretted, despite true intent and interminable suffering”—

and no doubt capacity and a lack of coercion. Dr Youd continues:

“No one can EVER be sure they want to die until the moment of death. They may still change their mind and then it is too late. No one can know what patients will truly face, emotionally and cognitively, at the point of death. I have witnessed firsthand the tragic circumstance of someone changing their mind after choosing to die. There is no peace in that.”

I hope that hon. Members will not consider that this amendment is unnecessary embroidery or that requiring a simple statement to be made is some kind of imposition on the autonomy of doctors or patients. Someone should still be able to turn back and change their mind at this point.

10.45 am

Kim Leadbeater: The hon. Gentleman is making a powerful speech, and I thank him for the respectful way in which he is doing so. He has given an example of a very personal story; it is also important to remember the other personal stories we have all heard. We have with us today in the Public Gallery family members who have lost loved ones. Catie’s mum went to Dignitas in Switzerland for an assisted death, and her daughter could not go with her. As a family they have suffered to this day as a result of that experience.

We need to be really careful about the language we use around suicide. We have spoken about this before. The cases we have heard of are not people who want to die. They are people who want to live, but they are terminally ill. We need to be really sensitive to that, having heard so many examples of families who have been through these really difficult situations. But the hon. Gentleman makes a very good point, and I am minded to support his amendment because I think it comes from a good place.

Danny Kruger: I am grateful to the hon. Lady. I hear what she has said; we have had this conversation before. I am afraid that I do insist on my right to use the English language accurately. What is proposed in the Bill is a carve-out of the Suicide Act, so I regret to say to the hon. Lady that I will continue to describe it in terms that are appropriate to it. I hope I do so with absolute sympathy and respect for the many families who have suffered from the trauma of seeing their loved

[*Danny Kruger*]

ones die badly—loved ones who would have wished for an assisted death under the terms of the Bill. I am very glad to hear that the hon. Lady supports my amendment. I do not think it would be any sort of imposition on families for the doctors to let the patient know at the last moment that they have the opportunity to turn back.

Sean Woodcock (Banbury) (Lab): The hon. Gentleman is making a really powerful speech, and I am minded to support the amendment on the basis that there will be a small but significant group of people who, having gone through the whole process, will feel they have been a burden on the people who have gone to all the effort, through every stage, to get to the end, so if they have doubts at the end, they may be reluctant to change their mind. It will be a very small group, but I do think it is significant. I see it as the re-establishment of autonomy for the patient, which we all believe in; does the hon. Gentleman agree?

Danny Kruger: That is absolutely right. We have to think about the no doubt quite turbulent emotions that people will have as they approach the end of their life, and to reiterate their genuine autonomy. They are not on a conveyor belt that they cannot get off until the very last moment—until they have passed through this gateway. The amendment seeks to remind them and, indeed, their families of that. I am afraid we do hear terrible stories of people who have arranged their assisted death: often family members have flown in from abroad, doctors have been summoned and so on, and then they feel they have to proceed because, as the hon. Gentleman says, they feel a burden as it is and do not want to be an annoyance at the end by making everybody wait. I am afraid that is indeed the reason for the amendment. I am pleased to hear that it sounds like it will be accepted, and I am grateful to Members who will support it.

Amendment 463 is the other, more substantial, amendment in my name in this group. It would leave out paragraph (c) of clause 18(6), which says that the doctor can assist the patient

“to ingest or otherwise self-administer the substance.”

Here we are in a lot of difficulty and a grey area. Let me try to unpack the reasons for objecting to paragraph (c). The hon. Member for Spen Valley argued in an interview that there is a “very clear line” between the Bill and euthanasia, which is someone else doing the deed. She said that the act

“has to be the decision of the individual, and it has to be the act of the individual”,

which

“creates that extra level of safeguards and protections”.

I agree with her—it is right that we introduce the additional safeguard of insisting that the patient performs the final act themselves.

I recognise that there is a distinction between euthanasia and assisted suicide, and I support the hon. Lady’s attempt to insist on that distinction in the law. It is another safeguard. But the fact is that there is a blurred line between the two, and I can also understand why many people object to the exclusion of euthanasia—of

the fatal act being administered by other people. A doctor from Canada said it was inherently ableist to require the patient to self-administer, and I think that is unarguable. If that is the case, the logical provision would be to enable euthanasia, if one believes in the autonomy of the patient.

I am afraid my strong belief is that the reason why euthanasia has not been proposed in the Bill or by the campaign, which has been led by an organisation that used to call itself the Voluntary Euthanasia Society, is because the campaign has concluded that such a Bill would not pass Parliament and believes—I think correctly—that Members of Parliament and members of the public would object to euthanasia. But the logic of the Bill and of the campaign is actually for euthanasia, if one believes genuinely in autonomy, in equal rights and in not discriminating against people who are physically unable to perform the act themselves.

Despite my efforts, hon. Members have not been able to conceptualise the difference between withdrawing a medical treatment that affects a particular medical condition on the one hand, and administering drugs that annihilate the person on the other. There is a meaningful and important difference between those two things. One is a person declining to use a shield, and the other is the person using a sword against themselves. I think there is a difference there, and I regret that colleagues do not see it.

Where I do not see a difference, however, is between a person injecting themselves and asking someone else to inject them. There are two versions of the death of Saul in the Bible. I think this is the only reference to the Bible that I will make in this whole debate, and I make it partly to show that there is an inconsistency in the Bible—there is not a single Biblical view of these matters. In one account of the death of Saul, having been defeated by the Philistines, he asks his servant to run him through with his sword, but his servant refuses, so he falls on his own sword and kills himself. In the other version, he gets a passing soldier to run him through—to kill him.

To me it does not matter: the inconsistency in the story is interesting historically, but conceptually, logically and morally I do not see the difference. Whether you fall on your own sword or ask someone else to do it to you, it is still a sword, you are still actioning it and you are still responsible, if we recognise that the individual has autonomy. But there is a practical difference. We are talking about assistance to die and the role of another person who supports your decision and helps you to fulfil it, but that results in an obscuring of the practical difference. In practice, as we see in clause 18(6), the assistant comes very close to euthanasia. The role of the assistant, in my view, is closer to that of the soldier who kills Saul than of the servant who refused to do it.

Kim Leadbeater: The hon. Member is making an interesting philosophical point with his biblical references. I think the point he may be making is that there might not be any difference for the individual, as the result is sadly the same, but I put it to him that there is quite a significant difference for the other person. If we think about the autonomy of the medical professionals we ask to be involved in the process, there is a strong argument that it would be very different for them to be more involved in the process. Does that make sense?

Danny Kruger: I am grateful—I really do thank the hon. Lady, because the effect of this process on the medical professionals who will be involved is a very important consideration, and one that we have perhaps not given enough attention to. That is why we will come to the conscience clause in due course, although we have discussed it a little already. The hon. Lady is absolutely right that there is a difference for the medics in the extent to which they are involved in the administration of the death. I am afraid I do not see a major moral difference between providing the wherewithal—setting things up for, or indeed helping, the patients to ingest or otherwise self-administer the fatal drug—and people performing the act themselves. The distinction is very obscure; there is a significant grey area there.

On the hon. Lady's point about appropriate consideration of the feelings of the medical profession, if she believes in doctor autonomy, she should believe that doctors ought to have the autonomy to decide for themselves whether to perform euthanasia, if euthanasia were legal. That is what happens in other countries. In Canada, doctors can decline to take part, or they can participate.

Given the question of autonomy, it is worth noting that in countries where euthanasia is legal, it is the overwhelming choice of the patients, as I think it would be for me. If I were facing that terrible moment and choice—we will come in due course to the question of the drugs involved and the process of taking them, but swallowing all these pills is not a pleasant process—it would be far easier, more humane and less painful for a doctor to administer the drugs intravenously. I visited Canada and met a doctor who had been responsible for over 300 deaths, which she herself has performed, because that is the overwhelming choice of the patients. As I am sure the hon. Lady would agree, that doctor is acting with full professional discretion and autonomy.

To go back to my point, I am afraid this is one of the impossible dilemmas that the Bill and the whole concept of assisted dying set up: whether we allow the doctor to do it to us. My concern is that if the stress on self-administration is genuinely felt—not, as I cynically believe, because this is the only way to get assisted dying through the House of Commons—because the Bill's authors recognise the need to be absolutely sure that the act is voluntary, and if the reason why we insist on self-administration is because we want to be sure that the act is voluntary, what does that say about all the so-called safeguards that exist up to this point? We have been told that those safeguards are sufficient to ensure that we have absolute confidence about the person's clear and settled wish.

If we are sure that people at this stage in the process have a settled, informed and free wish to end their lives, why should they not be able to ask a doctor to do it to them? The only answer to that question can be that we do not genuinely believe that we are completely sure. We want, subsequent to death, to be sure—in terms of our own moral propriety and sense of *amour-propre*—that those people did it themselves. It was not our choice; it was not us doing it to them—they did it.

Kit Malthouse: I am a little confused by my hon. Friend's logic. He has literally just proposed an amendment for the doctor to ask, at the last, whether the person still wants to proceed. Surely self-administration is the ultimate act of consent, which his own amendment requires a doctor to establish right at the last moment.

Danny Kruger: My right hon. Friend is absolutely right. I support the distinction between self-administration and euthanasia. I am in favour of all possible safeguards and every possible opportunity to give the patient the chance to step back from the brink. The point I am making is that I do not recognise the logic of the distinction that the Bill insists on. Indeed, in the provision that I am concerned about, subsection (6), the distinction in fact does not apply.

If we believe in autonomy and in giving people the opportunity for assisted suicide, we are, naturally enough, concerned that that should be available to people who cannot physically perform the act themselves. I am not trying to argue in favour of euthanasia; I am saying that we will get to euthanasia if we let the Bill through. Even in the Bill as it stands, we are halfway to euthanasia with subsection (6). I am confident that, in due course, the campaign for it will grow. In fact, it already exists: people already object to the restrictions implied in the Bill. The campaign will grow to widen the opportunity for assistance to ensure that we can have physician-administered suicide, as happens in Canada and elsewhere, very logically. Once we have crossed the Rubicon of assisted death, it is a straight road to euthanasia. *[Interruption.]* I am sorry that the hon. Member for Stroud is amused.

11 am

Let me unpick this a little further. There is clearly a problem with subsection (6), because two further subsections appear to qualify it, apologise for it or make what it says clearer. It is always dangerous drafting in a Bill when a subsequent provision casts doubt on an earlier one. Subsection (7) starts with “But”—that is the big red light suggesting there is a problem. It comes after subsection (6)(c), which says the doctor may “assist that person to ingest or otherwise self-administer”.

The next line is:

“But 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.”

Subsection (8) says that subsection (6), the one about assisting,

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

That is all very helpful. That is what we thought the Bill said anyway. It is not clear to me what the purpose of subsections (7) and (8) is, except that there is inherent danger in subsection (6). I am afraid that subsections (7) and (8) do not cancel that danger, because of the inherent lack of clarity—the blurring—that exists in the concept of assisting the person to ingest or otherwise self-administer.

Sojan Joseph: Will the hon. Gentleman clarify something? He is making a valid point, and I have been thinking about it. As a nurse who has worked in many areas, I know that a disabled person may not be able to take medication by themselves, and sometimes a nurse has to administer it with a spoon. There may be occasions on which a person's medication comes back out and they have to do it a few times. Is that something the hon. Gentleman is concerned about—actually pushing the medication into the person?

Danny Kruger: Once again, we are in an extraordinary no man's land between medical treatment and something else that we cannot find a word for. The hon. Gentleman is absolutely right. Of course, it is appropriate in medical treatment for a nurse or doctor to assist in the administration of a treatment. As he suggests, if the person found it difficult to raise a cup to their lips, the nurse would help them. Indeed, if they found it difficult to perform an injection, it would be expected that that would be done by the nurse or doctor anyway. But here we are setting up a strange new method of administering a so-called treatment in which the patient has to perform the physical act themselves.

It is apparent from the clause that it is very unclear what assistance actually looks like, so yes, I absolutely imagine that if the patient were struggling to raise the cup to their lips, a nurse or doctor who was present at the final act in an assisted suicide would help them to do so. Similarly, if the patient were finding it difficult to put their finger on the syringe, it would be appropriate—normally, one would expect—for the medical professional to lift the patient's finger and put it in the right place. What happens next? Do they then apply a little pressure if the patient is finding it difficult to depress the plunger on the syringe? If the cup is at the lips, do they tip it up and let gravity take its course? These very complicated questions about where assistance ends and autonomy begins are, I am afraid to say, impossible to specify in the Act; therefore, it is apparent that we have a grey area.

I conclude with some evidence that we received from Iain Brassington, professor of applied and legal philosophy at Manchester University. He says:

“how are we to determine how the ‘final act’ of self-administration is to be differentiated from the penultimate act, in which the doctor may assist? How would helping a patient lift the cup to her lips be distinguished from helping her ingest its contents?”—

the hon. Member for Ashford referred to that. He goes on to say that

“the definition of the ‘final act’ is unclear, especially granted the wording of”

subsection (6)(c), and:

“The proposed law says that a doctor may not administer a substance with the intention of causing death, but also that a doctor may help a person self-administer. But how should we draw the boundary between helping a person self-administer, and playing a role in administration?”

I come to the penultimate point—not the final act—of my speech. There is some odd phrasing in subsection (7), and I wonder whether the hon. Member for Spen Valley or the Minister can help to parse the English. It says that

“the decision to self-administer the approved substance and the final act of doing so must be taken by the person”.

We understand about the decision being taken by the person, but the phrasing is that the final act “must be taken” by the person. I am not familiar with that construction. Does one take an act? Is that English? You perform an act—an act is not taken, it is done, by a person acting autonomously. The question of whether this is an active or a passive concept runs to the heart of my concern about the clause, and we need to think about redrafting, at least in deference to the English language.

Somewhere in this clause there is a magic moment when assistance gives way to autonomy, and the penultimate act by the doctor yields to the final act, which is supposed to be by the patient. We cannot tell when the responsibility for the action passes from one to the other. In proper medicine it does not matter because the medic works with the patient, but here it does matter. We are insisting that there is a difference between a doctor setting up a death, and the patient performing the action of suicide.

I will end by referencing the case of *R v. Kennedy* in 2007, a case on which Lord Bingham opined, about the culpability of someone who died from a heroin overdose. Was the person who gave him the drugs and tied the tourniquet around his arm responsible? Was it murder, or indeed assisted suicide? The judge decided that it was not, but made this point:

“It is possible to imagine factual scenarios in which two people could properly be regarded as acting together to administer an injection.”

Given that ruling, we are in a world of difficulty with the suggestion that it is legally possible for a doctor to assist a patient to ingest or otherwise self-administer. To assist someone to self-administer is tantamount to administering. I welcome suggestions from other Members, the Minister, or the hon. Member for Spen Valley about whether it is possible to provide guidance that gives greater clarity on what the clause means, or whether subsequent amendments will help to resolve the problems that I have, but I am afraid I do not think it will be possible to make an adequate distinction between assisted suicide on the one hand—in which full responsibility, not just for the decision but for the performance, rests with the patient—and euthanasia on the other. I do not think there is an adequate logical difference, and the practical difference we are attempting to enshrine here will be very quickly obscured.

Naz Shah: I thank the hon. Member for East Wiltshire for his amendment, and for speaking in the powerful, sensitive way that he did. I also thank my hon. Friends the Members for Spen Valley and for Banbury, who made interventions.

I did not intend to speak to this amendment, but having heard the hon. Member for East Wiltshire speak so powerfully and sensitively, it is important for me to share a few things. My hon. Friend the Member for Spen Valley has said a couple of times that the difference between people who commit suicide and those who will take this route is that the patients have been given less than six months to live, and that was not a choice. I was a Samaritan for years, because I had two failed suicide attempts in my early years, and since then I have battled with mental health demons all my life because of my experiences. To suggest that there is a difference between someone who gets a terminal illness and wants to take this act and people who want to commit suicide, and to suggest that they are doing it out of choice, is wrong. I felt really emotional when that exchange was happening. The reason why I think it is wrong is that, at the time that I wanted to commit suicide, I did not feel that I had a choice. I could not see a way out.

When I was on those Samaritans phonelines, speaking to people who rang in to unpick their feelings about what was driving them to feel suicidal in that moment, it was not because they want to die, but because they

were in circumstances that drove them to feel that they had no option but to commit suicide. In some instances, it takes an amount of courage and bravery to even contemplate that option. To diminish that, which I feel is what has, intentionally or unintentionally, happened on occasion, is really wrong, because I have been there, and it was not easy and it was not because I wanted to die.

Kim Leadbeater: My hon. Friend makes a powerful point. I certainly have not heard anyone try to diminish the experience of suicidal people. We probably all have our own stories of loved ones who we have either lost to suicide—I know that I do—or who had very severe mental health issues. The point I would make is that the families I have met who have lost loved ones through assisted dying or a harrowing terminal-illness death have said that they desperately wanted to live. That is the distinction I would make, but I appreciate that my hon. Friend is absolutely right that people with suicidal tendencies and ideation also want to live—they just do not feel they have a choice. It is a very delicate debate to have, but please be assured of my sensitivities to it.

Naz Shah: I am genuinely grateful for my hon. Friend's intervention, because I do not want the Committee—or our constituents—to feel that there is an equivalence. There is not. People who are in that space, who ring the Samaritans helpline to speak to them, all desperately want to live a brilliant life. That is what brings us here: each and every one of us wants to make this place the best it can be, so that our country is the best it can be and all our communities, people and constituents—all members of society—thrive. It is a sensitive debate, but let us be careful not to draw a parallel where there is not one. It was important for me to put that on the record.

I will support the amendment tabled by the hon. Member for East Wiltshire because we have already voted down an amendment requiring doctors to simply ask the question why. This speaks to the point that my hon. Friend the Member for Banbury raised: I know, through my experience at the Samaritans, as somebody who has attempted suicide and as somebody who has gone on to chair a charity that leads mental health interventions, how difficult it is for a patient has gone through the process of having had that conversation with their family, who might not necessarily agree, and having convinced them that they are going to take this option because they want autonomy, and fear losing it.

I cannot imagine what it must be like for those people, at that moment, saying their final goodbyes, and the level of potential pressure they face right at the last minute, having spoken to everybody and put their family members, and indeed themselves, through the process. Would they not feel internal pressure on themselves to go through with it? Would they really have the option, and not feel, in a sense, obliged to say, “Yes”? Do we really not want to ask that question?

When we debated the amendment requiring doctors to ask the question why, my hon. Friend the Member for Stroud said that doctors would ask it anyway, but that argument would not work in this instance because doctors would not do this anyway. They would not say, “I am about to give you something—have you changed your mind?”, because by that point they are in a process.

The drug, in whatever form it takes, is in the process of being, or will have been, handed over to the person who wants to take that option, so it is not the same. I genuinely hope that the Committee will support the amendment, because it is our last option to make this intervention.

11.15 am

Dr Neil Shastri-Hurst (Solihull West and Shirley) (Con): It is a pleasure to serve under your chairmanship, Ms McVey. I will speak briefly to this group of amendments, setting out why I support amendments 462, 497 and 498, but oppose amendment 463. My hon. Friend the Member for East Wiltshire set out very eloquently the reasons behind amendment 462. On the one hand, there is a cogent argument that it is not strictly necessary in the light of the provisions set out in subsection (4)(b) and (c), which set out that the individual wishing to have an assisted death must have

“a clear, settled and informed wish to end their own life”
and is

“requesting provision of that assistance voluntarily”.

However, it appears to me a logical and entirely appropriate extension of the intentions behind clause 18(4) to express that in slightly more explicit terms in the Bill by adopting my hon. Friend's amendment 462. It strikes me that, after doing so, the Bill would provide a further check and balance that creates no greater onus on either the individual seeking an assisted death nor the co-ordinating doctor who is assisting them. In those circumstances, it appears eminently sensible to improve the Bill in that way. From the indications we have already heard, it appears that there is significant support for that amendment.

I struggle with amendment 463, which would remove paragraph (c) from clause 18(6). The effect would be to prohibit the co-ordinating doctor from providing assistance to the person seeking an assisted death, either through ingestion or other self-administration of that substance, in any circumstance. In my view, the amendment would make the operation of the Bill, were it to become an Act, unnecessarily restrictive. Clause 18(7) already stipulates that

“the decision to self-administer the approved substance and the final act of doing so must”—

I stress the word “must”—

“be taken by the person to whom the substance has been provided”.

On any interpretation of the construct of that, it is clear that the person seeking an assisted death must be the active participant in the process; it is mandatory. There is no discretion in that, by virtue of the word “must”.

Were we to remove clause 18(6)(c) and the Bill passed into law, it would have the effect, in what is an entirely legal process, that a doctor would be unable to aid a patient in any circumstance. For example, they would not be allowed to hold a glass or steady a straw as a patient moved towards it to imbibe a substance. Those are circumstances that are entirely foreseeable, when through the ravages of an illness, somebody is limited in what they are physically able to do. Of course, assistance could be provided in alternative ways—for instance, through assistive technology, which we have seen being used in other jurisdictions. The Swiss, for example, use a significant amount of assistive technology in administering and assisting the process of self-administration at the end of life.

Danny Kruger: My point is that it is very difficult to draw a line here. I recognise the scenario that my hon. Friend raises: why should a nurse not be able to hold a straw for a person to drink from? I might say that should be acceptable; however, I do not think it should be acceptable for the nurse to tip the pills into the patient's mouth. Does he think that scenario would be acceptable? Or to give another one, would it be acceptable to actively provide force on top of a patient's finger to press a syringe? Would he regard that as acceptable assistance?

Dr Shastri-Hurst: That is why clause 18(7) is so important: the final act must be undertaken by the person seeking an assisted death. The example my hon. Friend gives of tipping tablets into a mouth is a final act. Pushing a syringe is a final act. There is a significant distinction between an individual or practitioner holding a cup with a straw and the person seeking an assisted death moving their mouth towards the straw, sucking from it and imbibing the substance and the passive act of a substance being raised to that individual's lips and poured in without any movement by the individual seeking an assisted death themselves.

Danny Kruger: When we talk about this in future debates, it might be appropriate for this conversation to be referenced. I think my hon. Friend is suggesting that it should be acceptable, and that assisted death would be legal, as long as the patient moved their head towards the straw and cup, and that it would be illegal, according to my hon. Friend's definition, were a doctor applying a cup to a patient's lips and the drugs fell in by gravity. Is that right? Is that how judges in future should determine whether assistance has crossed the line?

Dr Shastri-Hurst: It is very clear from subsection (7) that this must be an active step taken by the individual. There is a risk that we go down a rabbit hole in terms of—*[Interruption.]* I am sure my hon. Friend would like me to finish my point. We risk going down a rabbit hole in drawing examples. I raised the example of a cup, but of course there are much wider assistive technologies that can be used and are used in different jurisdictions. I gave the example to illustrate the point that this is an active act, not a passive act.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): The hon. Gentleman mentions subsection (7). Subsection (8) states quite clearly that it

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

I think the passive and active roles are quite clear between the two subsections.

Dr Shastri-Hurst: I agree entirely with the right hon. Member's interpretation of the Bill.

There is a further unintended consequence of the amendment tabled by my hon. Friend the Member for East Wiltshire, which I am sure is not his intention but would sadly be the effect: were an individual to qualify under the Bill, should it pass and were the amendment to be adopted, they would inevitably be forced to take the final decision at an earlier stage. If there is a restriction that they can have no assistance whatsoever in performing the act, they will end up making the decision when they know that they have the entire physical strength available for them to do it, and that actually brings forward the point at which they choose to die to an earlier stage.

Kit Malthouse: After 10 years of campaigning on this issue and spending so much time with people whose family have gone to Switzerland, one of the things they consistently say is that people went to Switzerland much earlier than they wanted to because they had to go while they were still physically able. I think this is a critical point that people have to realise. We should not compel people to do this earlier than they would otherwise wish to simply because of these restrictions.

Dr Shastri-Hurst: My right hon. Friend makes an important and powerful point. I think there is a consensus among the Committee that there is no desire for people to take this ultimate step at an earlier stage than is absolutely necessary for them. My very real fear is that, were we to adopt this amendment, we would bring forward that point of decision.

Danny Kruger: The logic of that argument is to allow physician-administered suicide, because there will be a point at which people are physically unable to perform the act but have capacity, and their autonomy should be respected—

The Chair: Order.

11.25 am

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

Adjourned till this day at Two o'clock.