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Con Ind	Conservative Independent
DUP	Democratic Unionist Party
GP	Green Party
Ind Lab	Independent Labour
Ind LD	Independent Liberal Democrat
Ind SD	Independent Social Democrat
Lab	Labour
Lab Ind	Labour Independent
LD	Liberal Democrat
LD Ind	Liberal Democrat Independent
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House of Lords

Friday, 7 November 2014.

10 am

Prayers—read by the Lord Bishop of Norwich.

Assisted Dying Bill [HL]

Committee (1st Day)

10.06 am

Moved by ***Lord Falconer of Thoroton***

That the House do now resolve itself into Committee.

Lord Newby (LD): My Lords, it may be for the convenience of the House if I highlight the estimated rising time of 5 pm that is advertised in this morning's edition of today's list. Noble Lords will be aware that it is a firm convention that the House normally rises by about 3pm on Fridays but in view of the level of interest in this Bill, as reflected in the volume of amendments tabled, we anticipate that the House may wish to sit a little beyond 3 pm on this occasion. As ever, progress on the Bill of the noble and learned Lord, Lord Falconer, and our rising time will ultimately be in the hands of the House.

Lord Trefgarne (Con): My Lords, before the House resolves itself into a Committee on the Bill, as I have no doubt it will in a moment, can the noble Lord who has just spoken say whether there are any further plans? There are 175 amendments on the Order Paper today and I doubt very much that they will be finished. Are there any plans for a further day in Committee and does the noble Lord realise what effect that will have on all the other Private Members' Bills waiting in the list?

Lord Newby: My Lords, it would not be conducive to making progress and good use of the time available today if we started thinking about what happens after today. We will decide what we do after today after today.

Lord Deben (Con): On a further point, may I ask my noble friend two things? First, what discussions took place with the interested parties? I do not mean the parties on either side because this is, after all, a cross-party division. Secondly, what are the precedents for this and will he ensure that this does not become a precedent for all kinds of Bills in the future?

Lord Newby: My Lords, my noble friend the Chief Whip had numerous discussions earlier in the week with the principal protagonists on the Bill. On precedents, noble Lords will remember that we sat beyond 5 pm for the Second Reading of the Bill from the noble and learned Lord, Lord Falconer, as we did in the 2005 Parliament when the noble Lord, Lord Joffe, brought forward a Bill on the same subject. The House sat beyond 5 pm for its Second Reading on that occasion. If your Lordships look at the pattern of Fridays, we have risen at 3 pm or thereabouts on the vast bulk of them. This Bill is clearly unusual in its significance and the amount of attention that it has generated, both inside and outside your Lordships' House. I do not think that either my noble friend the Chief Whip or I detect any mood to move beyond 3 pm as a normal finishing time on Fridays.

Lord McAvoy (Lab): My Lords, to follow up on that issue, will the Minister indicate how much consideration was given to noble Lords who do not stay in London? If no consideration was given to the inconvenience, extra travel time and all the rest of it for anyone who does not stay in London, that would only confirm the trend towards this place becoming a metropolitan House rather than a House of the United Kingdom.

Lord Newby: My Lords, consideration was given to that, which is why we are not suggesting that the House sit beyond 5 pm, although it is conceivable, given the number of amendments, that one could go on beyond even then. The other thing that was in my mind, although I cannot speak for anyone else, is that for the country, looking in at our deliberations, the idea that it would be impossible to sit beyond 3 pm on a matter of this importance does not necessarily put your Lordships' House in a good light.

Lord Jopling (Con): My Lords, to avoid confusion, and because the Minister tends to mumble, may I make it clear that the noble Lord, Lord Joffe, who presented the previous Bill was not me?

Motion agreed.

Clause 1: Assisted dying

Amendment 1

Moved by ***Lord Pannick***

1: Clause 1, page 1, line 2, at beginning insert "Subject to the consent of the High Court (Family Division) pursuant to subsection (2),"

Lord Pannick (CB): My Lords, it is a privilege to open the Committee stage of this important Bill, the significance of which is demonstrated by the very large number of your Lordships who are present today. The Second Reading debate on the Bill was commended by many observers outside the House as illustrating the expert scrutiny that this House applies to legislative proposals, and I am confident that your Lordships will demonstrate again today the enormous value of this House.

In the first group I shall speak to Amendments 1, 4 and 24, which are in my name and those of the noble Baronesses, Lady Neuberger, Lady Mallalieu and Lady Shackleton of Belgravia. I shall speak briefly because we have much business to get through. I support the Bill, but I think that adequate safeguards are essential.

[LORD PANNICK]
It would be improved, and some of those who are concerned about it may be reassured, if judicial safeguards were to be added.

These amendments would require that the person concerned must satisfy a judge of the Family Division of the High Court that they have made a voluntary, clear, settled and informed wish to end their life. Judges of the Family Division already decide the most profound questions of life and death. Can doctors separate two Siamese twins, knowing that one will die but that the operation is necessary to save the life of the other? Should the life support system be turned off for Tony Bland, a victim of the Hillsborough disaster who was in a persistent vegetative state? Judges already decide these questions of life and death—and, tragically, there are many of them—in a principled manner but also with great compassion, and, where necessary, they decide them speedily.

In the Nicklinson case, decided in our Supreme Court in June—I declare an interest because I represented the organisation Dignity in Dying—some of the judges suggested that a judicial safeguard for assisted dying would be appropriate and would provide greater protection for the vulnerable than they have under the present law. The noble and learned Lord, Lord Neuberger, the President of the Supreme Court, said at paragraph 108 of his judgment, that less protection for the vulnerable is provided by the current system of a lawyer from the DPP's office inquiring after the event into the motives of the person who provided the assistance, and whether the individual concerned was voluntarily ending their life, than under a new law that would require a judge to be,

"satisfied in advance that someone has a voluntary, clear, settled and informed wish to die and for his or her suicide then to be organised in an open and professional way".

The noble and learned Lord, Lord Wilson, at paragraph 205, and the noble and learned Baroness, Lady Hale, at paragraphs 314 to 316, spoke to similar effect. I respectfully agree with them, and I hope that your Lordships will too. Amendments 1, 4 and 24 would provide for these judicial safeguards. I beg to move.

10.15 am

Lord Carlile of Berriew (LD): My Lords, I have put my name to Amendment 2 along with the noble Lord, Lord Darzi of Denham, and the noble and right reverend Lord, Lord Harries of Pentregarth, and I wish to speak to Amendment 2 now. It is always a pleasure to follow the noble Lord, Lord Pannick, and I both agree profoundly and disagree profoundly with the amendments that he has just proposed. I need to explain very briefly why I agree, because he has given a very cogent argument for that aspect of the matter, and, at a little more length, why I disagree. I and the two other noble Lords who have signed Amendment 2 have also signed a number of others and I will explain why in a moment. They propose a very different judicial system from that which has just been advocated by the noble Lord, Lord Pannick.

I agree with the noble Lord that there should be a court-based system. Indeed, that is what the Supreme Court, in the case in which he appeared with distinction, appears to have advised. The judgments in the Supreme Court are not uniform, of course, and a degree of interpretation is required to distil common themes from them. But in my view there are some. I often take train journeys from Euston to the north-west or mid-Wales and as I get on the train I show my ticket to the person standing at the platform entrance. Then the train manager comes round and asks for my ticket again, and, to my intense annoyance, never asks me for my senior railcard—he takes it for granted that I have one. I am sure other noble Lords here suffer the same indignity from time to time and wish it were otherwise. In a sense, that is a metaphor for my view of what is proposed by the noble Lord, Lord Pannick. What he has proposed is not a robust, analytical, court-based, evidence-founded system of whether it is right in law for a person to be given assistance to commit suicide. The way it has been drafted gives the court the opportunity to verify whether the procedures set out in the Bill have been carried out. There is no merits-based assessment in his recipe and I reject that approach.

That said, I agree entirely with the noble Lord that the Family Division of the High Court is extremely well equipped to deal with these cases. The adjudication on the switching off of life support machines, on Jehovah's Witnesses refusing operations that involve blood transfusions and on other similar issues was very nobly pioneered by the Family Division of the High Court, particularly under the presidency of the noble and learned Baroness, Lady Butler-Sloss, who I am delighted to see in her place. The Family Division of the High Court contains on its bench real experts on issues that cover not only the nuts and bolts, complex as they are, of family life, but also the moral, ethical and even philosophical issues that may move decisions as to whether, for example, deaths should be allowed to take place in a particular way by the switching off of a life support machine. There is no doubt that the expertise lies there.

The clue to what I and the other two noble Lords who have kindly signed my amendment wish to do is actually to be found in another amendment, which we will debate in the next group. I think it is right to draw your Lordships' attention to the very last amendment on the Marshalled List, Amendment 175, which provides that an applicant may,

"apply to the High Court of Justice for assistance with suicide if they consider that in the absence of such assistance their rights under Schedule 1 to the Human Rights Act 1998 would be breached".

In other words, our court-based system is an evidence-based system which would require the High Court of Justice Family Division to decide whether there had been a breach of convention rights and, in particular, the convention right under Article 3 and, as it is always spoken of in this context, the article right which covers family life, privacy and so on.

The philosophical difference between me and the noble Lord, Lord Pannick, and the noble and learned Lord, Lord Falconer, on this is about where the real decision-making should lie. In what I am sure I can be forgiven for calling the Falconer-Pannick approach—I hope I will be forgiven for the shorthand—we have a medical model for decision-making. In my approach, with the noble Lord, Lord Darzi, and the noble and

right reverend Lord, Lord Harries, we have a court-based approach to decision-making. I much prefer the experience of the courts and the court-based approach.

My father was a general practitioner. He was born in 1904. He practised in two countries in two very different capacities, spending the last decades of his life practising as a general practitioner in Lancashire. He was a very wise and reasonable man—my mother used to say I took after her. He always used to say to me that there are some wonderful people in the medical profession, but there are some terrible rogues as well, including famous ones, such as Dr Shipman. I spent 10 years, to my father's great delight, as a lay member of the General Medical Council, and I saw a procession of outrageously badly behaved doctors going through the GMC conduct and health committees. They were very difficult to detect. It certainly did not amuse me as it amuses one or two senior Members of your Lordships' House sitting opposite me who really should not find this a laughing matter.

I turn to the reason why we propose what we do, for there is a rational basis to this. I turn to exactly the same points as the noble Lord, Lord Pannick. I refer to the judgments in the Supreme Court of the noble and learned Lord, Lord Neuberger, the president of the court, and Lord Wilson. As the president of the court, the noble and learned Lord, Lord Neuberger, obviously has a very important role to play and is seen to represent a view, perhaps a corporate view of the court, although it does not flow from this case necessarily. Lord Wilson, as he pointed out during his judgment, has a very important role to play because he is by experience a very senior family court judge and has widespread experience of matters relevant to this issue.

It seems to me—other noble Lords may disagree with this—that two themes emerged from the Supreme Court judgment, if one can draw themes from 130 or so pages of several judgments, which is not easy. The first theme that emerged is that their Lordships thought that there is a possibility—they did not put it much higher than that—or perhaps something between a possibility and a probability, that there may be cases in which the Suicide Act, as amended, is incompatible with the European Convention on Human Rights and that therefore there might be a case, which has not arisen as yet, in which there might be what is called a declaration of incompatibility between existing United Kingdom statutory law and the European Convention on Human Rights. I am going to leave out of all today's discussions that I raise any question about whether we should still have the European Convention on Human Rights because I think all reasonable people agree that if we did not have the European convention, we would have a convention with at least the same rights in it, so I park that point and hope that we do not have to return to it later.

Lord Wilson said that Parliament might consider setting up a situation in which the Family Division of the High Court would consider a large number of matters upon which evidence would be required to satisfy the court that there would indeed be a breach of convention rights justifying a declaration of incompatibility. My view is that declarations of incompatibility between European convention law and UK statutory law are extremely undesirable because they stir up the sort of political argument which I adverted to briefly a moment ago about whether we should have the convention at all. Lord Wilson said in paragraph 205 of his judgment that,

"Parliament might adopt the procedure approved in the *F* and *Bland* cases and require that a High Court judge first be satisfied that a person's wish to commit suicide was … voluntary, clear, settled and informed".

He then set out in his list a to r—a long list—factors which the court might wish to investigate before deciding whether it could be so satisfied.

My Amendment 2, and all my other amendments on the judicial model, which we will be debating later, seek to provide exactly what Lord Wilson had in mind. I shall not go through the list from a to r because I do not want to take up undue time in your Lordships' House as we have plenty to debate, although I would strongly recommend to your Lordships that nobody should speak on this issue without being able to put their hand on their heart and say that they have read Lord Wilson's judgment, or at least paragraph 205. However, it includes, for example, the nature of the individual's illness, physical incapacity or other physical condition; the aetiology of the condition; the attitude, express or implied, to his proposed suicide on the part of anyone likely to benefit, whether financially or otherwise, from his death; the motive of the person proposing to give assistance; and any financial recompense or other benefit likely to be received by such person in return for or in consequence of the proposed assistance. Those are just five of the factors in the a to r list which he set out.

What I propose to your Lordships—in my view this is something that should have been taken up by the noble and learned Lord, Lord Falconer, in redrafting his Bill, as I believe he should have done, to a court-based model—is intended to provide—I do not speak for perfection in drafting—a complete court-based model in which the merits could be considered by a court in a proper way, just as it is done in other cases now. I believe that a system of this sort—contrary to the views which I conscientiously hold, by the way—might allow some cases of assisted suicide in those cases where it was shown beyond reasonable doubt that there was a breach of the relevant articles of the European convention.

Lord Framlingham (Con): My Lords, I am not a lawyer, but I want to get something quite clear. Is all this happening while the family and the patient are wondering what is going to happen? Just how long is it likely to take?

Lord Carlile of Berriew: That is a very good question and I am very happy to answer it. Those who have studied these cases as they go through the Family Division know that it is capable of dealing with them very quickly indeed, according to the needs of the case. I believe that these cases would be given sufficient priority for them to be dealt with within a reasonable time—by which I mean days rather than months if necessary. There is really no difference between me

[Lord Carlile of Berriew]
and the noble Lord, Lord Pannick, on this subject because we both require the cases to go before the courts.

I should like to complete this because I have taken nearly a quarter of an hour and I do not want to take more than that—[*Interruption*.] This House must not seek to stifle debate on serious issues.

Noble Lords: Hear, hear!

10.30 am

Lord Carlile of Berriew: I have in mind the words of the *Companion.* I say to any noble Lord who is intending to make this less than the sort of the debate we would hope for in this House that we will, if necessary, have a full discussion on all the issues. Please bear with me for another minute and a half or so.

I hope that the noble and learned Lord, Lord Falconer, will take back and consider in due course what is proposed in Amendment 2 as I do not wish to force the House to decide on these issues today. What is proposed is the sort of court-based model which could make the United Kingdom an exemplar to the world of how we have a judicial system that is flexible enough to take in cases at the extremes but sustains the principles in which it has long believed.

Baroness Tonge (Ind LD): I thank the noble Lord for giving way. I would just like to ask a very simple question, because I am ignorant of these matters. How much would this cost for a dying patient who desperately wants to end his suffering surrounded by his family, and would he get legal aid?

Lord Carlile of Berriew: I am grateful to my noble friend. I believe that legal aid would be available if necessary under the exceptionality provisions. When I was asked this question yesterday, I reflected on the cost of the recent funeral of my own mother. I anticipate that these costs would potentially be about the same as for a funeral. We are talking about life and death here. My noble friend is a distinguished member of the medical profession. We are talking about taking a huge constitutional step which would allow a medical practitioner to participate in the killing of another human being, deliberately bringing about their death. This is very different from the doctrine of double effect, about which the noble Baroness, Lady Finlay, and other noble Lords have spoken on numerous occasions in your Lordships' House. I do not regard the cost issue of life and death as being very significant in this context.

In conclusion, I hope that I have made the basic—

Lord Warner (Lab): My Lords—

Lord Carlile of Berriew: When I have finished my sentence, I will give way. I hope that I have made the basic reasons clear. Now that I have finished my sentence, I will delay sitting down in order to respond to the noble Lord opposite.

Lord Warner: I am extremely grateful to the noble Lord. Does he accept that, under the amendment in the name of the noble Lord, Lord Pannick, the family court would have to have regard to the Human Rights Act in forming its judgment?

Lord Carlile of Berriew: I accept that the family court would have to have regard to the considerations which are set out in the amendment of the noble Lord, Lord Pannick. The difference between that amendment and ours is that ours sets out a very clear way in which the convention issues would have to be considered by the court rather than what amounts to verifying that a process has been followed. On the one hand, we have a process-driven amendment; on the other, we have a legal framework. I will happily give way to the noble Baroness.

Baroness Farrington of Ribbleton (Lab): My Lords, I cannot speak for anyone else on these Benches. I smiled while the noble Lord was speaking because, when he was referring to the fact that there are occasionally rogue doctors, it occurred to me that rogue lawyers have occasionally been known, too.

Noble Lords: Hear, hear!

Lord Carlile of Berriew: First, I would say that, when I see the noble Baroness smile, I always assume that she is smiling at me rather than at anything I am saying. She is known in this House for her ineffable charm and courtesy.

Noble Lords: Oh!

Lord Carlile of Berriew: Secondly, the noble Baroness has reminded me of something which I intended to say, did not say and therefore will say now. Yes, there are rogues in the medical profession and there are most certainly rogues in the legal profession and in politics. What we are talking about under this Bill is a model that relies, unacceptably in my view, on the medical profession.

Baroness Williams of Trafford (Con): My Lords, before we continue, may I refer noble Lords to the *Companion*, which suggests that, in debates where there are no formal time limits, contributions are kept to 15 minutes?

Baroness Butler-Sloss (CB): My Lords, I should like to continue on this subject of the law. I was in the Bland case in the Court of Appeal. As President of the Family Division, at one stage I tried nearly all the permanent vegetative state cases. On the assumption that this Bill is passed, it seems to me critical and essential that the court should have an input. I would prefer the version of the noble Lord, Lord Carlile, but, speaking as a former judge, I would say that the version of the noble Lord, Lord Pannick, would actually require the judge to take account of all the relevant factors. I would be astonished if the High Court did not wish to confirm that it is satisfied, and that is a

high standard. The judge would have the power to require, for instance, a psychiatrist or other medical opinion, if the judge was not satisfied that the patient—we are talking about the rights of the patient—had the full capacity necessary to make this absolutely crucial decision.

As to how the case would be tried, it would likely go before a Family Division registrar. It would go before a High Court judge. In my day, I was able to try cases on the day that the problem came before the High Court and it was able to go to the Court of Appeal on the same day if it was sufficiently urgent. I would expect the President of the Family Division to treat all these cases with the utmost seriousness and would see it as crucial that they be heard as quickly as possible. It would be a matter for the Government of the day as to whether legal aid were given, but in a matter of this absolutely enormous importance as to whether somebody is entitled and has the capacity to make the decision that they wish to end their life, I would think it quite shocking if legal aid were not granted.

Baroness Neuberger (CB): My Lords, I rise to speak to the amendment of the noble Lord, Lord Pannick, to which I have put my name, and to add to that of the noble Lord, Lord Carlile. I agree with almost everything that has been said but, if responsibility is given to the Family Division in some way or other, there might be reason for a ticket system, as happens in serious sex or murder cases. That way, the judges within the Family Division who are going to hear these cases very quickly will have had training in how to look at them and, where necessary, examine the medical evidence in detail. A ticket system and specific training for members of the Family Division in this area would be an improvement on simply saying that it was available to everybody. I support the amendment of the noble Lord, Lord Pannick.

Baroness Wheatcroft (Con): My Lords, we have heard from three lawyers. I am not a lawyer—I have to confess that I have not read even paragraph 205 of Lord Wilson's judgment—but I feel obliged to stand up and say that I think we are missing the point, as I see it, of the Bill of the noble and learned Lord, Lord Falconer.

This is not about medical decisions or judicial decisions; it is about compassion for people nearing the end of their lives. These people have decided that they have had enough. The thought of having to go through a legal process—even if, as we have heard, it has been curtailed as far as possible—and incurring legal bills is the last thing that they want to deal with, if they have complied with the law that the noble and learned Lord, Lord Falconer, is suggesting and have actually come to a reasoned decision that they have gone on long enough and the time has come for them to die. We ought not to prolong that procedure for any longer than we have to. I do not think that lawyers have the final view on all that is right.

Lord Deben: My Lords, my noble friend is assuming that every one of these cases is of someone who had voluntarily made all those decisions. We are here concerned that there will be some cases—from my long experience as a Member of Parliament, rather more than some people think—in which that is not so, and somebody has to protect them against being thought to have made that decision when in fact they have not done so.

Baroness Wheatcroft: My Lords, there may indeed be one or two occasions on which that is the case. However, we are looking for at least two medical opinions here, both of which will regard the sanity of the individual. If that individual decides, in full knowledge of what is going on within the family, that that is the decision they want to take, then, on balance, I suspect that we should let them.

Baroness Mallalieu (Lab): My Lords, I have put my name to the amendment. I support the Pannick version of judicial intervention for the reasons already given with great care by the noble Lord, Lord Pannick. I also listened with care to almost all of the 129 speeches at Second Reading on 18 July in this House. There is a need to address two major reservations expressed by a number of noble Lords, which I accept have validity.

In essence, those reservations relate to two undeniable traits of human behaviour which we must accept exist and which no Bill of Parliament or amendment can extinguish. The first is selfishness. I see the noble Lord, Lord Tebbit, was trying to speak and I hope that he will shortly. He referred in his Second Reading speech to "the vultures": relatives or friends who might have a financial or other interest in the death of a dying person and be tempted to put pressure on that person to end their life, to bring forward the date of the realisation of their expectations or, perhaps, to save care fees—albeit that, under the Bill, they would only have to wait a maximum of six months in any event.

Secondly, there is selflessness: those who feel guilty about the expense, trouble, time, worry and distress which they are causing those whom they love, and who may be tempted to shorten the process—not because they truly wish it—not for themselves, but for others. There are, of course, subdivisions: the relatives who cannot bear to see mother suffer, and so on. I accept that those are genuine concerns and they are the reasons why I primarily support the amendments of the noble Lord, Lord Pannick.

Although neither selfishness nor selflessness can be eliminated, through judicial oversight it can be guarded against, possibly even better than it is at present. The medical condition of the applicant can be assessed by a medical expert and by a wholly independent, experienced judge—although there are crooked lawyers and experts of every kind, our judiciary is still, thankfully, totally respected—who by training and expertise is qualified to judge pressure, coercion and genuine or false wishes, and to examine or evaluate evidence as to whether somebody has capacity, is acting voluntarily and has a clear understanding and a settled wish to end his or her own life. I want someone like that to have the ultimate say on the decision.

However, it is not a question of a decision being made by a doctor or by a judge; I want the decision to be that of the person that is facing death. We have got

[Baroness Mallalieu]
to get back to that. Judges, especially in the Family Division, are dealing with judgments of that kind—about what people really want, whatever they say, and about pressure and coercion—day in and day out. I will of course listen carefully to the amendments in the next group that have been tabled by the noble Lord, Lord Carlile, and others on judicial oversight. However, on the basis of what we have heard already from the noble Lord, they appear to present a bureaucratic, legalistic obstacle race which is bound to be both lengthy and costly to the applicant. One of the objects of the Bill is, I hope, to leave behind the absurd anomaly we have at present whereby, if you are rich enough, you can go to Zurich, but if you are not you have no choice but to endure possibly totally unnecessary suffering at the end of your life.

10.45 am

That the law at present forces some people to endure such suffering at the end of their lives, because doctors either cannot or are afraid to help, was graphically illustrated by some of the speeches and personal experiences we heard at Second Reading. I shall never forget my noble friend Lord Judd reading out that moving letter from the widow of a man who had died in excruciating pain, with the doctor afraid to give him more painkiller for fear of killing him.

That is the cruelty that the Bill is trying to address. Its provisions have the support of the majority of the country. The Supreme Court has given Parliament this chance to grasp this issue and make the law. If we do not, then the courts will. We can improve the Bill with these amendments, and must do all we can to see that it reaches the statute book. I know that some noble Lords will have religious, ethical, moral or personal objections to assisted dying in any form. That is their right and their choice. However, others must be free, under the law, to choose another way.

The major reservations to the Bill, about protection for the vulnerable, will be met by the amendments of the noble Lord, Lord Pannick. I urge all noble Lords to support them.

Lord Tebbit (Con): My Lords, I worry a little, because I do not quite understand some of the proposed legislation. It is very much about process, which is very important. However, it should also surely be about deterrents against wrongdoing. I recollect that, when I had responsibility for taking legislation through Parliament, some of which one or two noble Lords opposite will remember quite well, one of the things I had to constantly ask myself was, "What are the means of deterring people from wrongdoing?".

This is about going to the High Court and all sorts of other things, with doctors doing this and that. Supposing there is wrongdoing, how do we deter it? At the moment, if somebody wrongfully puts pressure on, or wrongfully assists, a suicide, they know that the law is there and that its hand may fall on their shoulder. I may be wrong but, as I see it, if we enacted these measures we would only be adding to the procedures, not to the deterrents against wrongdoing.

I speak with some feeling. I have had the prime responsibility of the care of my wife for the last 30 years. She has been in constant pain. It is getting worse. She requires more and more care. I fear for the day when she will say again to me what she said to me a little while ago: "You know, you would be better off without me". There are many ways in which pressure can be brought to bear to make people who are perhaps approaching the end of their lives—although I hope that my wife is not—to "do the decent thing". These amendments do not do anything to avoid that, and that is what worries me.

Lord Condon (CB): My Lords, I declare my registered interest in policing. I support the amendments put forward by the noble Lord, Lord Pannick, and other noble Lords, for the reasons that he outlined. At Second Reading I expressed a wish that the involvement of the High Court was perhaps the way forward on this issue. Like many of your Lordships, I had the privilege and honour of sitting through the previous debates on this issue, and like everyone in this House, past and present, we felt enormous compassion and wanted to find a way through this issue, which resonated with the feelings out there in the wider community.

For my own part, I have never been able to be satisfied that abuse, coercion and the prospect of malpractice of the sort outlined by the noble Lord, Lord Tebbit, were addressed in our previous attempts to deal with this tragic issue. However, we are now tantalisingly close to finding a way through this issue. It will assuage those of us who fear abuse, coercion, the right to die becoming the duty to die, and so on. Therefore I hope that we will find a way through this issue that involves judicial oversight and scrutiny.

At the moment I find myself favouring the approach of the noble Lord, Lord Pannick, in his amendments, as a medical-based approach but with judicial verification and oversight, because it is not quite so bureaucratic as the way forward suggested by the noble Lord, Lord Carlile. However, I hope we will find a way through this issue through judicial intervention.

Lord Tebbit: What does the noble Lord feel about the fact that a number of doctors who, quite wrongfully, signed chits, or whatever they are called, to allow sex-selective and frequently late abortion of patients whom they had never seen and whose names they did not know, have gone unpunished? Where is the deterrence to that?

Lord Condon: The noble Lord raises a very vital issue. We can and will address it in two ways: first, through the judicial oversight, and secondly, by amending Section 10, which at the moment has insufficient offences, but which can be amended to have a range of offences that will satisfy just the concern that the noble Lord has raised.

Lord Phillips of Sudbury (LD): My Lords, it is in the very best traditions of this House that there is standing room only at this debate on a Friday. It is entirely appropriate, is it not, given the profound issues that are involved? I have no doubt at all that the

country will be watching and listening to this debate in a way in which it perhaps has not done since the last of these debates, because this is one in a series. Like other noble Lords, I have taken part in all those debates; I come at the subject from having spent six years in the early part of my legal career as a part-time assistant to a part-time coroner and occasionally deputising for him. I was very vividly thrown up against the issues that are at the root of this legislation. I have to confess—I see the noble Lord, Lord Joffe, sitting yonder—that whereas I was wholly unconvinced when the noble Lord started his pilgrimage, the Bill contains the sort of protections that could make it one which we should support, given that it blocks off the thin-end-of-the-wedge fears that many of us had formerly.

I will make only one major point. We do not want to go from a situation where, as now, you have to be rich enough to go to Switzerland to get some sort of justice in these complicated matters. However, we could be in a comparable if lesser dilemma because of the cost which will attach to going to the High Court—with representation, as one would have to have—and getting an order. I have no doubt that the cost will be more than most of us expect and more than some of us fear, and legal aid is now available only to people at a very low level of income, and it will leave at least 80% of the public of this country unsustained if they wish to use the remedies that the Bill will provide. That is not right in a matter of death. One of the things we need to contemplate is whether we have some special arrangements for this life and death matter.

Secondly, the noble Lord who produced the Bill has done wonderful work, and those who tabled the amendments—the noble Lord, Lord Pannick, and my noble friend Lord Carlile—have also done great work. However, there is a huge number of problems at the back of either amendment; a great number of issues that have not been considered carefully, in the round, and reported on. I hope very much that we will not vote on these amendments now or indeed at all today, because we all need time to reflect on and contemplate them. However, I would like us to think about—and, if necessary, to form— an ad hoc group to report on whether one could not deal with the issue at the heart of these amendments just as well by having either a county court judge or a special panel of justices of the peace to determine the issues concerned. Some may think, "That's not good enough". As one who spent a lot of time in magistrates' courts and county courts in years past, I do not hold that view. In some ways, given that the issues are—how shall I put it?—common-sense life experience issues that will have to be determined by whoever adjudicates on this, I am not so sure that a county court judge or a panel of magistrates might not be at least as good, competent and able to undertake the decisions involved.

Lord Harries of Pentregarth (CB): My Lords, my name is down in support of the amendment in the name of the noble Lord, Lord Carlile, with the noble Lord, Lord Darzi, and I very much support the reasons he set out so cogently.

I was very glad to see the amendment in the name of the noble Lord, Lord Pannick, because it points in the right direction. I cannot support it, because I believe that doctors should not be involved at all in the final decision-making process. Under the noble Lord's amendment, the courts would check that a good decision had been made, and they may ask for witnesses, as the noble and learned Baroness, Lady Butler-Sloss, said.

We need, for all the reasons set out at Second Reading, to take doctors out of the decision-making process altogether. I remind your Lordships of points made at Second Reading about the erosion of trust if a Bill such as this went through Parliament, and the minority of doctors who are willing to take part in the system—four out of five doctors are totally opposed to taking part in it, so only a minority of doctors would be willing to do it. That would lead to a lot of looking around for the right kind of doctors. I do not want to get into the business of knocking doctors—they have been in my family for some time; my wife and my son are doctors, and my grandson is on the way there—or weighing the relative merits or demerits of rogue doctors and rogue lawyers. However, we are not talking about individuals, but about the Supreme Court. The Committee on Standards in Public Life carried out a series of polls about how the public regard various professions, which shows that trust has been eroded in so many professions, but not in judges. Trust in judges remains at about 80%. That is a very significant factor; decisions made by the court on this issue, if we eventually went down this road, would be trusted by the general public.

I would just like to mention one point that has not been mentioned. I have a quotation from the noble and learned Lord, Lord Neuberger, in the judgment that the noble Lord, Lord Carlile, was discussing. He said:

> "Quite apart from the notorious difficulty in assessing life expectancy even for the terminally ill, there seems to me to be significantly more justification in assisting people to die if they have the prospect of living for many years a life that they regarded as valueless, miserable and often painful, than if they have only a few months left to live".

11 am

The reason for mentioning that is that, if we are moved by compassion for people who feel that their lives are intolerable with only a few months to live, how much more are we moved by compassion for people who have years and years? It is no secret that the people behind the Bill see it as the first step. Suppose that it eventually became the settled wish of this country to have some kind of system whereby people who, on finding that their lives were utterly miserable and unbearable, wanted to end it, the only system that the country as a whole would trust would be one set out along the lines set out by the noble Lord, Lord Carlile. I do not support going down that road but, if it became eventually the settled wish of this country and people, moved by compassion, did not want to stop at those who were dying with a few months to live but who might have years of totally intolerable life ahead of them, the only way in which decisions could be made that would be trusted would be if they were made by the courts.

The noble Baroness, Lady Wheatcroft, spoke of compassion, but we are all moved by compassion. I believe that everybody in this House on all sides of the

[Lord Harries of Pentregarth]
debate is moved by compassion—but there is not just compassion for people who have a few months of intolerable life to live. There is also the compassion for those who might be put under all kinds of intolerable pressure, whether it is meant or not, as was stated so movingly by the noble Lord, Lord Tebbit. In response to what he said, I believe that a court-based system would actually act as a deterrent. First, the number of cases that went to it would be relatively few and the tests would be very stringent. If people did not meet those tests and acted on their own, they would be liable to criminal prosecution. So I very much welcome and support the amendment proposed by the noble Lord, Lord Carlile, as I know the noble Lord, Lord Darzi, does as well, as he also has his name to it.

Lord Ribeiro (Con): My Lords, I should like to speak as we have heard many noble Lords speaking but we have not heard from the medical profession. Noble Lords will have heard that the majority of doctors are not supportive of being involved in the decision-making process. The reason is very clear. I, as a surgeon, on more than one occasion had to deal with children and adults—but children particularly—whose parents were Jehovah's Witnesses. If an operation was needed that required transfusion there was a dilemma between my opinion that surgery and transfusion were necessary to save that child's life and the parents' decision that under no circumstances was a transfusion to be given.

What has made life easier for doctors is that we can now go for a judicial decision, made by the judges as to what should happen. That happens when, as was mentioned earlier, you have to divide a Siamese twin, to which the noble Lord, Lord Pannick, referred, or when you have to switch off the machine. These are important life and death decisions. Surgeons have always been referred to as people who play God and carry out life and death decisions, but the fact is that this is a situation in which they feel comforted that the decision is taken outwith their domain and taken by the judiciary. The same principles apply here, in this case.

I am slightly varied in terms of whether I support the noble Lord, Lord Pannick, or the noble Lord, Lord Carlile, but, in either case, doctors should be as far removed from decision-making as possible. If it is decided that assisted suicide should then happen, the mechanism and how it is done and whether it involves the medical profession is something to which we can then apply our minds. But the initial decision must be underpinned by the judiciary.

Baroness Finlay of Llandaff (CB): My Lords, as another doctor I follow the noble Lord, Lord Ribeiro, who has explained so clearly why doctors do not feel that they should be involved in this. Indeed, my feeling is that the noble Lord, Lord Pannick, has made a very important first step, but I worry that his amendment does not go far enough. For that reason, the amendment tabled by the noble Lord, Lord Carlile, about which we will hear more in further groupings, is the way forward.

I reassure all Members of this House that compassion is at the heart of those who do not support this Bill. My objection is on public safety to protect those who are vulnerable. I declare an interest, having looked after these patients for more than a quarter of a century. I have looked after thousands of people—I have had hundreds of conversations with people who wanted their lives to end. Then we have done things, and they have not persisted with those requests.

I address very briefly the issue of finance. Please do not forget that many people who are dying are already reliant on charitable funds of different sorts to support them. I do not believe that it is beyond the wit of our society to find a way of having pooled funding that can be drawn on to support the fees for a legal process where it is absolutely right to go through one, and society deems that it is. It is dangerous to have the illusion that money would get in the way.

I address a couple of points that have already been raised in the previous excellent and outstanding debates, when examples were given of poor pain control. As a clinician, I was horrified at the bad care. There is no excuse for not redoubling efforts to relieve symptoms or to withhold analgesia from someone who needs it; even if you know that you are taking a risk and you are clear with it, there is absolutely no excuse, and our law does not require doctors to withhold all efforts to relieve distress. But doctors have to look after patients, and we are often in a difficult situation.

The noble Baroness, Lady Mallalieu, laid out very clearly the problem of coercion and coercive pressures, and I completely agree with her. There are external pressures, and pressures now coming from healthcare. Sadly, it is true that not all doctors are good doctors. At a meeting this week, we heard from the CQC that 2% to 3% of general practices will probably have to go into special measures and that 20% to 30% are below substandard. Yet the Bill without these amendments leaves decision-making in the hands of people—we know not what. We will go on to address all the inadequacies in the Bill.

There are families where there is carer fatigue—they are worn down. I have had families refuse to take patients home because they are fed up with their relative. That is a really difficult conversation to have with anybody. Indeed, I have had relatives pressurise me to give something to end a life and get it all over with—yet the patient has not wanted their life to be ended. As I have already explained to your Lordships, I discovered later, after the birthday of one female patient, that it was her fixed-term life insurance policy running out that drove the request to push up the drugs. After her birthday, they did not get the extra money and they visited less. I am afraid that I was taken in before I knew that, and I have been taken in time and again—because, while most parents love their children, sadly, not all children love their parents. It is difficult to detect coercive pressures, but then there is also the selflessness that patients may feel when they know that they are imposing a burden on their family.

Let me give a cogent example. I was asked to see a man by a GP who said that the man was a clear case for euthanasia or assisted suicide but that he could not

give him a lethal injection. That was the only reason the GP was referring him. The consultant surgeon, oncologist and GP all thought that the man had a life expectancy of three months. His wife had just given birth to their third child. There was a small baby there. I went straight out and I was there until 11 o'clock that night. The distress was overwhelming. Weeks later, the distress was calming down. Much later, when I had conversations with that man, he said that the pain had been overwhelming and the prospect of becoming paraplegic and wheelchair-bound was overwhelming and terrifying but that also at the back of his mind he wondered how his lovely, beautiful postnatal wife could cope with their three children, particularly the new baby, and look after him as well. He felt that it might be best for everybody if he was not there. I spoke to him this morning. He said that I could relate his story. He can see the dangers of what is proposed because he lived way beyond three months. We will discuss prognosis and the difficulty of determining who is terminally ill later.

However, if the court were to receive evidence from experts, not the doctors described in the Bill, and assessment of capacity were done properly by experts, the court could make a balanced decision and that would not contaminate the way that clinicians behave. It would not put clinicians under a lot of pressures which are difficult to untangle and it would maintain their prime duty to relieve the distress of the patient in front of them, and to help the family and carers cope and redouble their efforts when they fail. It is for that reason that I think the Bill is wholly inadequate without such a control.

Lord Berkeley of Knighton (CB): On a point of information, given my noble friend's enormous experience, I would be very grateful if she would say whether she has ever been in the position—or what she would do if she were in that position—where she has felt that she should give a patient a dose of analgesia that might end their life. How would she deal with that situation?

Baroness Finlay of Llandaff: I shall answer that directly and attempt to be as clear as I can. I have seen patients who are in overwhelming distress. I have sat there with a syringe full of diamorphine—heroin—and titrated it in milligram by milligram, minute by minute, until the patient's pain level changes from unbearable—usually, 10 out of 10 or even 11 out of 10—to a level that they can cope with where they tell me the pain score is three or four out of 10. When I have done that, I have known that I may suppress their respiration but that is a risk that I am prepared to take and I have adjacent to me what I would need to maintain their respiration if it dips. I have seen patients who have been given an inadvertent overdose, where their respiratory rate has dropped to critical levels but we have found ways round that and restored their respiration without having to reinflict pain. I have been in one situation which was, I think, the only time that I could say honestly that I have used the principle of double effect. I had a patient with a horrible head and neck cancer. The whole of his neck was solid. The nurses asked me first thing in the morning to go to see him—

Baroness Blackstone (Lab): My Lords, I am extremely concerned about the time. I am certainly worried that we are drifting—

Noble Lords: Oh!

Baroness Blackstone: Please let me finish what I wish to say. This is a Committee Stage of a Bill and it is very important in Committee that we stick to the amendments on the Marshalled List and do not debate a whole lot of other issues when we are considering a particular grouping.

Baroness Finlay of Llandaff: My Lords, I am simply trying to answer the question as succinctly and honestly as I can and not to waste the Committee's time. I hope that my intervention so far has not done that; it is still under 10 minutes.

I realised that the man I was talking about was unable to breathe and that there was no way we could restore his airway. He was terrified and standing in a panic. I therefore gave him what I thought was a tiny dose of midazolam to calm his anxiety from the breathlessness. Unfortunately, as he relaxed, he obstructed his airway and I was then faced with somebody with no airway but still conscious, so I injected all of the ampoule and another one that I had taken with me in case I dropped the first one, knowing that I may be bringing about the end of his life. As he became blue, purple and blotchy and collapsed, the nurse and I caught him and got him on the bed. After what seemed like an eternity, he started to breathe again. He lived for four and a half hours in a peaceful and comfortable state. As I administered the drug, I thought that my defence in court would be that of double effect. That is the only time that I have thought that I would need to use that defence.

I hope that explains to the noble Lord why we go up to the limit and we know the risks that we are taking. However, that is fundamentally different from deliberately foreshortening a life that would otherwise go on for days, weeks, months or possibly years because we cannot predict prognosis.

11.15 am

Lord Campbell-Savours (Lab): My Lords, this issue is for me very personal. I have deep sympathy with those who are standing outside Parliament today, demonstrating on this issue, and with the millions of people who also feel strongly about it, many thousands of whom have written to Members of this House over recent weeks. I want to explain why this issue is very personal. I have now been ill for 31 years, and I have struggled on many occasions to survive different operations. Only last week I spent another week in hospital. Whereas five or 10 years ago I was opposed to assisted dying, I now realise that some people desperately want out. They want to leave the world. That has never crossed my mind but one day it might, and I want that right. To be frank, I do not want the courts to interfere in it. The courts will create congestion in the system which people want to avoid.

[Lord Campbell-Savours]

I also recognise that something is missing in the Bill to cover the issue of duress and coercion, which have been referred to by a number of noble Lords. We have to add something to the Bill to reassure people that that matter can be dealt with. I would go down the route referred to by the noble Lord on the Liberal Democrat Benches—forgive me, my memory is not too good at the moment—who referred to an alternative to court proceedings. We need a panel, perhaps comprising community-based guardians. I do not know whether they should be elected or appointed, or how they should be appointed if they are to be appointed, but they should be people who are capable of handling these sensitive situations. They need not necessarily receive a professional remuneration but they should be able to talk to people who have taken this decision. If, having talked to those involved, these people are uneasy, they should be able to instigate a further hearing of the issues, not necessarily in a court of law but in some forum. I say that because I am concerned that medical practitioners, whether the attending medical practitioner or the independent medical practitioner, may simply not have the time to sit down and ask the detailed questions that are necessary to secure the information to meet the criterion set out in the Bill.

When you are lying in a hospital bed—I have done it dozens of times over many years—you hear the conversations with doctors. They are going on around you all the time when they do their rounds in the morning or when they come back if there is a problem on the ward. I simply cannot imagine the circumstances in which doctors would be able to sit down and have that very meaningful, subtle conversation that can dig out the truth behind a particular application or declaration made by the person involved.

I therefore say to the House: please do not go down this judicial route; find another way of sensitively seeking to establish where the truth lies. If we do that, we will meet the objectives and concerns of all those outside who are basically worried that the Bill is going to be killed by the House of Lords because people have put up so many obstacles and amendments to wreck it. It would be a tragic day if that were to happen.

Lord Howard of Lympne (Con): My Lords, I declare an interest as the chairman of Hospice UK, formerly Help the Hospices, which is the umbrella organisation for hospices in the United Kingdom. Hospice UK does not have a collective view on the principle behind the Bill, so everything that I might say in this debate is the view that I express personally, not the view of the organisation—although I hope that it is a view informed by the knowledge that I have acquired of the remarkable extent to which palliative care, an area in which we in this country lead the world, can alleviate the suffering, which is the backdrop to all the issues that we are discussing during the course of this debate.

I want to limit my brief remarks to the issues that arise in the context of the amendment. Palliative care is increasingly—not yet, alas, universally—available, but we are making good progress towards that objective. However, one of the problems that arise is that not everyone who could benefit from palliative care is aware that it is available. That has a direct bearing on the issues we are discussing and on these amendments. One of the things that it is vital to bring to the attention of someone who is contemplating the awful decision that the Bill makes possible is that they should be fully aware of the extent to which they could take advantage of palliative care to relieve their suffering.

In the context of these amendments, one of the factors that I would expect a court to take into account is the availability of palliative care for the person making the application, the extent to which that person knows about the availability of palliative care, and the extent to which that has been made available to the person concerned. I give way to the noble Lord.

Lord Blair of Boughton (CB): I merely wish to ask whether the noble Lord is aware that Clause 3(4) requires both doctors to be satisfied that the patient has been fully informed of palliative, hospice and other care available to that person. In other words, this is in the Bill.

Lord Howard of Lympne: I am so aware but I would prefer that investigation to be carried out by the court. That is the issue between us. It is another reason why one or other of these amendments—I prefer the amendment in the name of the noble Lord, Lord Carlile—should be passed if the Bill is to become law.

Baroness Hollins (CB): My Lords, as a doctor, I would also much prefer a judicial process. I had the good fortune yesterday to speak to Professor Peter Rubin, the chair of the General Medical Council. I asked him whether many doctors had yet been referred to the GMC because they had failed to provide adequate pain relief to someone in the last days of their life. He said he did not know the answer but kindly drew my attention to the GMC's guidance, which I thought would be good information and useful for our discussion. It is entitled, *Treatment and Care Towards the End of Life: Good Practice in Decision Making*. He referred me in particular to paragraphs 24 to 27. I shall read just a short part of paragraph 27, which states:

> "You must seek advice or a second opinion from a colleague with relevant experience … if … you and the healthcare team have limited experience of the condition … you are uncertain about how to manage a patient's symptoms effectively",

and if,

> "you are in doubt about the range of options, or the benefits, burdens and risks of a particular option for the individual patient".

I will not finish reading out the paragraph. Although we may lead the world in palliative care, it is still a developing but important specialty and area of expertise, and we should give it adequate opportunity to continue to develop without interfering and changing the role of the doctor.

Baroness Murphy (CB): My Lords, I will stick to the amendment. I told the noble Lord, Lord Pannick, a few days ago that I would not support it for all the reasons that the noble Baroness, Lady Wheatcroft, mentioned, and the reasons raised by the noble Lord, Lord Campbell-Savours. This is a decision by patients—let us come back to them—it is not a decision by doctors.

Any judicial intervention placed between the patient and the processes by which they could be helped in what they want is likely to be difficult. Remember also that patients every day make decisions to end their lives. They make a decision not to have that last chemotherapy offered to them. They have had perhaps a year of it and they do not want any more. That wish is respected, their capacity is rarely mentioned and they make that decision.

However, I have thought a great deal over the past few days and looked again at the Second Reading debate. The anxiety raised was sufficient to suggest that perhaps we need to put in a process that can be quick. Operating in the mental health world, I know that the courts can readily convene at 24 hours' notice; I have often had to take a magistrate's order and get a court decision quite quickly. It is possible for someone to have judicial oversight within a short time if the process is developed correctly. Looking at the range of options provided in this group of amendments, I would say that the amendments of the noble Lord, Lord Pannick, are worth supporting, and I will go with them despite my original anxieties. They will make the Bill workable and not destroy it, whereas the amendments of the noble Lord, Lord Carlile, would make it unworkable. For that reason, I urge all noble Lords who like the principles of the Bill to support the noble Lord, Lord Pannick, in his amendments.

Lord Cormack (Con): My Lords, I hope we will not be called upon to vote on either amendment but very much hope that the noble and learned Lord, Lord Falconer, will reflect most carefully on what has been said. He knows that I totally respect, indeed honour, his motives in bringing the Bill before the House. He knows also that I have considerable misgivings. However, this House decided, rightly, to give the Bill a Second Reading, and it is now our duty to try to improve it so that those of us with misgivings have them allayed so far as possible, and so that those who believe in the Bill, and are a little impatient in their belief, will accept that we are in no sense seeking to retard the Bill's progress, but rather to improve it. I make that point in particular to the noble Baroness, Lady Blackstone, who intervened a few moments ago.

11.30 am

We have been debating this issue for only one hour and 18 minutes. It is central to the Bill. One of my reasons for having grave misgivings was encapsulated in the speech made by my noble friend Lord Ribeiro. Doctors are extremely concerned about being put in the driving seat. Doubtless most of your Lordships will have received the letter from the Association for Palliative Medicine, which came to virtually all of us this week. My noble friend's phone believes in a little musical accompaniment. Noble Lords must surely have been influenced by what was said by the eminent doctors in that letter.

In varying ways, the noble Lord, Lord Pannick, with admirable brevity, and my noble friend Lord Carlile of Berriew, with a little less brevity, advanced extremely powerful arguments to your Lordships' House. I very much hope that when the noble and learned Lord, Lord Falconer, responds to these amendments, he will indicate that he will not only take on board what has been said but have personal discussions with the two noble Lords who proposed these amendments and with others. It was proposed during the debate on my noble friend Lord Saatchi's Bill a couple of weeks ago that the best way to move forward would be to have a sort of round table, where all those with concerns could come together. I hope that the noble and learned Lord, Lord Falconer, will be willing to do something similar. This is the most important human issue with which the House can ever grapple. If we are to put a measure on the statute books—I say this to my noble friend Lady Wheatcroft—we must not be impatient, but we must strive for perfection and underline the reputation for careful scrutiny that this House justifiably enjoys.

Lord Stirrup (CB): My Lords, I will speak very briefly. I intended to preserve my first intervention for an amendment to which I have attached my name in the second group, but a couple of things have been said in this excellent debate that we should reflect on and that need a little clarification. It has been said that the Bill is not about doctors or lawyers, but about patients and patients choosing to die. That is not the case. The Bill is about others being permitted to contribute to a patient's death. This is not the dying Bill, but the Assisted Dying Bill. It is imperative that we focus our attention on the rules and safeguards that would be applied to those who will contribute to a particular patient's death.

In his very moving speech, the noble Lord, Lord Campbell-Savours, said that people simply want out. I understand that entirely and I absolutely respect it. Some people will of course have religious objections to that. I do not. I get that, I understand it and I do not believe that anyone should stand in their way. However, this is not just about people wanting out, but about people wanting others to help them through the exit. That raises fundamental issues of ethos in a number of professions. As the noble Lord, Lord Ribeiro, has said, this is a significant issue for the medical profession. I am not a member of it, but I have family connections and have spoken to many doctors—some of them relatives—on this issue. There is huge concern about it. I will expand on those issues in a later amendment. However, we should not concern ourselves with who in this House feels compassion; we all do. I am sure that we are all very sympathetic to the motives behind the Bill. As I said at Second Reading, I have the profoundest respect for the people who have brought the Bill forward and for their motives. However, I also have the profoundest reservations that, in attempting to do something good, we may in the process do something that will be much more harmful in the long run.

Baroness Cumberlege (Con): My Lords, I totally agree with what the noble and gallant Lord has just said. I come from a medical family. I am not a doctor, but I was made a fellow of the Royal College of Physicians, which asked me whether I would chair a working party to look at medical professionalism. That comes very much into these amendments.

[Baroness Cumberlege]

We spent a very long time thinking about this extremely difficult issue. Do people care about professionalism? Where is it? How is it defined? What is it all about? We had a very interesting scribe—the editor of the *Lancet*, Richard Horton—who devised an extremely good definition, which was very long. I said to my working party that I would not remember that great paragraph if somebody said to me, "Lady Cumberlege, what do you mean by 'medical professionalism'?". We put our heads together and thought very strongly. We decided that medical professionalism is signified by the values, behaviours and relationships that underpin the trust the public has in doctors.

I very much support my noble friend Lord Carlile's amendment. I fear that if we do not adopt something like this, which he described as a complete court-based model, trust in the medical professional will be eroded. That is surely the last thing that any of us wants. The noble and right reverend Lord, Lord Harries of Pentregarth, made a very interesting speech and I very much support what he said. However, I take issue with one thing. He talked only about doctors; we have heard only about doctors. Reference is made in the Bill to clinicians and to nurses. The noble Lord, Lord MacKenzie, and I have tabled a number of amendments, which we will come to later, on the role of nurses in this. They are mentioned as clinicians. I met with the Royal College of Nursing yesterday—I am also a fellow of its college—and we had a long discussion on this. There are one or two wrinkles on prescribing, but the same issues of professionalism are shared by nurses.

My noble friend Lady Wheatcroft dismissed very quickly the idea that there was a lot of abuse. We have already been urged to think about the patients. On 14 May, I initiated a debate in your Lordships' House on elder abuse, in which 12 noble Lords took part. I had to research that topic. It was very interesting. If you look at things such as the Care Quality Commission and recent reports into Mid Staffordshire and all the rest, we know that a certain amount of abuse is taking place, certainly in residential homes, nursing homes, hospitals and prisons, but also in people's own homes. The Department of Health estimates that just under 500,000 elderly people are subject to abuse in the community. That is why we want a differently shaped Bill and why we want to take the National Health Service—healthcare—out of making the final decisions. As my noble friend Lord Tebbit said, it is very hard to discover where the abuse is taking place, especially in people's homes. That is why it is essential that we accept the amendment tabled by my noble friend Lord Carlile.

Lord Alton of Liverpool (CB): My Lords, I support very strongly what the noble Baroness, Lady Cumberlege, has just said about the effect of the Bill on medics. I was struck by a recent conversation that I had with one of my sons, who is a fifth-year medic. He very much welcomes the stand that the BMA and the royal colleges have taken in saying that they would not wish to see a change in the law because of the position that it would place doctors in. He argues, as I would argue, that you do not need a doctor to kill you to die with dignity. I was very struck by what the noble Lord, Lord Howard, said about the roles that the hospice movement and palliative care can play.

However, I see the point of these amendments and I understand what my noble friend Lord Pannick and the noble Lord, Lord Carlile, are trying to do in improving the Bill. It is right that we should, at a Committee stage of the House, take the amendments extremely seriously, as we are required to do. Therefore, I honestly believe that today we should not be pressurised by either time or the thought that we are going to be railroaded into taking votes at this stage. I hope that those who have been calling for greater reflection on the amendments will be listening, too.

My noble friend Lady Murphy said that this is a decision for patients. However, implicit in the amendments is the fact that it is not just a decision for patients. This will require an assessment process. It is not an "on demand" situation, and therefore there is the possibility that from time to time such proposals will be rejected as well by the courts.

My noble and gallant friend Lord Stirrup rightly made the point that there will be people who are unable to take these decisions for themselves. That returns to one of the cases raised during the opening remarks of my noble friend Lord Pannick. He mentioned the case of Tony Bland, who went into a persistent vegetative state as a result of the football game that took place at Hillsborough. On Monday, I went to Warrington. I was incredibly impressed by the extraordinary resources and time that have been put into the new inquest process and by the work being done by the Independent Police Complaints Commission in reinvestigating the events. I made my own deposition there.

I was thinking not about the Tony Bland case—although I am well aware of it and well aware of those of my then constituents who died at Hillsborough—but about the case of Andrew Devine, who was a constituent of mine and who also went into a persistent vegetative state. It was predicted at that time that he, too, would die. Of course, Tony Bland was never on a life support machine; he had food and fluid withdrawn—a decision made through the court process. I just reflect that Andrew is still alive and is loved and cherished by his family. Having been in a persistent vegetative state and been told that he would never be in a position to take solid foods again, within a couple of years he was able to do so. Therefore, we have to be careful about prognosis. We have to be very careful in assuming that we will always get these things right.

Every single case matters, and that is what I would say to the noble Baroness, Lady Wheatcroft, following the intervention made by the noble Lord, Lord Deben. Every single case matters; it is not just about the one or two people who will not be able to take decisions for themselves. Public safety goes to the very heart of the concerns raised by my noble friend Lady Finlay and in the amendment put before us by the noble Lord, Lord Carlile.

I was struck by what Lord Sumption said in the Supreme Court judgment. He said:

"It is right to add that there is a tendency for those who would like to see the existing law changed, to overstate its difficulties",

by suggesting that,

"the current law and practice is less humane and flexible than it really is".

So we are not at a settled point as far as this legislation is concerned.

I have been genuinely surprised that another place has not been given the opportunity to reflect on the extraordinary moral and ethical issues in this legislation, which are also contained in the questions raised by this amendment. One should recall that the *Guardian* said about the Bill:

"It would create a new moral landscape. It is also, potentially, open to abuse".

That is what I think the amendment of the noble Lord, Lord Carlile, seeks to address. The newspaper went on to say:

"Reshaping the moral landscape is no alternative to cherishing life and the living".

The *Daily Telegraph* said:

"The more assisted dying is discussed, the more its risks will become apparent".

That was the point made in the eloquent remarks of the noble Lord, Lord Tebbit, who reminded us today of the pressure that can be placed on vulnerable people. We should recall the speech made at Second Reading by my noble friend Lady Campbell of Surbiton: it is not just the BMA and future medics; it is not just the hospice movement; it is also the disability rights organisation, whose representatives are standing outside this House today. I spoke to them this morning on my way in. They hope that, if we proceed with the Bill, we will do everything we possibly can to put in greater and stronger safeguards. Therefore, I hope that we will have a chance between now and Report to reflect on the different approaches contained in these two amendments and that the noble and learned Lord, Lord Falconer, will also go away and reflect on them following today's debate.

11.45 am

Lord Reid of Cardowan (Lab): My Lords, I will probably make the shortest speech that I have made in this House, and your Lordships will no doubt be relieved about that. I am not a medic or a lawyer, nor have I put in the hours that many noble Lords have obviously put in on the details of this legislation. However, we should ask of this group of amendments: "What is the essence of the subject that we are addressing?". Surely it is the essential question of whether a decision of this nature should be based on the free will of the patient and the expertise of the medical profession or whether we ought to go further than that, whether through legislation, via the amendments of the noble Lords, Lord Carlile and Lord Pannick, or whether through the suggestions of my noble friend Lord Campbell-Savours.

I have a view based on a very banal and simple old principle. Perhaps I may paraphrase one old philosopher who said, "Yes, men and women do have free will but they don't exercise that free will in circumstances of their own choosing". Surely what we are essentially asking is whether there should be an examination of the circumstances in which men and women operate their free will and make a decision. I believe that, on such a profound question, there should be, and I do not believe that the medical profession is adequately equipped to do that in all aspects of the circumstances.

Therefore, I say to those who are proposing and advocating this Bill: please do not believe that those of us who think that circumstances affect a decision that people make of their own free will are somehow opposing the principle behind the Bill. It is a safeguard that recognises an eternal reality.

Lord Winston (Lab): My Lords—

Lord Deben: My Lords, I speak from a position in which I must declare an interest, although it is a surprising interest and your Lordships will wonder why I am declaring it. I am chairman of the Association of Professional Financial Advisers. I declare that because the organisation has at its heart a determination to make sure that, if you advise someone on finance, you should be on their side and there should be no question over which side you are on. It is quite difficult to fight that battle because people feel that they can do both: they feel that they can be on both sides perfectly reasonably. Of course, people outside do not feel that. They want to be absolutely sure that the person advising them has only one interest, which is them and their concerns. If that is true in finance, it ought to be true in matters of life and death.

For me, at the heart of this—and, with apologies to the noble Lord, Lord Winston, it is why I wanted to follow the noble Lord, Lord Reid—is ensuring that at no point, in the mind of the patient or in the minds of the patient's friends and relations, should doctors be equivocal. That is just as important when a patient himself is making the decision to end his life quite decently and honourably as it is when there is pressure. If the patient is making that decision, his family and friends want to feel that it is a decision in which the doctor has not played a part, for the doctor ought to be, right to the last moment, concerned only with the nature of the illness, the palliative care that can be carried through and the way in which new techniques might be applied.

I hope that the noble Baroness who intervened earlier will accept that there are many of us who do not approach this from a prejudiced or religious point of view. As somebody who fought very hard for same-sex marriage, I can hardly be accused of always taking the view of the church to which I belong. I take this view after 40 years as a Member of Parliament or candidate. I have seen so many people in circumstances in which they begin to doubt the advice of their doctors. Although I have no connection at all with the medical profession, I care about it so much that I do not want it to be treated with less care than the Association of Professional Financial Advisers. It should be on one side and not on the other. That is why we must have an external decision-making principle.

I am not qualified to intervene in the discussion between lawyers about what would be best. I intervene partly because I do not think that lawyers should have it all their own way in any circumstances. I agree with the noble Lord, Lord Alton, and my noble friend Lord Cormack. We have to say to lawyers that this is a

[LORD DEBEN]
situation in which getting an answer that satisfies everybody is something that we lay people would like to see. Frankly, what lawyers have to do for us, as the noble Lord who spoke previously said, is to provide us with an answer in which we feel that the decision is made outwith the medical profession so that the medical profession can do what it is there for and can never be questioned.

I finish with a comment to my noble friend Lady Wheatcroft and the noble Baroness, Lady Blackstone. It is not possible to debate this whole issue or any of the amendments unless you recognise that there is a serious issue of pressure on individuals. I am afraid that after 40 years in Parliament, seeing people at the level that you do if you are a decent Member of Parliament, you discover man's inhumanity to man is very much further advanced than the comfortable views of many people who do not get to that level. We have to protect people and this is an essential protection.

Lord Winston: My Lords, I was delighted to give way to the noble Lord, Lord Deben, because I agree with so much of what he has just said. I want to echo something that the noble Lord, Lord Alton, said. This is an extraordinarily important Bill, which goes to the heart of our society, and it is desperately important that the Government Front Bench and Members of this Committee allow full and adequate debate on it. If this House is to survive, flourish and be respected, it is very important that it debates these issues adequately and fully and takes as much time as is necessary. If we have to come back on another day to complete Committee, we should do so. It is essential that we understand that, no matter how inconvenient it might be to come back on another Friday.

I always find myself agreeing with the noble Lord, Lord Cormack, but I feel that there is a massive difference between this Bill and the Medical Innovation Bill, which is completely unnecessary. That is why it troubles me that we should be comparing the two Bills.

Very briefly—I shall not detain the House greatly—I want to say why I disagree with my noble friend Lord Campbell-Savours. I apologise to him for disagreeing. It is essential that we have something like the amendment in the name of the noble Lord, Lord Pannick, to protect our society. The reason for that is absolutely clear. It was raised to some extent by the noble Baroness, Lady Cumberlege, in her short speech. The issue, of course, is that in our hospitals we have increasing numbers of elderly people who come into hospital, a foreign environment, and find themselves distressed and not understanding what is happening, and are seen almost as demented; certainly, they will be people who are completely out of touch with what is happening to them and they will not understand. Therefore, it is essential that we have some kind of legal process that ensures that the Bill, if it is to succeed, is properly policed. That is essential. It cannot be left to members of the medical and nursing profession to make their minds up. For that reason, I absolutely support the amendment introduced by the noble Lord, Lord Pannick.

Lord Hunt of Kings Heath (Lab): My Lords, it is not for the Opposition Front Bench to state an official view as to what action should be taken in relation to these sets of amendments. It is up to our own individual consciences to make our own minds up. However, it is an opportunity for me to say to the Government that it is important that we have sufficient time to debate this important Bill. I hope the government Chief Whip will take to heart the comments that have been expressed—by noble Lords who have different views but who certainly think that we should have further time to discuss this.

Although the noble Baronesses, Lady Wheatcroft and Lady Hollins, and my noble friend Lord Campbell-Savours expressed doubts about bringing the courts into this process, essentially these two sets of amendments, although they differ about the role of doctors, bring the courts into the process, and can be said to respond to the debate at Second Reading about the need for safeguards. Given that, I want to put two points to the Minister, which I hope he will be able to respond to.

The first is about the capacity of courts to deal with applications in a timely manner. The noble and learned Baroness, Lady Butler-Sloss, spoke from great experience and she was clear that the courts would be able to respond very rapidly. I think she said that they would be able to deal with the process in a matter of 24 hours. Of course, we do not know how many cases are likely to be brought. I hope the Minister will be able to say a little about how the Government would respond in relation to capacity in the courts if it were needed.

The second point I want to put to the Minister is about the financial support available to persons who would go to court under the process envisaged in either set of amendments. It surely must be open to everyone to be able to go to court without fear of the financial consequences. We know that legal aid has been heavily reduced in previous years. I ask the Minister to reassure us that if either set of amendments appeared in the Bill, and it was eventually enacted, that public funds would be available to allow people to go to the courts.

It is important that the Minister clarifies these points as clearly they have an important bearing on the attitude that noble Lords may take to these amendments.

The Minister of State, Ministry of Justice (Lord Faulks) (Con): My Lords, I congratulate the noble and learned Lord, Lord Falconer, on steering his Bill to a stage that no previous Bill on this difficult and controversial issue has reached. I know he will have listened very carefully to all contributions from your Lordships and that he will respond carefully to this amendment and to the others that will be debated here today. The number of amendments tabled is testament to the careful scrutiny of legislation that is characteristic of this House. The debate on this Bill at Second Reading was much admired outside the House, as well as within it, of course. The respect that was shown by those with very different views was remarkable for its lack of rancour. That has been echoed today and I am sure it will continue to be the case throughout the debate, whenever it concludes.

It may be helpful, in order to save time later—and perhaps your Lordships' patience for listening to me—if I make some more general remarks while addressing

this group of amendments. As I said at Second Reading, the Government believe that any change to the law in this sensitive area is an issue of individual conscience and a matter for Parliament to decide rather than one for government policy. It follows that the Government will take a neutral position in today's debate and that these Benches will have a free vote should the House divide.

Inevitably, the extent to which I may usefully contribute to the debate is limited from a position of neutrality. It is for the noble and learned Lord, Lord Falconer, to respond to the amendments moved, and to respond as appropriate on whether the clause should stand part of the Bill. My role, as I see it, is to assist the Committee in any way that I can without compromising the Government's position, and to draw the attention of the Committee to any discrepancy that I might identify at this stage between the intended purpose and actual effect of any amendment.

Noon

I hope that these introductory remarks will assist the Committee. I do not propose to rehearse the Government's position each time I speak to an amendment or group of amendments, so your Lordships may be pleased to learn that my subsequent contributions may, necessarily, be short.

That said, I turn to the amendments proposed by the noble Lords, Lord Pannick and Lord Carlile of Berriew, which, essentially, have the same purpose: namely to make the provision of assistance to a terminally ill person who wishes to end his or her own life subject to the consent of the Family Division of the High Court, although there are significant differences in the approaches which they suggest. It should be recorded that by no means all your Lordships feel that the courts should be involved in the process.

Your Lordships may, however, feel that there is something to be said for the approach advocated by the noble Lords. A number of the judgments of the Justices of the Supreme Court in Nicklinson thought so. The Family Division of the High Court is accustomed to dealing with such sensitive life-and-death decisions and would be well placed to take on the role that these amendments envisage. I cannot, of course, predict what demand there might be from the Family Court in the event that the Bill became law. Its record and experience of dealing with these difficult decisions, and dealing with them at speed, is a matter about which I think the House would be reassured, but I feel that I can say no more than that the courts have shown themselves equal to not identical but similar challenges in the past.

On the question that I was asked by the noble Lord, Lord Hunt, regarding financial provision, he will understand that it would be inappropriate for me to comment from the Dispatch Box about a scenario that does not currently exist. He will be aware that the LASPO Act retained an exceptional cases provision which deals with questions of the Human Rights Act and the convention requirements. I am sure that that matter will be considered by all noble Lords. That is as far as I can go on the question of legal support, but I think that the House and the Government will be very much aware of the concern that finance should not be a matter that stands in the way of any provision which your Lordships should approve.

As the Supreme Court has recognised, there is a diversity of opinion about the degree of risk involved in relaxing the law in this area but not about the existence of the risk. It is unlikely that the risk of vulnerable people feeling pressure to end their lives can ever be wholly eliminated, but requiring a judge of the High Court to be satisfied that a terminally person's wish to die is voluntary, clear, settled and informed may perhaps help to reduce the risk to an acceptable level.

I am sure that the noble and learned Lord, Lord Falconer, will have his own view on that. In keeping with the Government's position, I offer no view but simply leave it to your Lordships' House.

Lord Falconer of Thoroton (Lab): My Lords, I express my gratitude to everybody who has contributed to this short debate. It has been an excellent debate. I completely agree with what the noble Lord, Lord Winston, said: there should be a proper and full debate, because the sorts of decisions that this House has got to make are extremely grave.

I think that the issues in this short debate can be divided into effectively two: should we have any court-driven process to give greater protection; and if we should, what should that court-driven process be? The noble Baroness, Lady Wheatcroft, put most clearly the view that there should not be any court-driven process because it might deprive some people of the opportunity to use the Bill. The fear of going to court, the expense of going to court and how they feel at the time might well be a barrier. I am very conscious of that argument—from time to time, it has been high in the mind of many people—but my own view, having heard the debate at Second Reading, having heard the debate here and having spoken widely to people who might be involved in the decision, is that what would give much greater confidence regarding the Bill would be some sort of judicial process that raised the minimum barrier to people using the Bill but provided protection.

In the course of this debate, people have sought to say, "Well, it's got to be the judges and not the doctors". I think that it has got to be both, because you cannot even get to the judge unless two doctors have indicated that the person is terminally ill and, as far as they are concerned, the person has a firm and settled view to do it. However, I do not think that one can leave it to doctors alone, in particular to form two views: first, on whether it is the voluntary, clear, settled and informed wish that somebody wishes to end their own life; and, secondly, whether they have the capacity. I have been worried about whether the courts could deal with this quickly enough, but I have looked quite deeply into that. I am very influenced by points of the sort that the noble Lord, Lord Ribeiro, made. I think he will agree that the blood transfusion cases to which he referred are inevitably incredibly urgent, and the court could deal with them. The noble Lord, Lord Patel, referred me, not in the debate but separately, to the emergency caesarean section cases. Again, they are urgent. The noble and learned Baroness, Lady Butler-Sloss,

[Lord Falconer of Thoroton]
who has experience in this matter, spoke very persuasively of the speed with which the courts can deal with such cases, and the conjoined twins case was done very quickly.

I am worried about the costs issues. The noble Lord, Lord Faulks, gave some reassurance by referring to the exceptional funding. I cannot imagine a more grave decision than one such as this, and I hope that well meaning people in the Government would make sure that it applied to it.

In principle, therefore, I think that judicial process, although it may deter some people, will ultimately give greater protection. Which of the two options should one choose? Under the Lord Pannick option, if I may call it that, one could get the prescription,

"only if the High Court … by order, confirms that it is satisfied that the person … has a voluntary, clear, settled and informed wish to end his or her own life".

That means that the High Court will have to decide whether the person has voluntarily decided to do this, which means that there is no coercion. In addition, the court has to be satisfied that the person has the capacity to make the decision. So it will be a primary decision for the courts.

In addition to those requirements, the amendment in the name of the noble Lord, Lord Carlile, says that the court can allow this to happen only if it is satisfied that the person is suffering what is the equivalent of "torture"—that would satisfy Article 3—and that not to allow it would be a breach of their Article 8 rights. I respectfully submit that those are very high hurdles and are utterly inappropriate to a Bill that basically says, "Your free will should determine it", but I completely adopt what the noble Lord, Lord Reid, said about free will, properly examined, as being right.

This is a very difficult issue and the main one that we have got to decide today. I have heard what the noble Lords, Lord Phillips and Lord Campbell-Savours, said. They asked whether we could find an alternative, perhaps the magistrates or a committee of well meaning people in the community. Honestly, those ideas sound great, but they just will not work. I think that you need the highest-quality judges to decide these issues, and I do not think that the proposals being made there are really sensible.

People have said, "Let us not have votes today". I think that we should resolve this issue today. We have had a very full debate. It is a matter for the noble Lord, Lord Pannick, whether he wishes to divide the House, but I am strongly of the view that we have debated this long enough. We have debated it very fully today, and very fully at Second Reading. My position is that I accept the arguments made, that there needs to be some degree of additional oversight. I believe that the proposal made by the noble Lord, Lord Pannick, is the right one, and I think that the time has come for this House to make up its mind on this very important issue.

Lord Pannick: My Lords, it has been a valuable and informed debate on the most profound moral issues. Like the noble and learned Lord, Lord Falconer of Thoroton, I of course respect what the noble Baroness, Lady Wheatcroft, says—that people who wish to end their life should not be impeded by a legal procedure. However, I think that the judicial safeguards, as so many of your Lordships have said today, are essential to protecting vulnerable people, which was one of the main concerns expressed at Second Reading. A judicial process will also bring home to the individual seeking assistance to end their life the gravity of the decision they are taking. A judicial process will also assist the doctor, as the noble Lord, Lord Ribeiro, pointed out. The noble Lord, Lord Tebbit, in his moving speech—

Lord Mawhinney: I am grateful to the noble Lord. I am one of those who was against the Bill, but I am being persuaded that there is a court role that might go a considerable way to being helpful to the outcome of this legislation. There were a number of suggestions that, rather than going to a vote in Committee, it would be helpful if the noble and learned Lord, Lord Falconer, with the noble Lords, Lord Pannick, Lord Carlile of Berriew, and others, sat down to see whether it would be possible to produce an amendment on Report which did not require all of us to be legal experts and have read paragraph 205, but which showed a degree of continuity and cohesion among those who have led the House to this position. Would the noble Lord be willing to put off a vote until Report so that such conversations could prior take place?

Lord Pannick: I am grateful to the noble Lord, but my position is exactly the same as that of the noble and learned Lord, Lord Falconer. The amendment is not legalistic. It says that the judge of the Family Division of the High Court should ask himself or herself whether the person concerned has made,

"a voluntary, clear, settled and informed",

decision. They seem the right criteria. With respect to the noble Lord, Lord Carlile, I have not heard any convincing argument as to why the criteria should be more onerous—that the person concerned should be able to proceed along this route only if a further criterion is satisfied. Indeed, the addition of further criteria seems contrary to the valuable purposes of the Bill: to give effect to the autonomy of the individual.

Lord Carlile of Berriew: Does the noble Lord not think on reflection that Report stage on a Bill of this kind is an extremely important stage for your Lordships' House? Does he not think that it would be far better for your Lordships to discuss and reflect so that when we come to Report we are able to make a considered decision in which even those of us who feel strongly about these issues will understand the essential need to be prepared to compromise, through a proper discussion reflective on the debate of the past two hours? In that context, I am certainly not going to vote on any of these amendments either way. I invite the noble Lord to reflect for one moment on what has just been said. I think that others may well agree.

Lord Pannick: Of course I reflect on what the noble Lord says, not least because I have great admiration and respect for him. However, he will know, as will as any other Member of this House, that we often vote

on issues of principle in Committee. If there were an issue that could be resolved by further analysis and debate then I would see the force of the point.

Lord Harries of Pentregarth: There are some issues that need to be further clarified. The noble Lord, Lord Carlile, has a whole range of amendments going into more detail about what his proposal would actually mean in practice. The House has not had a chance to hear those amendments, which I think will go some way to addressing the point that the noble Lord made against the point that the hurdle was too high. I very much support those who urge that the noble Lord should get together with the noble Lord, Lord Carlile, and the noble and learned Lord, Lord Falconer, to see whether there is some more common ground.

12.15 pm

Lord Mackay of Clashfern (Con): I had intended to make a short observation but the intervention came from the opposite Front Bench so I did not find it possible to speak. I rather go with the form of the amendment proposed by the noble Lord, Lord Pannick, subject to this. It is essential in the Bill that there should be a terminal illness. That is a very important issue which requires determination before the Bill operates. The amendment tabled by the noble Lord, Lord Pannick, as far as it goes, does not actually require—if I have understood it right, and I am subject to correction like everybody else—the judge to be satisfied that the patient is suffering from a terminal illness. I think that that is a part of the definition that requires to be taken into account.

For my part, I was rather expecting that the detail of the amendment would be settled before Report. In the mean time, what we are really considering is whether, as the noble and learned Lord, Lord Falconer, said, there should be judicial intervention at all. On that point, I think that a very large proportion of the noble Lords here today are rather in favour of it. However, the precise detail of it is quite important. Therefore, I find it hard to believe that it is right that we should settle on the particular form of the amendment today.

Baroness Butler-Sloss: I very strongly support the noble and learned Lord, Lord Mackay of Clashfern. I actually think that the amendment tabled by the noble Lord, Lord Pannick, has a great deal to commend it, and I would have said that to him. However, the point made by the noble and learned Lord is terribly important. Who is going to be the deciding factor on the terminal illness? I believe that this is an enormously important issue for Report—and I am at the moment assuming that the Government will give us time to have Report. I refer to what was said by the noble Lord on the Front Bench. This has got to a point of such importance that I really do not think that it should be addressed at this stage.

Lord Cormack: What can possibly be lost by having further conversation and discussion? If the amendment is put to the vote and is carried, other amendments cannot then be discussed because a number of them will fall by the wayside. That is not going to assist our progress in having a full-ranging discussion. I would beg the noble Lord, Lord Pannick, not to move his amendment today so that discussions can take place. I make this suggestion, as I did in my speech, in a wholly constructive manner. I would beg of the noble Lord to heed that, because pre-empting other amendments is not the best way of taking this forward.

Lord Pannick: I am grateful to all noble Lords who have put to me pleas, begging—or however it is put—and I do take them very seriously indeed. However, it seems to me that after two hours we have had a very considerable debate on an issue of principle relating to the Bill. There is widespread agreement that there should be a judicial protection included in the Bill. As I understand it, only two real concerns have been expressed. The noble Lord, Lord Carlile, has suggested that the protections in my amendment are not sufficiently robust. With great respect, I do not accept that. The other objection raised is that it should not be judges of the Family Division who hear this. I think that this is so grave an issue that it is right and appropriate that the judicial protection is at that level. As the noble and learned Baroness, Lady Butler-Sloss, will confirm from her experience, there is nothing formal about the Family Division in appropriate cases. Judges hear the disputes around the bedside of the patient when necessary.

The noble Lord, Lord Tebbit, in his moving speech, was concerned about wrongdoing. I say that if the judge is satisfied on hearing evidence that the decision is,

"voluntary, clear, settled and informed",

by a person who has capacity, then the noble Lord's concerns about wrongdoing will be met. It is time that we came to decision on this matter of principle, encouraged as I am by what the noble and learned Lord, Lord Falconer of Thoroton, says. I willingly give way.

Baroness Finlay of Llandaff (CB): I am grateful to the noble Lord, Lord Pannick, for giving way. We have had a wide-ranging discussion. I felt that we were at the point of getting people to come round a table to find a solution. Like others, I am concerned about this process, but I respectfully state that I do not believe that we have heard the full debate. Other amendments in the next group in the name of the noble Lord, Lord Carlile, will expand on what he has proposed, and they have not had a fair hearing. I fear that to vote now may force the House to amend the amendments of the noble Lord, Lord Pannick, at Report. If that is what he wants, I am concerned about that. The House's debate to date has been balanced and careful. I do not understand what is to be gained by having a vote now, rather than going through the issues, because we agreed that a lot in the Bill needs to be debated and sorted out. I state clearly that I am not aware of any wrecking amendments; the debate has been extremely informed.

Lord Pannick: I am not suggesting for a moment that anyone has proposed wrecking amendments, but I certainly do not accept that the noble Lord, Lord Carlile, has not had a fair hearing. He made a speech of 15 minutes or so—most appropriately—in which he

[Lord Pannick]
set out his case, and the House has heard the arguments for and against. I do not think that there is anything unfair or unbalanced about putting to the opinion of the House an issue of principle so that we can make progress. I wish to test the opinion of the House.

The Deputy Chairman of Committees decided on a show of voices that Amendment 1 was agreed.

Amendment 2 not moved.

Amendment 3

Moved by ***Lord Carlile of Berriew***

3: Clause 1, page 1, line 2, leave out "request and lawfully" and insert "apply to the Family Division of the High Court to"

Lord Carlile of Berriew: My Lords, we come to a group of amendments, starting with Amendment 3, which stand in my name and those of the noble and right reverend Lord, Lord Harris, and the noble Lord, Lord Darzi, and, I am pleased to say, in one case, the noble and gallant Lord, Lord Stirrup. I am grateful to him for putting his name to that amendment.

I am gratified that we have had a serious and detailed debate on court intervention. I applaud the noble and learned Lord, Lord Falconer—

Baroness Jolly (LD): My Lords, please could those leaving the Chamber do so quietly, as we have moved on to the second group.

Lord Carlile of Berriew: My Lords, I was about to say that I applaud the way in which the noble and learned Lord, Lord Falconer, accepted something that was not in his Bill and which, in my view, should have been: court intervention. That is an important principle. I agree with the noble Lord, Lord Pannick, whose amendment has just been carried, that it would not be right to say that we have not had a proper debate on the previous group of amendments. I make no complaint about that. However, I make clear that if there is a Report stage of the Bill, there will be further detailed debate on the issues we have discussed and those in this group, to which I will turn in a moment.

I just wanted to pick up on three remarks made in the excellent previous debate. One was made by the very distinguished lawyer, whom I admire greatly, the noble Baroness, Lady Mallalieu—which I suppose is an inevitable preface to disagreeing with her—when she referred to a legalistic obstacle course. The noble Lord, Lord Campbell-Savours, referred to congestion in the system, and the noble Baroness, Lady Murphy, who I see has left her place, said that my proposals were unworkable. I reject all those concerns. Indeed, I and those who have signed the amendments have sought to provide a very straightforward road map. It may at the moment look a bit like a menu, but this is a House of Parliament and your Lordships are Members of a debating Chamber. Like any other noble Lord, I hope, I accept that parts of what looks like a menu may be accepted and others rejected in due course. I respectfully submit that the amendments are worthy of consideration.

Briefly, I refer your Lordships to the rationale of each amendment, other than Amendment 3, which speaks for itself. Amendment 64 requires the court to be satisfied beyond reasonable doubt of certain things. Why "beyond reasonable doubt", given that these are civil, not criminal proceedings? I have spent—I wrote on a piece of paper last week that I had spent 42 years at the Bar, but I had to consider afresh and added another two years as I was writing the piece I was preparing—44 years at the Bar and, throughout that period, I have dealt mostly with criminal cases in which there has been an assertion that death has been caused unlawfully. It always has to be proved beyond reasonable doubt, so that the court is sure, as judges say to juries in murder cases. It is a straightforward proposition that, if Parliament is to allow one human being deliberately—not through double effect, of which the noble Baroness, Lady Finlay, spoke so eloquently earlier—to take the life of another human being, the standard should be "beyond reasonable doubt".

Secondly, Amendment 64 requires the court to be sure that there would be breaches of Articles 3 and 8 of the convention. I mean by that that the court should be sure that the person concerned would be suffering from inhumane and degrading treatment by not being allowed to have their life taken with the assistance of another, and that there would be, to use shorthand for time's sake, a breach of their right to privacy and family life.

Further, in Amendment 64, I suggest to your Lordships that it is important that the rights of others should be considered if they are affected by the applicant's potential suicide. By that, I refer to wives and husbands, children and grandchildren, carers and other people who feel on strong grounds that the applicant is taking the decision—albeit with capacity—on an entirely mistaken basis that does not amount to breaches of Articles 3 and 8 of the European Convention on Human Rights. It seems to me common sense that they should be heard.

Finally, I suggest that the court may, in its discretion—please note that those words mean exactly what they say—allow other persons in addition to the applicant to be heard. In that context, we are aware, because the noble Lord, Lord Pannick, told us about it, that in the Nicklinson case, the noble Lord appeared on behalf of an interested party—no doubt to enormous value, as one can see from the judgments in the case. It seems to me right that the court should retain the discretion, which might be useful in very early cases, to permit such interventions.

I turn to Amendment 67, which sets out part of the road map by which the Family Division would decide these cases. In personal injury cases and indeed in some others, the court is free to appoint an independent medical expert to assist the court. What that expert can do, if he or she is a good expert, is to look at the medical evidence produced by the parties, draw its threads together, discuss the medical evidence with other experts—it can be done at high speed—and present an independent medical view to the court. It is

of course not the independent expert who decides; it is the judge and the court that decide. But I believe, and I have seen this happen in personal injury cases on one or two occasions, that such independent experts add considerable value, particularly if they put their report into writing. That does not mean necessarily that there has to be a dissertation. What I mean by writing is that there has to be a written record of the doctor's view, which is always available to others.

12.30 pm

Lord Davies of Stamford (Lab): I am grateful to the noble Lord for giving way. How long does he think that the whole of this process would take? What is the minimum amount of time that realistically would be involved, if an independent report is required in writing? Does he not recognise that we are going to be dealing here largely with people who are suffering extreme pain or other discomfort and who would really wish to reduce the time to an absolute minimum when they have to continue to suffer that kind of condition?

Lord Carlile of Berriew: I do not know whether the noble Lord was here during the last debate—I apologise if he was—but I thought that that question was answered clearly. These things can be done very quickly indeed. Some of the answers could possibly be given in less time than it took the noble Lord to ask the question that he just asked.

Also in Amendment 67, a simple system is provided which involves the intervention of another independent person about how the act of assisted suicide would take place. That seems to be a straightforward safeguard.

Lord Richard (Lab): If the noble Lord will allow me, why does he make the provision of an independent medical examiner mandatory and not discretionary? In the word that he uses, the court "shall"; it is not that the court "may".

Lord Carlile of Berriew: I am grateful to the noble Lord, who has great experience in law, for asking that question. It is one that I considered carefully. It seems to me that in cases where one human being is having their life ended deliberately by another, the court should have the safeguard in all cases of an independent expert, albeit that that expert may in the end be able to deal with the matter briefly.

Amendments 67 and 68 also deal with the way in which the assisted suicide, if it takes place, is to take place. It seems a wise, safe course that the independent person who oversees any act of assisted suicide should submit a report to the chief coroner. I think that it is the view of most lawyers, at least, that the chief coroner—currently, his honour Judge Peter Thornton—is doing an absolutely superb job and has shown how the coronial system can be made to work much better that it ever did in the past, so that seems to be a reasonable provision.

I turn finally to Amendment 172, because I referred to Amendment 175 briefly in the earlier debate. Amendment 172 provides for a form of declaration which in my respectful view should go with every one of these decisions, if they are to be made, and which will stand as a record of what occurred not only for the court but as an explanation to the individual's family and descendants as to why he or she decided to act as they did.

Those are the very brief reasons why these amendments, in my respectful submission to your Lordships, have merit. Despite the passing of the earlier amendment in the name of the noble Lord, Lord Pannick, these are issues that remain for consideration. I repeat that I do not propose any votes in this House on any of these issues today. These are serious matters which require debate and then reflection. I reserve the position as to what would happen on Report.

Baroness Finlay of Llandaff: My Lords, I stated earlier that I saw merit in the amendments tabled by the noble Lord, Lord Carlile, because they took doctors out of the gatekeeping role. I would like to expand on that briefly now.

The advantage of an independent medical expert is that you will know that you have somebody who has been properly trained, whose assessments are audited and, where there is a monitoring in the process, that they have to be updated in that area and discipline—and that they carry credentials, as well as being able to negotiate the court process. As part of that assessment, it seems essential that others affected by the death are also considered in the process, in particular children. I have spoken before in this House about the problems for children who are bereaved. I do not think that the House should underestimate the emotional problems for a child whose parent has committed suicide or had an assisted suicide, or the difficulties that they may go on to feel: that their love was inadequate to support the person who they loved—their parent—through the last days, weeks or months of their life, and how damaging that can be for the rest of their lives.

I also strongly support the concept of having a court-appointed person who could take the drugs out to the person who has gone through the process and for whom assisted suicide is being agreed. The way that the Bill of the noble and learned Lord, Lord Falconer, is written at the moment is completely impractical because in reality not all patients die rapidly on ingesting their drugs. Some die within minutes but the median time is actually 25 minutes, if we base it on the Oregon experience. However, some take 41 hours to die. That is going to tie people up for a very long time.

We are not talking about therapeutic drugs but about a massive overdose of a drug at a fixed point. Later we will come on to debate lethal drugs and the difference between those and medication. There can also be monitoring of who the drugs go to when they go out, and the return of drugs to a central point if they have not been used—as well as having someone who is trained to deal with the complications that occur, which has not been addressed and which, I respectfully point out to the House, almost no doctors are equipped to cope with at the moment. Yes, they may learn, but that would be at the expense of patients.

The other reason why I see the merit of having a completely independent process of assessment is, as I

[Baroness Finlay of Llandaff]
said before, that it does not contaminate the care that is being given to the person by the clinicians. It allows conversations to go on without the patient feeling that they have locked themselves in—that in a way they can pursue a parallel track. They can be assessed by the court but they can still have their own practitioner working to improve their quality of life, not believing that, now they are applying to fix a date for their death, some of the interventions feel pointless and futile.

Lord Jopling: My Lords, the noble Baroness has just said something that has totally appalled me: that in these circumstances—in Oregon, particularly, I believe—it can take 41 hours for the injections to take effect. I am horrified to hear that. Would she be kind enough to try to give us rather more of an explanation from her background and experience about how this happens? It has come as a shock to me.

Baroness Finlay of Llandaff: I will certainly try to explain. The data come from the Oregon Health Authority's own reports, which are written annually, based on the returns by the doctors. We know only the information that is given by the doctors; we do not know what goes on otherwise. If a doctor does not report it, it is not known. We also know from the Oregon health reports that three patients have actually woken up again and did not go on to die.

The point is that you are giving a massive dose of barbiturates. That is at least 20 times what you might use therapeutically to render someone unconscious but leave them alive; it is a huge dose. When someone is frail and very near death, they may well die rapidly from ingesting a small amount of an additional drug, but I would also point out that in its data the Oregon Health Authority says that the shortest time was one minute, and that is before any drug would be absorbed. I found that interesting because, in my own clinical experience, there are patients who, when the family says to them: "It's okay, you can let go", die within minutes of that statement being made. In other words, when they are given permission to die, they let go of the drive to stay alive. I wonder whether the figures in Oregon showing a very short time demonstrate that the person has signalled that now they are letting go, and that is it. I am worried by the prolonged figures, however, and I would point out that the median means that half the cases take longer than 25 minutes. That still seems to me to be quite long time, but we will discuss complications later in the debate, not in relation to these amendments.

There is merit in not using the clinical team that is looking after the patient, whoever they are, but in using an independent assessment of people who are properly trained in assessing capacity and who have the ability to ask questions about the family that the doctor who was looking after the patient may, for whatever reason, feel uncomfortable or inadequate about asking. They may not be adequately trained, because very few doctors are properly trained in assessing capacity. I also emphasise to the House the merit of having an independent person give the drugs.

My final point is that it is important to look at those jurisdictions that have changed the law regarding what happens if you do not have the kind of control that the amendments of the noble Lord, Lord Carlile, have been trying to put in. We know from Belgium that 32% of its physician-assisted euthanasia—that is how its law is framed—now happens without the explicit request of the patient, and we know from Belgium's own data that it estimates that 47% is not reported. So without having these kinds of controls, you develop a very leaky system. The thought of people's lives being ended without their explicit request is something that I find horrifying.

Baroness Cumberlege: I return to the point raised by my noble friend Lord Jopling about 41 hours. Does the noble Baroness envisage that there would then have to be a turnover of the staff with that person because we do not want people to die alone? I am thinking of how nurses operate their shift systems. This would possibly mean that you would get different people unknown to the patient coming in to sit with them during the 41 hours. Normally, nurses will try to stay with their patient for as long as possible.

Baroness Finlay of Llandaff: I thank the noble Baroness for her intervention. She has made a very important point. You would be tying up healthcare staff for an extremely long time. Indeed, there would have to be a change of shift. It is important for whoever has been involved in whichever process. The court-appointed person could change shifts and be in attendance to make sure that there was no foul play. It not adequate just to deliver the drugs because the patient might not take all of them, and then what happens to the residue? I know the noble and learned Lord, Lord Falconer, has tried to address that. You need somebody there to make sure that people do not think, "This is going on too long. Why haven't they died yet?", and put a pillow over their head. If the patient is going to be one of the people who wakes up again—and the number is very small—it is worth noting that those who woke up again in Oregon did not go for a second attempt at physician-assisted suicide but continued living until such time as they died naturally of their disease. There is something much more important going on here, but it would be extremely dangerous not to have that court-appointed person or system provide for accompaniment to be there.

12.45 pm

Baroness Butler-Sloss: I would like to add something to what the noble Baroness, Lady Cumberlege, said. In case of permanent vegetative state, it is well known that a number of nurses are not prepared to work with those who are bringing the person's life to an end. Therefore, it is necessary to place the patient in a permanent vegetative state from whom nutrition and hydration have been withdrawn with those who are prepared to look after that patient, who may sometimes live for a week. This is obviously a much shorter time, but if one takes 41 hours as a possibility, I suspect there will be nurses who will not be prepared to have anything to do with what is happening. That is another point that needs to be taken into account.

Baroness Masham of Ilton (CB): I shall tell the noble Lord, Lord Jopling, about the death penalty in America where the lethal drugs had a disastrous effect, with prisoners dying very slowly.

Lord Harries of Pentregarth: My Lords, I have my name down in support of the amendment tabled by the noble Lord, Lord Carlile. He has explained the rationale behind it with his usual clarity and I am not going to repeat his arguments. I support very strongly what the noble Baroness, Lady Finlay, said about the importance of taking the whole process—the independent assessment and the administration of the drug—out of the hands of doctors and making it from beginning to end in every detail a court-controlled process.

I shall address briefly one question which may be on the minds of many noble Lords. Indeed, it has been said before that this may be to set the bar too high. It is true that under this amendment the tests are very stringent and rigorous, but surely on an issue of life and death such as this, they need to be as stringent and rigorous as possible. Provided that a decision can be made quickly—we have heard many reassurances that the courts can make decisions like this quickly—surely the test cannot be too stringent or too rigorous. What many of the opponents of the Bill are worried about is not that they are failing in compassion for people who find their life unbearable, but about the overall effect of the erosion of the value of human life in our society by decisions on this kind of issue. If the tests are rigorous and stringent and are made from beginning to end by a court process, people will be able to see that these are truly exceptional cases and there will be less effect in terms of eroding more generally the value of human life and in the way we nurse the sick and treat other people who feel their life is a burden.

Lord Deben: My Lords, I do not believe that hard cases make bad law. I have always thought that that is one of the phrases which make it difficult to have a sensible conversation. I believe that you have to be careful not to make law because of a stereotyped position. One of the difficulties in this debate is that we tend to have stereotyped views about what is happening at the bedside. It is important to realise that a whole range of different things happen at the bedside and the relationship between the patient and his or her friends and family is never the same.

I listened with great care to what the noble Lord, Lord Carlile, said. I am not a lawyer and I cannot be precise as to whether his particularities are the best that we can achieve, but I hope that the House will think seriously about the need for three key elements. First, there is speed. If we are going to have this Bill, we want someone to be able to make this decision with the courtesy that speed demands. The process needs to be fast enough to be commensurate with the seriousness of the decision. Otherwise it lengthens something which someone is in desperate need to finish.

Secondly, it needs rigour. The noble and right reverend Lord, Lord Harries, said that. There is nothing wrong with rigour, unless it is of a kind which makes speed impossible. I do not think that the rigour which the noble Lord suggested makes speed impossible. It says to the public as a whole that we have made this change in the law, but it is not a change in the way in which we think about human life. Those who support this Bill believe that it is an enhancement of their view of human life and that the rigour is the mechanism whereby society says that it still believes deeply in the standards and values which respect human life. On this specific and particular occasion, according to these very rigorous rules, they believe it right for someone to take their own life with the assistance of someone else.

Thirdly, we have to do this in a way in which the aftermath is as manageable as possible. I hope that noble Lords will think very carefully about the effect of assisted suicide on the family and friends after it has happened. I believe that the Victorians spoke far too little about sex and far too much about death. The reverse is true today. We do not understand—because very often we are unprepared to talk about it—the effect of death on the rest of the family. I remember receiving a very considerable rebuke when I allowed—and, indeed, organised—my children to see their dead grandmother. I thought it was necessary to start the whole process of grieving. I have become more aware of the different ways in which people react today and of the difficult issue of how someone might react to death before it happens. Anyone who has been involved pastorally—whether in parliamentary or religious terms or just in terms of neighbourliness—recognises that it is hard to know how a particular person will react ultimately to what has happened.

Changes in the law along the lines that the noble Lord, Lord Carlile, has proposed are very important. We should be prepared to recognise that, although this is a decision of the patient, guaranteed by the law to be an individual decision, we as legislators have to legislate in a way which also respects and protects the effect of that decision on society. In an odd way, that is actually our biggest job. We represent society in trying to make these tough decisions. I hope that your Lordships will take seriously the need to do as my noble friend Lord Carlile has suggested, not just for the patient, not just for the doctor and not just for the assurance that we have really professional assessment of the medical advice, but also to make sure that when the children look back on the occasion, they are protected in the best possible way and are able to accept it. After all, whichever side of this argument you are on, that is crucial. Anyone who does not realise what grieving has to be if the future is not going to be seriously tarnished and damaged has not been through that experience.

Lord Blair of Boughton: May I ask the noble Lord, Lord Carlile, about the declaration in Amendment 172? I have no difficulty with the declaration except that it changes the nature of the Bill. Is this a typo or a deliberate change? The declaration declares that the person is going,

"to die within three months".

However, the Bill says six months. If we are going to change what is in the Bill by such a significant amount, it would be better if it were an amendment in its own right.

Lord Carlile of Berriew: The intention is to reduce the period. That does appear in other amendments.

Lord Stirrup: My Lords, my name is attached to Amendment 67. At Second Reading I made it clear that my principal concern with the Bill was the way in which it affected the medical profession. The medical profession is essentially about saving, protecting and enhancing life. It is true that doctors can make decisions to withhold or withdraw artificial support for life. It is also clear, as has been said today, that they make decisions that will result in death; for example, choosing between a mother and child on occasion, or between Siamese twins. However, the intent—the driving purpose—is always to save and protect life.

In the Bill, the medical profession will be called on to cross a distinct line. It is invited to participate in the active termination of someone's life—to participate in killing them. That is a very serious line to cross. Once it is crossed, as I said at Second Reading, there is no easily defensible position behind it. No one knows when the retreat will end.

This amendment does not allay that concern; indeed, I am not sure that any possible amendment to the Bill would address that concern completely. However, it does at least ease it to a degree. The crucial point is to remove the medical profession from the decision-making part of the process. Of course it has to be involved, and of course you need medical opinion. However, doctors are called on in the Bill to decide things that are, frankly, not even within their competence. Whether they are in the competence of anybody, including lawyers, is a matter for debate, but it is better that they should be removed from the medical profession.

The medical profession is of course called on to make a prognosis. My son is a cardiologist and has made it clear to me that, although he is called upon to make prognoses and does so, they are guesses. They are educated guesses—I have to say that they are very expensively educated guesses—but they are nevertheless guesses. They turn out to be right sometimes; they turn out to be wrong quite often—far more often than the medical profession would wish. It is an entirely different matter for a doctor to say to a High Court judge, "In my opinion, the most likely outcome in this case is X, but of course it could be Y or Z", and for the court, on the basis of that expert opinion and all the other evidence that it has sought and assembled, to reach a comprehensive judgment. However, to ask doctors to do that is to put too great a burden on the shoulders of those who are already heavily burdened.

One of the concerns about this whole process is getting doctors to be involved in it in the first place. We know that a great many people in the medical profession are very concerned about the Bill, and would be unwilling to participate in the process. It might just be that if we are able to come up with some better decision-making process such as the one that has been outlined in the various amendments put forward by the noble Lord, Lord Carlile, we might get more of the medical profession engaged than would otherwise be the case. Surely, for those who are proposing the Bill that would be a good thing. Therefore, for those reasons, I support the amendment in the name of the noble Lord, Lord Carlile, including Amendment 67, to which I have put my name.

1 pm

Baroness Grey-Thompson (CB): My Lords, I will briefly pick up on a few points that my noble friend Lady Finlay of Llandaff raised, and on the point made by the noble Lord, Lord Deben, on stereotyping. Quite rightly, we are spending a lot of time thinking about the process of the Bill. It is absolutely important that we get this right. However, we also have to think about what someone's end of life may be.

I have never met anyone who wants to talk about their own death or think about the process of dying. The purpose of the noble and learned Lord's Bill is for people to die without pain. However, we also have to remember that death, in some cases, is not a stereotype. It is not always a Hollywood death, whereby people just slip away. We have to be very careful of that.

A German documentary was shown in August 2004 about the scandal of Auhagen's death, in which the man in question wanted to use a machine to end his life, not wanting any assistance from another person. He was hooked up to the machine, and 24 hours later, he had not died. The nurse who was with him said:

> "The machine … couldn't pump all the poison into his system. The man was partially poisoned, in agony and thrashing around in a coma, frothing at the mouth and sweating".

That cannot be allowed.

In Oregon, some of the data have shown that in the last few days of life patients who have requested assisted suicide go through more pain than they did before the legislation was introduced because the palliative care is not there. If the Bill progresses, we cannot allow it to happen that, if someone wants to end their life, goes down the path of requesting suicide and then goes through the cooling-off period, the proper and appropriate palliative care is not there to support them all the way through.

Lord Davies of Stamford: My Lords, I will make three points, which are important at this stage of the debate.

First, I very much deprecate the frivolity with which the noble Lord, Lord Carlile, answered my question about the time involved in producing an independent expert's report. It is quite wrong to be frivolous about such a very important subject. Clearly, there has been a tendency to put forward a number of amendments in this group, all of which would increase both the time and the cost required to enable someone to benefit from the new regime brought in under the Bill. It is quite wrong of us in this Committee to underestimate the fact that if we passed these amendments we would add a considerable degree of cost and time. There would be the need to go to a coroner, the need for an independent medical expert, and for another independent expert who would be supposed to collect the drugs and oversee the process, and so forth. All that would mean more people, that arrangements would have to be made—in practice they cannot be made in a second or two—and that reports would have to be produced. We all know that people take some time to produce written reports, and on a matter of this kind one would take particular care to get every word in the report right. Therefore, I was not wrong to raise the issue of time and cost.

On costs, we heard with great relief some of the remarks made by the noble Lord, Lord Faulks, about the possibility of using legal aid, but we know that, however generous the Government will be, not all the costs involved in this process will be defrayed from public funds. Therefore we do not want to produce a certain situation but, as a matter of fact, we already have a situation whereby if you have enough money you can go to Zurich and solve the problem that way. There is a significant gulf at present between those who have greater financial means and those who do not as regards the choice they have as they reach the end of their lives and how they want to go. We do not want to exacerbate that, and by increasing the cost we are doing so. We simply have to take that into account and it should not be frivolously dismissed, as it was this morning.

Secondly, I want to pick up the point made by the noble Baroness, Lady Grey-Thompson, a moment ago. I see no reason why palliative care should not be continued until the moment when the patient decides to exercise his or her option to terminate his or her life under the procedures laid out in the Bill, if it becomes law. I see no reason why there should be any need to withdraw palliative care some days or weeks beforehand. That seems to me a problem that should not arise at all.

Finally, I want to address the point made by the noble and gallant Lord, Lord Stirrup, whose main objection to the Bill seemed to be that the medical profession should not be involved in decisions about the deaths of patients. That is a very serious point; I made a point along those lines at Second Reading. At present, what most of us face if we have a slow death is palliative care, which generally ends up with palliative sedation. That means that the patient is put into a medically induced coma and all means of life support, including food and liquids—not invariably so but certainly in many cases liquids as well, so that the patient is dehydrated—are withdrawn, along with any life support in the form of oxygen and antibiotics. If the patient has had kidney failure and been on dialysis, that is withdrawn, so the patient dies from blood poisoning. The patient dies in a coma, which takes a great deal more than the 25 minutes that is the average in Oregon, when people use that regime for the right to die. It takes many days, in many cases; I have known at least one case when dehydration took two weeks to kill the patient, who of course did not awaken from the coma during the whole of that period. That is the reality: every day of the week and every hour of the day, doctors and nurses take decisions determining the timing and cause of their patients' death. They are taking the decision to withdraw antibiotics and life support, putting the patient into a palliative coma.

It is the alternative to that regime that my noble and learned friend Lord Falconer is proposing this afternoon, so that people have a choice. The whole object of the Bill is to give the patient a vote. At present, in many cases, the patient does not even know about the decision being taken by doctors and nurses, which will determine the precise means and timing of their demise. Under the Bill, undoubtedly the patient would be in the front line and the driving seat, taking the key decision, and the doctors and nurses would respond to a decision made explicitly by the patient. That seems to me an enormous improvement. I hope that even those of us who do not want this particular regime and would not want to use it ourselves will not want to deny others the opportunity to have a choice between death in a palliative coma and death as it could be chosen under this Bill.

Lord Cavendish of Furness (Con): My Lords, there seems to be developing some suggestion that people opposed to the Bill are introducing amendments simply to add time and cost and to make it unworkable. Would the noble Lord, Lord Davies, understand that those of us who were in principle opposed to the Bill from the very outset realise that it is intended to be compassionate—as we all feel compassionate—but just find it impossible to reconcile compassion and the objectives of the Bill with the necessary safeguards? That is at the heart of the whole matter.

Lord Davies of Stamford: I am grateful to the noble Lord for giving way, but I must intervene on him. I said nothing designed to impugn the good faith and sincerity of anyone in this House, let alone people who have gone to the trouble of producing these amendments. What I said was that, whether it is intended or not, many of these amendments would have consequences in terms of time and cost, and it would be wrong of us to underestimate those consequences—and certainly very wrong frivolously to dismiss that whole issue, as happened this morning.

Baroness Finlay of Llandaff: Would the noble Lord accept the premise that we are trying to provide the evidence based on what we know happens elsewhere? My noble friend Lady Grey-Thompson outlined a reality—that we know reports come from those countries that have changed the law about patients whose symptoms are not being addressed in the days between the time that it has been agreed and when they have their lethal overdose. That is a reality that we abhor.

I would like to correct the perception about palliative sedation to which the noble Lord referred, as it is important that people out there do not have the misconception that patients are either not consulted about treatment decisions or that they are put into some kind of coma by those who are looking after them.

The evidence from Holland was presented at the international conference on clinical ethics in Paris in April this year. In Holland, about 2.7% of all deaths are from euthanasia or physician-assisted suicide. Their regime of palliative sedation is used in between 12% and 16% of cases. That is completely different from what we do here. In this country we may use sedation, titrating the drugs up temporarily to get on top of symptoms but then lowering the dose again and adjusting it to meet the patient's needs. That is quite different from deliberately using a dose of drugs to induce coma and using uncontrolled escalations of opioids and benzodiazepine cocktails to produce absolute loss of awareness as a therapeutic goal. There is concern among those of us who are operating in palliative care in this country about that way of managing patients at the end of life. That is not standard practice here.

[Baroness Finlay of Llandaff]

If the noble Lord would like to look at the recommendations on the use of sedative drugs at the end of life, I would be happy to take him through them. They are on various therapeutic websites. However, I hope he will accept that what may be said casually by people and propaganda is not necessarily what should happen, and that nobody condones the withdrawal of fluids and dehydrating people until they die. That was exactly why the noble Baroness, Lady Neuberger, undertook an inquiry into the Liverpool care pathway. It was misused because that was not what the relevant document said should happen. That was abuse, not treatment.

Lord Empey (UUP): My Lords, I wish to speak on Amendment 67 in the name of the noble Lord, Lord Carlile, but, before doing so, I want to say how much I regret the direction of travel of our Committee stage today. I should have thought it would be more profitable to debate all the amendments in Committee and make decisions on Report. However, noble Lords have decided to take the proceedings in a different direction and we will have to deal with that.

There is no perfection to be found with this Bill or without it. As we have said many times, the Second Reading debate gave an opportunity for a large number of noble Lords to express their views and the compassionate arguments that were expressed throughout that debate were very moving. Indeed, there have been similar contributions today.

I have no complaint about the way that the amendments have been grouped today, but that does mean that certain amendments are more relevant to certain issues than others. That is inevitable. My anxiety, as I expressed at Second Reading, concerns the position of the medical profession. I am not a doctor but a close relative is starting out on that road. We have given insufficient consideration to the impact that the Bill, if it is enacted, will have on the profession. As I see it, it would completely change the status of a doctor and the doctor-patient relationship.

How often have we said that, in order to provide a lethal dose or drug, the best medical person to judge that is somebody who knows the patient because no two patients are the same? Even then, that is no guarantee because you have to have some people who are specialists in the delivery of certain substances. Even then, as we have heard from the noble Baroness, Lady Masham, when people deliberately set out judicially to end a life, it turns out to be a mess. By introducing an independent element, the amendment at least separates out from this process the role of the carer and the medical profession up to that point. That is extremely advantageous. Simply to assume that we can subcontract to a profession that does not want this, against its will and without even having a discussion on it, is presumptuous, to say the least.

1.15 pm

Imagine the implications of this at ground level. Not everyone is capable of having an intellectually balanced debate on the pros and cons of whether they are going to die. As the noble Lord, Lord Deben, said, for any of us over the years who have had constituents, human nature is, sadly, not perhaps as ideal as we would like. I have seen in my home patch mothers and grandmothers dumped on Christmas morning at a community centre to have their lunch, while the family cleared off to enjoy the rest of the day. This is human nature. To believe that it is anything else and there is a rational family debate on what we do with granny on Christmas morning is nonsense. Life is not like that. We are not perfect. There is no perfection to be found.

The other factor that is not considered is the effect of this on the doctors as individuals. They are carers who have given their lives to a particular profession or calling. The relationship between them and the patient will change. Whenever someone goes to a doctor, if they can be persuaded to do so, they are going for help; they are going to trust that person with intimate details of their lives. Perhaps they would say or convey more to a doctor than perhaps to anyone else. I am sure that the right reverend Prelates on the Bishops' Bench might agree that they get a lot of that—but so do doctors. If at some point that patient, even reluctantly, goes to the doctor because they are afraid, a new dimension of fear will be added because this is not simply the person who could help them but the person who might switch out the lights. Much as I oppose the principle of the Bill, at least bringing an independent element into the decision provides some protection and begins to separate the role of the doctor-patient relationship from this process. That is important.

There is another factor. Things change and we learn. People in some countries already know the cures for certain things that perhaps we do not know in this country. There are doctors in hospitals in this city who are better than others. There are doctors who know more than others. Therefore, there is no equality of information or professionalism within one city, one country or around the world. If a doctor decided that it was right to terminate or recommend the termination of a patient's life today, and tomorrow discovered that they had missed or failed to learn something, what would be the downstream consequences for that person? I have seen cases at home; for obvious reasons, sadly, my part of this country has experienced huge reservoirs of post-traumatic stress caused by different things. Are we going to add to that today by this process? Who knows? However, it needs to be discussed and that is what Committee is for.

Therefore, much as I am uncomfortable with this whole process, it is better to have an independent, completely separate relationship between the patient and his or her circle of medical advisers. At least by introducing that independent element, one hopes that that crucial, sacred relationship can be preserved without let or hindrance.

Lord Alton of Liverpool: My Lords, I echo very strongly the remarks made by the noble Lord, Lord Empey, about the special and sacred relationship between doctor and patient. It is worth reminding the House of what the General Medical Council said unambiguously and robustly:

"A change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities of doctors and their relationships with patients. Acting with the

primary intention to hasten a patient's death would be difficult to reconcile with the medical ethical principals of beneficence and non-maleficence".

I agree with what the noble Lord said about relationships, but I also agree in particular with the importance of Amendment 68, in the name of the noble Lord, Lord Carlile, which is about the importance of independent safeguards. I will speak to it in a moment. I come from a region where Dr Shipman was a general practitioner. He was referred to by the noble Lord, Lord Carlile, in his opening remarks on this group of amendments. Hundreds of cremation forms were signed by doctors who were not Dr Shipman; they were signed and those patients went to their deaths. That is why we are right to talk in detail about the safeguards that I know the noble and learned Lord, Lord Falconer, wants to see incorporated in the Bill, should it proceed.

I am particularly enthusiastic about what the noble Lord, Lord Carlile, said about providing an independent element in this process. I think back to an exchange in a constituency surgery. The noble Lords, Lord Deben and Lord Empey, are right to remind the House that sometimes the exchanges one has on the ground as a local politician can inform the way we think about these moral and ethical issues, on the basis of human behaviour and human nature. Just after the Toxteth riots in Liverpool a man came to see me in my surgery about the death of his father. His father had divorced from his mother. They had lived in Germany and at the end of the war they went to Holland. After their divorce the mother and son came to live in England. After his mother died, the son wanted to be reunited with his father, whom he had not known since childhood. He went to Holland, only to find that, under the Dutch laws, his father, in a state of deep depression, had taken his own life.

What really distressed this young man was that he had a half-brother who had inherited all his father's wealth and had given permission for his father's life to be ended. That reminded me of something that the noble Baroness, Lady Cumberlege, said to us on an earlier occasion. I thought it a wry but very accurate remark. She said that where there is a will, there is a relative. There are profound implications. People can gain from these circumstances. That is why an independent element is so important.

One thing that has united the House is the sense we all have about public protection. For me it is the key question for whether we support the Bill or not. Public safety is the issue. Polling data have been referred to, but those data reduce massively to only 43% approval for a change in the law if people believe that public safety will be compromised. That is the issue that your Lordships have to deal with if the Bill is to go on the statute book.

Amendment 68 takes us to the point where we can have an independent overview of any decisions that are to be made. It builds on what the noble Lord, Lord Deben, said on how we assess the effects of any individual act in the context of society as a whole: how we look at the aftermath of these decisions.

We heard from the noble Lord, Lord Howard, about the role of the hospice movement in palliative care. I am a patron of a couple of hospices, I suspect like many of your Lordships. I know the wonderful work that they do, particularly on Merseyside, which I have been involved with throughout my political life. Every year at one of those hospices there is a walk of witness through the local community, where they raise significant sums of money. It costs a lot of money to keep those hospices going. However, for me, what is really wonderful about those walks of witness is the therapeutic effect that they have on all those who participate. It is a healing process in grief.

I accompanied my father in the last moments of his life. He had a healing moment, believing that he had seen his brother who, as a member of the RAF, had died in the Second World War. I do not know whether this was a near-death experience or whether it was accurate, but it certainly helped him. If he had been given a lethal injection earlier, he would have been denied that moment. I believe that the concept of a good death—the one that historically we have always treasured in this country—could be lost if we proceeded into the mechanistic view that authorised assisted dying would probably introduce. Therefore, for me, safeguards are important.

People have been talking of their own experiences during these debates. My father was one of five brothers who were in the Armed Forces. He was a Desert Rat. One of his brothers lost his hearing and took his own life after the war was over. I remember it even though I was very young at the time. It had a profound effect—a point made by the noble Lord, Lord Deben—on everyone in our family and it still has to this day. Therefore, the idea that these decisions are purely acts of autonomy and matters of private choice that have no effect on others is simply wrong. Indeed, it was your Lordships who said precisely that in 1994, when my noble friend Lord Walton of Detchant, who cannot be here today but who, in his 90s, still plays a very active part in the House, chaired the Select Committee in question. I know that the noble Baroness, Lady Warnock, has changed her mind since then but she has played a significant part in the debates around these issues over the years, and she, too, was a member of that Select Committee. The committee said:

> "Individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions … Dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole".

I repeat:

> "We believe that … the interest of the individual cannot be separated from the interest of society as a whole".

I profoundly believe that. There is great wisdom in what the Select Committee said at that time. We have to weigh up that issue as we consider this and all the other amendments that will follow. Are we able to provide the necessary public safeguards? Are we sufficiently concerned about what will happen in the aftermath? And are we sure that we can proceed without safeguards such as the independent element that the noble Lord, Lord Carlile, is suggesting to your Lordships in this amendment today?

Lord Singh of Wimbledon (CB): My Lords, I very much agree with the sentiments expressed by the noble Lord, Lord Alton, and I agree about the importance of total independence if we must go in the direction of this legislation. However, I still have great concerns about the direction in which we are going, especially in relation to independent capacity and settled will. In everything that we do we need to place ourselves in the position of the patient. Everything we do is influenced by those around us. A person suffering mentally or physically will undoubtedly be affected not only by the pain but by his or her view of what effects their disability is having on the lives of others. A desire not to be a burden can sometimes be induced by others, but little thought seems to have been given to that.

Equally, uncaring or selfish attitudes of others cannot but have an adverse effect on one's desire to live. I fail to understand how a couple of doctors or even independent judges can know the finer points of a family's interactions and what pressurises the individual to say, "I wish to end my own life".

Then there are the wider effects not only on the family but on society as a whole of going in the direction of this legislation. What are we saying to future generations when we know that palliative care can do so much? However, I know that so much more has to be done to improve it. Only this week we had a report saying that only 10% of nurses felt that they were properly equipped to deal with end-of-life decisions and end-of-life care. We can do much more in this direction rather than taking the easy route, which sets a marker to future generations that says, "You can go in this direction, you can end life". That is something that I personally find totally wrong.

1.30 pm

Lord Tebbit: My Lords, as I have listened, my mind has turned to the practice of those who may be seriously ill or handicapped in some way or another signing DNR—do not resuscitate—forms. Are they affected by these restrictions? Should we indeed be allowing DNR forms to exist? We do not ask whether the person who signs it is mentally competent to do so, nor do we involve the High Court or anybody else. Are doctors obliged to respect a DNR form? I am not quite sure—is anybody else here?

Lord Stirrup: Will the noble Lord accept—perhaps he will not—the proposition that there is a distinct difference between a doctor failing to resuscitate or withholding artificial support to life and actually participating in the taking of a life? That is why there is such a focus in this debate on the roles and responsibilities of those people. There is a difference of very great magnitude between that and the DNR case. Does he agree?

Lord Tebbit: My Lords, I entirely agree with the noble and gallant Lord. I think there is a distinct difference but I do not think that we should just go on, forgetting the existence of those forms or forgetting the role of the doctor in deciding whether or not to respect them. It is not an easy question to answer, always, is it?

Baroness Finlay of Llandaff: My Lords, it might be helpful to the House if I intervene very briefly. The whole policy of cardiopulmonary resuscitation is being revised. The noble Lord, Lord Tebbit, has raised a very important point. Resuscitation can be a whole batch of treatments. Giving insulin to a diabetic whose blood sugar has gone dangerously high is resuscitative. Similarly, giving sugar if they are hypo is resuscitative. I would like to park resuscitation per se and focus on cardiopulmonary resuscitation, which is a specific intervention to try to restart the heart when it has stopped.

We know that the chance of that having any effect is exceedingly low when people are already dying of a disease. It is in those patients, where death is anticipated and accepted by everybody and is a natural process at the end of life, that the forms are there so that a nurse who does not know the patient, who has just come on duty and finds that they have collapsed, does not have to run down the corridor and get the trolley and so on. That is completely different from the person who collapses on the station and people, rightly, grab the defibrillator and attempt to resuscitate them, as has happened in your Lordships' Chamber—gladly, successfully. We have a very good track record of resuscitation in this Chamber.

DNR forms are completely different because you are talking about a life that is coming naturally to a close. This Bill is about taking the decision to deliberately give lethal drugs, irrespective of how long that life may go on for, because, as we will come to in later amendments, we just do not know. I wonder if that helps the noble Lord.

Lord Tebbit: I think, my Lords, it does. It is a matter of whether it is a positive or a passive intervention. That is the distinction.

Lord Hussain (LD): My Lords, from day one, I was minded not to support the Assisted Dying Bill and made my views known to fellow Members of this House. However, I have listened to today's debate. My reasons for not supporting the Bill are my faith—everybody has their own faith and can choose whether to follow it—but also a personal experience.

Some 25 years ago, my father was critically ill. After he had been many days in hospital, I was told that he was going to die and that, if we wanted to take him home, we could. And we did. I was told that it could be a few hours, a few days, a few weeks or even a few months, but that he was on his way to dying and that there was nothing we could do to help him to live longer.

In the condition that he was in, I was feeling my father's pain. I would do anything in my control at that time to help him, but I could not. However, when we took him home, he surprised not only me but the doctors and everybody else. Not only did he pull through that situation but he is still alive. He is nearly 90 now. I am glad that this Bill was not approved at that time and that we did not have the ability to assist him to die, otherwise we would have helped to kill a person who is still alive after 25 years.

Lord Hunt of Kings Heath: My Lords, perhaps I may ask the noble Lord, Lord Carlile, a couple of questions. On his Amendment 67 and the question of independent medical experts, I think that it is right to say that in our first debate we reached a pretty satisfactory conclusion on the capacity of the courts to deal with these issues if the Bill was enacted. However, the noble Lord will know that sometimes the availability of medical experts can be problematic and I wonder whether he has given some thought to the issue of their availability.

The second question is about the connection between that amendment and Amendment 68, which provides that each report that was submitted to the court by the medical expert would be submitted also to the chief coroner, who would determine whether an inquest should be held into the death of the applicant. Could the noble Lord clarify the purpose of that amendment? Is it intended in effect that the chief coroner is almost put in a position of second-guessing the original decision of the court or the advice of the medical examiner? It would be helpful if he could clarify a little more his purpose.

Lord Carlile of Berriew: I am very glad to answer the noble Lord's two questions. To the first, there is a very straightforward answer: I do not anticipate any difficulty whatever. The medical profession will prioritise like the rest of us when needs must. So far as the chief coroner's role is concerned, I anticipate the chief coroner receiving not only the independent expert's report but possibly other representations and determining whether an inquest should take place in a particular case. I anticipate that there would be very few cases anyway if the recipe that I have proposed was brought into effect and I doubt that there would have to any inquest in those cases. However, we have to keep open the possibility of an inquest, and it is much tidier to have the chief coroner decide whether there should be an inquest than, for example, to have judicial review proceedings arising as a result of the complaints of affected persons. I think that these are both very quick routes to deal with simple issues that might arise.

Lord Faulks: This has been another useful and well informed debate, following on from the first group. I do not think that it is necessary for me to add anything from the point of view of the Government. The noble Baroness, Lady Finlay, made a particularly helpful clarification about DNR notices. The difference between DNR and DNACPR is probably insufficiently understood and I think that the House is grateful for that clarification. One final thing I should say, in responding to what the noble Lord, Lord Davies, said about legal aid, is that nothing I said about exceptional funding, I am glad to say, was wrong, it having been reviewed. However, as yet no assessment has formally been done on availability to cover this situation. I am sure that the House will understand that.

Lord Falconer of Thoroton: I understood that. I do not think that the noble Lord, Lord Faulks, suggested anything to the contrary in his previous answer. We went over quite a lot of this ground in the first debate. Like the noble Lord, Lord Faulks, I agree that this has been a useful debate in a number of respects. However, the key point in the debate is the factor added by the judicial model proposed by the noble Lord, Lord Carlile. In addition to provisions required to ensure that the person has a firm and settled view and that he or she has the mental capacity, there is an additional very significant requirement—namely, that to refuse an order would amount to a breach of both Article 3 and Article 8 of the European convention.

In effect, the noble Lord, Lord Carlile, is suggesting that the judge should make a judgment about the quality of the life of the person who has applied and, in particular, whether the quality of life of the person applying in effect constitutes torture, inhuman or degrading treatment. Only when satisfied of that can the judge make an order under the proposal of the noble Lord, Lord Carlile. I totally reject that approach as being inconsistent with the essence of the Bill, which is subject to appropriate safeguards. It is not for a court to make that sort of judgment; it is for the individual. The purpose of the court's involvement is to ensure that there has been no undue pressure and no lack of capacity in reaching that conclusion; it is most certainly not to make the sort of judgment that the noble Lord, Lord Carlile, suggests. That was my understanding from the way in which the noble Lord put his case in the first debate and it is my understanding that the House has rejected that approach.

Lord Carlile of Berriew: My Lords, first, I am grateful to all noble Lords who have participated in what I think has been a high-quality debate lasting something like 1 hour and 20 minutes—a debate that I suspect almost everybody in the House would agree has not been marked with any frivolity whatever.

I reject what the noble and learned Lord just said. I am not proposing that the court should make a judgment of the quality of the person's life. That is a caricature of what I am suggesting. I, and those who support these amendments, suggest that there should be an assessment of the quality of the decision that is made by the individual, which is quite different. Yes, it should be at a high bar. We deliberately set the bar high and we do so on conscientious and ethical grounds. Of course, I acknowledge that the noble and learned Lord, too, has conscientious and ethical grounds for his viewpoint.

Those of us who lie in the bath or climb out of the shower at 7.45 in the morning are fortunate to hear the wise vignettes of the noble and right reverend Lord, Lord Harries, and the noble Lord, Lord Singh. We get our bonuses in this House, as we have enjoyed moments of real wisdom from both of them this afternoon, as we do fairly regularly on Radio 4. I am grateful to the noble Lords, Lord Empey and Lord Alton, for highlighting the issue about introducing some independence into this decision-making process.

Indeed, I have in my hand a press release issued yesterday by the senior public affairs adviser, David Knowles, acting on behalf of the British Medical Association, of which the noble Baroness, Lady Finlay, is president. As I understand it, the BMA represents all doctors in one form or another. It states:

[Lord Carlile of Berriew]

"Legalised assisted dying could have a profound and detrimental effect on the doctor-patient relationship, even where doctors' involvement is limited to assessment, verification, or prescribing".

That was only one of its grounds. The noble Lords, Lord Empey and Lord Alton, answered that point. The noble and gallant Lord, Lord Stirrup, added to that observation by saying that, if we were to introduce the amendments, we might get the medical profession to participate in the process, rather than being opposed to it. In our reflections before we may have to vote at Report stage, if there is one, that point should be taken into account.

1.45 pm

I am sure that the whole House was taken by the speech of the noble Lord, Lord Hussain, which related to one of a number of personal experiences that the House has been able to enjoy in dealing with this difficult issue over the years. What marked out the debate for me was the opportunity to hear the thoughtful speech of the noble Lord, Lord Deben. He raised three elements: speed, rigour and a manageable aftermath. I would like to add one element, which is safety. My amendments would deal with the three key elements that he mentioned, plus would ensure that we have safety, which most certainly is not ensured under the noble and learned Lord's Bill.

The noble Lord, Lord Deben, also made the powerful point, which I strongly endorse, that we should be able to talk about death much more frankly than we do. We celebrate birth, but we do not look at death in anything like the same context, although it is just as powerful a part of our family lives. Those of us who have enjoyed—I use that word deliberately—deathbed experiences know what an extraordinary effect, as described by the noble Lord, Lord Deben, they can have on the whole family. I have enjoyed two in particular. I recall that the night before my original mother-in-law, who was a wonderful woman, died, she instructed me to go to a particular cupboard and remove a bottle of vintage brandy, of which I knew nothing. The family stood round and drank a toast to her in her presence. She died the following morning beside us in a bed as the family was eating breakfast. Those were experiences that celebrated her life, and her grandchildren talk about it frequently.

We seek through the amendments to produce a system which has speed, rigour and not just a manageable but a very positive aftermath and which is safe. The reassurance of that safety is through the menu of propositions for management by the court. I greatly admire the noble and learned Lord, but I earnestly entreat him before Report—we are of course willing to talk to him—to consider those elements, because they have not been sufficiently covered in the Bill. With that in mind, I beg leave to withdraw the amendment.

Amendment 3 withdrawn.

The Deputy Chairman of Committees (Lord Faulkner of Worcester) (Lab): I must advise the Committee that if Amendment 4 is agreed, I shall be unable to call Amendments 7 to 11 for reasons of pre-emption.

Amendment 4

Moved by ***Lord Pannick***

4: Clause 1, page 1, line 4, leave out subsection (2) and insert—

"(2) Subsection (1) applies only if the High Court (Family Division), by order, confirms that it is satisfied that the person—

(a) has a voluntary, clear, settled and informed wish to end his or her own life;

(b) has made a declaration to that effect in accordance with section 3; and

(c) on the day the declaration is made—

(i) is aged 18 or over; and

(ii) has the capacity to make the decision to end his or her own life; and

(iii) has been ordinarily resident in England and Wales for not less than one year."

Amendment 4 agreed.

Amendment 5

Moved by ***Lord Carlile of Berriew***

5: Clause 1, page 1, line 4, leave out subsection (2) and insert—

"(2) Subsection (1) only applies where the person—

(a) has capacity commensurate with a decision to end his or her own life and has a clear, settled and voluntary intention to end his or her own life;

(b) has made a written declaration to that effect in the form of the Schedule before two independent witnesses, one of whom must be a solicitor in practice; and

(c) on the day the declaration is made—

(i) is aged 18 or over; and

(ii) has been ordinarily resident in England and Wales for not less than one year immediately prior to making the declaration at paragraph (b)."

Lord Carlile of Berriew: My Lords, in speaking to this group of amendments, I propose to short-circuit a number of them and draw the Committee's particular attention to Amendment 65, which stands in my name and in the names of the noble Lord, Lord Darzi of Denham, and the noble and right reverend Lord, Lord Harries of Pentregarth.

This is about capacity. There is an awful lot on the Marshalled List today relating to capacity. There is hardly a Member of your Lordships' House with an interest in the Bill who has not had a stab at producing a good capacity provision. We have proposed this capacity provision because we do not believe that Clause 3 goes anything like far enough. There are two particular aspects of Amendment 65 which go further than Clause 3 and which, I suggest to your Lordships, would provide significant reassurance. I would be really disappointed if we were brushed off, in the way in which we have been, in relation to these amendments and in respect of the two particular matters.

I draw your Lordships' attention to paragraphs (a) and (d) of the proposed new clause in Amendment 65. In defining capacity, we talk about a,

"capacity commensurate with a decision to end his or her own life",

thereby highlighting the importance of the decision. In paragraph (a), we then suggest that it should be required that it should be proved that a person,

"is not suffering from any impairment of, or disturbance in, the functioning of the mind or brain",

then come the additional words,

"or from any condition which might cloud or impair his or her judgement".

For those of us who have taken an interest in mental illness over, in some of our cases, decades and studied the subject in detail, there is a real concern that if those words or something like them are not included then people may determine that their own lives should be ended as a result of a mental condition of a permanent nature, which is easily defined as such, or by a temporary medical condition.

I am an absolute rank amateur in that I think I know a bit about mental health but it is as a layperson. I know that there are people in this House—I can see at least one present—who have a great deal of expert knowledge and are internationally admired for their knowledge about mental health. Of course I defer, as the House quite rightly deferred earlier to the noble Baroness, Lady Finlay, on palliative medicine, to any such views on the precise diagnostic criteria. What is known—it is certainly known to lawyers because we have had to deal with this all the time during our careers—is that there are manuals of diagnostic criteria. One which I am accustomed to is an international document, ICD-10, which contains the details of many different mental conditions. Among those volumes there are mental conditions which could cloud or impair a person's genuine judgment, making it a judgment that was led by that mental condition and not by a person's general state. When mental illness occurs in a family—there will be people in this House who have had this experience—it can be very frustrating for the rest of the family because they know that the individual in question is not exercising an objective or genuine judgment but, worse still, not exercising what is in reality their own normal, rational judgment, which when they are not suffering they possess. That is the purpose of paragraph (a).

Paragraph (d) requires it to be shown that the person,

"is not the subject of influence by"—

that is in the Bill—

"or a sense of obligation or duty to, others".

Almost all those of us who have been fortunate enough to have our parents survive to a very great age will have heard that parent saying, "Oh, I shouldn't be doing this to you because there'll be less for you at the end", or, "I'm causing you immense trouble because you have to come 200 miles across the country when I have a small crisis", or, "You're paying people to look after me", and so on. We all know these scenarios; they are extremely common. They happen all the time, sometimes even in the best regulated families. Those are situations in which not all, but some, feel a sense of obligation or duty to die—"You'd be better off without me". In my view, it is a matter of simple ethics—if ethics are ever simple—that we should not be willing to countenance any person choosing to end their own life because they feel that that is going to benefit others.

Baroness Warnock (CB): My Lords, why is it thought wrong for someone to ask to die out of a sense of duty or a wish not to continue in a condition that is intolerable—the condition of being disruptive, indeed often destructive, to the well-being of their own family? All the way through their life until this point, putting their family first will have been counted a virtue, and then suddenly, when they most want to avoid the trouble, bother, sorrow and misery of disruption to their family, they are told they are not allowed to follow that motive. I simply find this extraordinary puzzling and I would like the noble Lord to explain it to me.

Lord Carlile of Berriew: People with much less strength of character than the noble Baroness, who is known for her views and her enormous strength of character, are at risk of those feelings being adopted, condoned and co-opted by their family. Those of us who have practised law for many years have come across such cases. Indeed, there will be people who have observed it in the lives of friends and family. It is our view that a sense of obligation—"It would be better for my children if I were carried away"—is not a sufficient basis for allowing an individual to do what is anticipated by the Bill, which is deliberately to end the life of another person.

Lord Alton of Liverpool: My Lords, I am grateful to the noble Lord for giving way.

Lord Ashton of Hyde (Con): My Lords, I think it is usual not to intervene before the noble Lord has moved the amendment.

Lord Carlile of Berriew: I believe that I moved the amendment right at the beginning of my speech, so I am very happy to give way to the noble Lord, Lord Alton.

Lord Alton of Liverpool: I am grateful to the noble Lord. I was aware that he had moved the amendment. On the point about the pressure that can be placed on people to take decisions that they might involuntarily be asked to take, does he agree that the "right to die", as it is sometimes described, can easily morph into a duty to die? I understand the point made by my noble friend Lady Warnock. However, I recall that in 2008 she made the point that you can become a burden to the National Health Service if you have something such as dementia and then you can become a burden to society. I am personally disturbed by the idea that we place on people's shoulders the idea that somehow they are a burden not just to their families but to the rest of us as well.

Lord Carlile of Berriew: I agree with the noble Lord. Indeed, there is a very slippery slope from saying, "I feel an obligation to my family or the NHS" to it being said, "Well, we have to deal with people

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who are an obligation to their family or the NHS". The safety that this provision would introduce into the system is, in my view, very important.

Lord Beecham: Before the noble Lord sits down, for the third time he has referred to a person ending the life of another person. Will he concede that that is not a description of what the Bill sets out to permit?

Lord Carlile of Berriew: I do not concede that for one moment. The purpose of the Bill is for a person to be put in the position of facilitating the death of another person in circumstances in which that death would not otherwise occur. It seems to me to be a distinction completely without a difference. Indeed, if one were to analyse it as a matter of criminal law, there is no difference. I beg to move.

2 pm

The Deputy Chairman of Committees: I must advise the Committee that if Amendment 5 is agreed to, it is not possible to call Amendments 7 to 11 for reason of pre-emption.

Amendment 6 (to Amendment 5)
Moved by ***Lord Mawhinney***

6: Clause 1, line 13, at end insert—

"(iii) has made a second written declaration to that effect in the form of the Schedule before two independent witnesses, one of whom must be a solicitor in practice on the day immediately before effect is given to his or her decision."

Lord Mawhinney (Con): My Lords, I was interested to note, subsequent to putting down this amendment, that it covers similar ground to Amendment 65, to which the noble Lord, Lord Carlile of Berriew, has just spoken. I should start by saying that my amendment is an addition to his Amendment 5. No one should assume from it any implication that I am dissatisfied with that amendment as far as it goes; I just took the view that it does not go far enough.

If noble Lords read my amendment, what will strike them is that I am suggesting that there should be a second written declaration, but I want to come to that at the very end because that is not the main motive for putting down this amendment. I read Amendment 5 a number of times with an intellectual itch that I could not quite resolve. There was something about it that I did not like, but I was not sure for some time what it was. I finally realised that it was the word "settled". We use the word "settled" regularly in daily language, but it actually has two quite distinct meanings. It can be used to say that something is settled—I have thought about it, I have given it due consideration, and I have come to a view, so it is settled—but "settled" can also mean that a decision has been made from which there can be no variation, turning back or deviation. It was that second aspect that bothered me in terms of this Bill.

We all know examples of "settled" in everyday language. We probably all know a fellow and a girl who fell in love and announced their engagement, and it was all settled, and then one of them walked away before they got to the altar. I was just smart enough not to say to my constituents in Peterborough, "We don't need to bother you at this general election because you voted for me last time and the issue is settled". I knew that they would respond by saying, "Actually, Brian, a number of things have changed since we settled it last time, so we want to settle it again". Bless them, five further times, they settled it. Closer to home, Governments settle things all the time. We call them government policy announcements, and they are settled, until a U-turn occurs.

I hope it is not too wearisome to your Lordships' House if I add my name to the list of those who recite examples of experiences when we served at the other end of the corridor, because I know of very few aspects of human experience and behaviour that teach you more about people than being a constituency MP. I remember the day when a lady came into my surgery. She did not really want any help from me. She had to tell somebody that she had decided to get a divorce. She wanted some advice as to how to go about it, but what she really wanted was to tell me that what had once been settled was not settled anymore. I advised her to get legal advice from a solicitor. I do not know what other colleagues did, but it was my custom never to recommend a particular solicitor. Some weeks later she came back in floods of tears—she was in floods of tears before she saw me. When she had calmed down, she said, "It's terrible. We got to the point where there was only one step to go in the divorce process. I told my solicitor that he was not to go that last step without consulting me, but I have been told by him this morning that he went ahead and I am now divorced. I do not want to be divorced. I have changed my mind, but I am divorced. What can I do?" Something that was settled that became unsettled then became settled in an entirely different manner.

The use of the word "settled" in this Bill bothers me. I have no problem about the person involved going through the steps set out in the Bill and coming to a settled view. That is fine. However, time will pass between the achieving of that settled view and the use of the lethal injection or whatever the cause of death might be. What happens in that period? Are we as a legislative body making an assumption that nothing of any significance is going to happen in that period which might call into question the settled nature of the settlement? I do not think we should make that assumption. I think we ought to be quite specific that whatever may have been settled earlier needs to be reaffirmed on the eve of the decision being implemented. There needs to be an opportunity for a second and final thought as to the seriousness and finality of what is about to take place.

I come back to the second written declaration. I could not put down an amendment for your Lordships' consideration which said that we ought to redefine "settlement". That would have been seriously boring and nonsensical. I put down one way in which settlement could be affirmed or confirmed, and that is that a second written declaration had to be undertaken 24 hours before the final event. Other noble Lords who may agree with me may have a better way of confirming what settled means than the option I have chosen.

Lord Avebury (LD): I just want to point out that the individual concerned has the right to revoke the decision right up to the point when he takes the medication. In fact, 40% of patients in Oregon do so.

Lord Mawhinney: I am aware of the point that the noble Lord makes. On the other hand, I have a lingering concern that the pressure of family and events can create circumstances in which it is quite difficult for people to express that reservation if they feel they are being a burden. At Second Reading, I gave the example of my own mother and the last years of her life. I quite accept that that provision is there; I know it and welcome it. However, it does not go far enough. There is a judgment call to be made at the very end which nobody can escape, which has to be affirmed, confirmed and made. It is one last chance. That does not seem unreasonable given the substance and significance of what the legislation is about.

In my earlier intervention I sought to persuade the noble Lord, Lord Pannick, to defer his vote. He and the noble and learned Lord, Lord Falconer, exercised their rights absolutely; I have no complaint about that. They disappointed me, but they were perfectly entitled to do so. Let me therefore be explicit: I do not intend to push this to a vote today. I want to stimulate people to think about whether a settlement made some time ahead is a sufficient safeguard or whether it ought to be mandatorily reaffirmed just before the act takes place. I would like your Lordships to think about that. If my proposal finds favour, that is good and we can come back to it on Report. If not, I am interested in hearing other suggestions.

Baroness Richardson of Calow (CB): My Lords, on Amendment 65, on capacity, it is hard to imagine how anybody who has just been told that they have less than six months to live, and who is in such pain that they do not want to continue living, should have absolutely no impairment or disturbance of the mind. This must be part of the condition—but I am not convinced that it would necessarily cloud or impair their judgment. When a person gets close to death, it clarifies the mind rather than clouds it, and gives them much more of an incentive to make decisions that will affect them in a very real way.

On the sense of obligation or duty to others, at the risk of sounding too much like a Methodist minister, there used to be in our Methodist hymnbook a hymn which started:

"Rejoice for a brother deceased;
Our loss is his infinite gain".

There are occasions when people, feeling not just a duty to others but a delight and a joy in leaving behind a mortal body in order to find a fullness of life—which some of us already experience—will want to do so at the moment of their death.

Baroness Butler-Sloss: My Lords, I will speak to Amendments 66 and 84, since I understand that I cannot speak to Amendment 9. Before I do so, I have one point about Amendment 6 of the noble Lord, Lord Mawhinney. I am not terribly happy about it. The written declaration in Amendment 5 of the noble Lord, Lord Carlile, ought to be adequate. We have to bear in mind that we are talking about people, according to the wording of the Bill, who have either six months to live or, if the noble Lord, Lord Carlile, is right, three months to live. To expect a second declaration in addition to a first, when one would expect the first declaration to have been seriously considered before it was signed, is probably a step too far and would, in my view, probably be unjust to a patient.

On Amendment 66, I need to explain to the House why on earth I am producing another amendment on capacity. There are three reasons. One is that I am not happy with the word "commensurate". This is a highly technical point, for which I apologise, but speaking as a lawyer the Mental Capacity Act 2005 talks about capacity. Nowhere, to my knowledge, is any word attached to "capacity" to explain it. One of the most important areas of capacity is the capacity to make a will. Perhaps it is not as important as the capacity to live or die, but it is certainly of great significance to lawyers and to those who witness a will. You should not use the word "commensurate" for a will, and neither should you use it for this matter we are now discussing. However, that is a technical point.

2.15 pm

I will make two other points on my amendment. First, I say in proposed new subsection (2):

"Unless the attending doctor is satisfied".

I am asking for the doctor to be satisfied—for it to be an onus on him to be satisfied that the person has capacity. Unless he is absolutely satisfied, he cannot go ahead. I hope that using the word "satisfied" would place quite a heavy burden on the doctor. I understand the point made about "the nearer you are to death", but some people are in deep depression and want to make a decision in that state of depression, when their mental processes may not be entirely coherent. That is why I would want one to be quite certain—to be satisfied—that the person is not in depression, does not have some other mental illness, and is not under the influence of drugs or anything else like that, and therefore to put the onus on all doctors to a greater extent than it otherwise might be under the wording of the Bill.

The second point, which is covered by proposed new subsection (6), is on appropriate training. Every doctor—and obviously the psychiatrist, if it ever gets to a psychiatrist—will have that training. However, as I understand it—of course, I am not a doctor—there are modules for training doctors in various other aspects which are not their particular expertise. I suspect that we are talking here largely about general practitioners, who will be the attending doctor, and the independent or second doctor. It would be very important for each of those doctors to have adequate information, at least at a primary stage, to understand what pointers they should be looking for when they are judging the capacity of a patient who is asking that doctor to assist them to die. I do not think the requirement for at least some training before they make that decision is to be found anywhere else in these amendments.

Lord Tebbit: Perhaps the noble and learned Baroness can help me with that question of capacity. There are some elements, such as depression, which come and go at various levels. A depressed person may sometimes have capacity and sometimes not. An alcoholic may not have capacity but, on the other hand, he may have it when he sobers up for a while. The same applies to a drug addict, who may or may not have capacity according to how much he has taken. I find that rather difficult to judge against the more permanent and unchanging stages of capacity and incapacity; for example, in a patient with Down's syndrome, whose capacity would be limited but probably more or less unchanging, or somebody in the later stages of Parkinson's disease, where that mental capacity was beginning to go but could only get worse. I am a little puzzled as to how one would make the decisions between those varying states.

Baroness Butler-Sloss: If I may be anecdotal, as other noble Lords have been, my mother died of multiple sclerosis in her early sixties. There was a point at which I, as a young lawyer, realised that she no longer had, in my view, the capacity to make decisions. However, that was at a very late stage of her illness.

If the doctor is not satisfied because someone is a drug addict or has been an alcoholic or has, for instance, a high degree of anorexia as a young person and is saying that they want to die, those are points at which a doctor should be saying, "I'm not quite certain whether he or she has capacity". That is why I suggest in my amendment that, unless they are satisfied, they should pass it on to someone who has the expertise, who would then, as a psychiatrist, look at whether the person actually has the capacity. Okay, we are talking about someone with three to six months to live but, if they do not have the capacity to make this incredibly important decision, they should not be allowed to do so. That is how I would see it, in answer to the noble Lord, Lord Tebbit.

Lord Winston: I thank the noble and learned Baroness for giving way, but would she not agree that sometimes people who have capacity and say that they wish to die, as indeed my mother did, may then change their mind some months later, quite unexpectedly?

Baroness Butler-Sloss: Yes, that seems to me to present one of the problems with the Bill.

Lord Griffiths of Burry Port (Lab): My Lords, may I offer something at this stage? The ground has been well worked in the past and I have here some of the hearings that took place 10 years ago, when we discussed this matter. The whole question of the psychiatrist was raised then. Again and again, in discussing competence, it is the psychiatrist who seems to be claiming that someone lacks it. Making a judgment about people near to death is very difficult. Some 25% to 40% of patients at the time of diagnosis, and a similar percentage at other times on the cancer journey, suffer from depression or despair, but those conditions can be reversed. It depends on when you take the decision. Indeed, a neurologist suggested that in some conditions the whole issue of cognitive impairment must be taken note of. For example, patients to the lay person might appear relatively normal but could have severe cognitive impairment and therefore be unable to give informed decisions in such an area.

The training is not just for the people that these provisions have in mind. Once we move the debate, as we have consistently through this day, into the hands of experts, we are removing from ourselves the recognition that the experience of death and dying belongs as much to the non-experts as it does to the experts. With great timidity, I have stood up to speak at this moment, having heard in this morning's debate from some of the leading lawyers and medical people in the land, and from people with a long experience of public life. I wonder whether it is true, for example, that a judge is, at the end of the day, the person in whom we can deposit all our confidence.

I remember the debates in my childhood that took place around the movement towards the abolition of capital punishment. You have a judge and a jury in that case, counsel for the defence and the prosecution, due process and forensic evidence—justifiable or not. You have the whole process of the law brought to bear on one case and one person, guilty or not guilty. The reason we went forward to abolish capital punishment was because of the possibility of an error of judgment—that with all that happening we might have got it wrong. As a simple lay person, I simply want to say that in this area it is infinitely more likely that we might get it wrong. It is for that reason that I stand against this Bill: because of the high possibility of getting it wrong, even when judges and the top medical people are involved.

My life sees me alongside dying people from first news to last rites and, indeed, beyond last rites—I have dealt with the people with whom one has to deal when they feel that they have not done everything that they might have done for mum. These are unhealed wounds that pastoral people have to deal with on and on, beyond the moment of death.

To think of the autonomy of the person as if that alone constitutes where this debate centres is, in my experience, utterly wrong. Consequently, when I saw the amendment that refers to,

"capacity to make the decision",

I wondered whether the capacity we were talking about was that which pertained to the decision-makers rather than to the person dying. This is an immensely complicated area and it seems to me that we must question these rather forensic points that are being made about the capacity of this person, that person or the other person. Death and dying are individual in every case, and sometimes a friend can do more good than an expert.

Lord Maginnis of Drumglass (Ind UU): My Lords, I have wondered at what stage I should intervene in this debate in so far as I am not a doctor or a lawyer. I find myself with the problem that life has not for me been exclusively about doctors and lawyers and those erudite few who can argue about other people's lives. I hope that those who would try to persuade us that this Bill is a necessity for this so-called sophisticated age in

which we live are able to understand that the majority of us live our lives on the basis of a moral code—it has never let me down in 77 years—where, collectively, we have least difficulty in finding ourselves able to coalesce in defence of what we usually refer to as the common good.

I get the impression that it is not fashionable to admit to a faith that is based on the 10 commandments but that there is a prevailing view of our times that favours—indeed, espouses—individual morality where there is no absolute right and no absolute wrong. It suggests that each individual has at a specific moment some inherent right to choose what falls within one's own moral compass. Surely that is a selfish, if not arrogant, position that in this specific instance must toss us on the horns of a dilemma. Should we, from within this comfortable and privileged Chamber, acknowledge the established right and wrong in how we seek to protect the vulnerable, the elderly and those unable to protect themselves, or do we absolve ourselves by criticising those like the extremists in the Middle East, those who mutilate young women through FGM or abortion doctor Kermit Gosnell as they comply with the tenets of their own moral compass?

All I have to say, because I am not a lawyer or a doctor, is that we can decide to look the other way, to pass on the other side, or we can show the compassion and the responsibility of the good Samaritan, however inconvenient that may be to those who would turn our lives into a philosophy that is questionable, contradictory and argumentative.

Baroness Murphy: My Lords, I have two amendments in this group which I wish to discuss briefly. I should say that I am an academic psychiatrist who practised in the community for many years. I have done more testamentary capacity cases than I care to remember, as I practised with elderly people for 30 years. Therefore, I reckon that I am as much an expert on capacity as anybody in this House.

2.30 pm

Of course, the noble Lord, Lord Tebbit, is right to say that people change their minds and the noble Lord, Lord Mawhinney, is right to say that a settled intention does not always remains settled. There are ample provisions in the Bill and, of course, within the code of practice whereby we would want to ensure that people had the opportunity. Nevertheless, as the noble Lord, Lord Avebury, so eloquently and briefly said, if someone changes their mind right up to the minute they are to take that drink of killing medicine—let us say it—until that very moment, the choice is theirs. In Oregon and in Washington state, we know very well that about 40% of such patients do not take it. They go on to receive hospice care and palliative care. That is their choice.

Lord Tebbit: My Lords—

Baroness Murphy: Can I just finish my points? Essentially, of course the capacity issue is one that doctors deal with every day. As the noble Baroness, Lady Hollins, has often pointed out, they are not very good at it unless they are specifically asked to do it. That is a crucial point. There is a difference between a doctor just ticking a box and those who have to say they are there to assess capacity. In this Bill, they are there to assess capacity. Should we have a "supercapacity" category? Should we ask for a solicitor? That would make it extremely difficult for the patient who would have to clear yet another enormous hurdle. It would be too much.

I have discussed this with the Royal College of Psychiatrists. There are, in fact, three fellows of the Royal College of Psychiatrists in this House; one is against the Bill while two of us are supportive of it. That indicates how most of the royal colleges are split. It is not that there is a split between those doctors who are for and those who are against, in the way that the BMA describes it. The BMA has never asked its members; it would not risk it. The Royal College of Physicians is consulting again but, in fact, most of the royal colleges are now neutral on the issue.

I suggest that we look seriously at how we can strengthen the Bill in relation to capacity as it is described at the moment. If those doctors who are not specialists in capacity, as happens now in relation to many decisions, have any doubt whatever, they should be able to refer to a specialist—a psychiatrist who specialises in capacity. I will sit down for a moment.

Lord Tebbit: I am grateful to the noble Baroness, because she has launched herself off into dealing with an argument that I did not make. She misheard what I said. I was not talking about people changing their minds. We all do that at times. I was talking about people whose capacity was changing. That is an entirely different argument, and it would help if she dealt with the argument I made, not with the argument she would like me to have made.

Baroness Murphy: I am happy to apologise to the noble Lord, Lord Tebbit. Of course people change in their capacity. The way in which the Bill is phrased and the way in which the code of practice needs to be devised must take account of people's changing capacity. I accept that completely. The noble Lord is right; people change in their capacity.

Amendment 54 adds a provision in the Bill that a patient should be referred to a specialist if there is any doubt in the minds of the attending consulting physicians on the patient's capacity. That safeguard is in the Oregon legislation and is worthy of being put in this Bill. It could easily be put into the code of practice also, and that is where those of us who originally were concerned about the Bill had in mind for that provision to go. However, if people would feel more reassured that it should be in the Bill, I would support that. We must get away from the notion that doctors somehow do not understand capacity or use it. They do so every day of the week—not always perfectly but sufficiently to this end. We cannot expect that people should have a sort of supercapacity over and above what is generally accepted by the courts.

This issue was given a great deal of thought during the creation of the Mental Capacity Act, but ultimately the way that Acts are implemented has to depend on

[Baroness Murphy]
the way that codes of practice are devised. That is where the professions must come in: to help us and to tell us what they would like and what people think. To take a very good point made by the noble Lord, Lord Griffiths of Burry Port, this is not just an issue for doctors to decide; it is about other people coming in to say what the code of practice would look like and what lawyers, relatives, indeed all of us would think was an appropriate level of mental capacity. It will, of course, be extremely high and quite different from testamentary capacity, where the test is quite low.

I propose that we support Amendments 54 and 59, but I do not support the amendments at the beginning of the group.

Lord Mackay of Clashfern: My Lords, technically speaking this is a debate on Amendment 6, which was moved by the noble Lord, Lord Mawhinney. Some of the observations that have been made are not very clearly directed to that. All the same, I will talk about one of them.

The amendment in the name of the noble Lord, Lord Mawhinney, is best dealt with by Clause 4(2)(c): that the doctors administering the poison are to be sure that they have confirmed that the person has not revoked and does not intend to revoke their declaration at the last minute. As has been said, the patient has the last word in this sense: they can stop the injection if they do not want to have it at that point. If they have changed their mind following the declaration, there is ample safeguard in the Bill against any, as it were, forced injection.

I will say one thing on the intervention by the noble Baroness, Lady Warnock. As I understand it, if we bring children into the world we have responsibilities for them. Those responsibilities should not be regarded as burdens that are somehow affected by the Bill. It would be extremely dangerous to take the view, for example, that a disabled child should feel responsible for the care responsibilities that they put on their parents. If that child thinks that there is an obligation to die, because it is the only way to remove that obligation from their parents, then that is a most dangerous doctrine. In view of what the noble Baroness, Lady Warnock, said, I felt that that was something that needed to be put on record.

Baroness Hollins: My Lords, I believe we are debating the whole of the group, although I do agree with the noble Lord, Lord Mawhinney, that the assessment of capacity and settlement of the decision needs to be done at the moment that that decision is finalised. I do not think that the other amendments in the group are rigorous enough. My Amendments 71 and 151 have three main elements. I am drawing on my experience as a psychiatrist working with disabled people—in particular people with intellectual disabilities—and of teaching medical students about the assessment of capacity for more than 30 years.

The first element to which I want to draw attention is that, in consideration of any request for assistance with suicide, positive action is taken to establish that there is no evidence of mental disorder. The second element is the need to establish the presence of a decision-making capacity that is commensurate with a decision of this nature, as has already been suggested by my noble friend. Thirdly, the amendments propose a regime for ensuring that clinical opinions about the absence of mental disorder and the presence of decision-making capacity are taken on the basis of expert assessment.

There are in England and Wales two circumstances when a person is not permitted to make healthcare decisions themselves. One is when they lack mental capacity in relation to the relevant decision. The Mental Capacity Act 2005 applies to many decisions but assistance with suicide is explicitly excluded. Other noble Lords will explain more about decision-making capacity and the findings of the recent post-legislative scrutiny Select Committee of your Lordships' House which examined this Act and of which I was a member.

The other circumstance when people are not permitted to make healthcare decisions for themselves is when they suffer from a mental disorder of a nature or degree that warrants, for assessment under Section 2, or makes it necessary, for treatment under Section 3, for the person to be in hospital in the interests of their health or safety or for the protection of others. If a person was depressed or anxious and wished to kill themselves, they would normally be stopped from doing so with the authority of the Mental Health Act 1983, so the additional assessments that I am suggesting in this amendment should relate not only to impaired judgment but, first, to whether the person has a mental disorder.

I remind noble Lords that the definition of mental disorder is,

"any disorder or disability of the mind".

The psychiatrist making such an assessment must be Section 12 approved, as required by the Mental Health Act. The Mental Health Act is risk based, not capacity based. If it is in the interests of his health, a person with a mental disorder can be detained and treated. It overrides personal autonomy. The Mental Health Act does not require any impairment of judgment or decision-making capacity to be present.

If you have a mental disorder then, whether you are capacitous or not, you will not be given assistance to die. The Mental Health Act would take precedence and the person's mental illness would need to be treated effectively before any assessment of their decision-making capacity was made. Therefore, the Mental Health Act provides another safeguard.

As I read the Bill, nothing would stop patients detained under the Mental Health Act, if they retained decision-making capacity, from being given medication to end their life. That is clearly wrong. I shall go further: it relates not just to patients who are already detained but to those who, if assessed, would meet the criteria for detention in order to treat their mental illness.

Wishing to end one's life is a common symptom of mental illness, normally regarded as constituting grounds for psychiatric assessment. Suicide itself is not unlawful but, as a society, we regard suicidal intent as a reason to protect a patient from self-harm. We do not take the view that we should intervene in a case of suicidal

intent only if we have reason to believe that the person concerned lacks capacity; we assume that a person who announces or otherwise indicates intent to take his or her own life is not acting rationally, and we do everything possible to discourage or prevent him or her proceeding. That is what all the suicide watches and all the suicide prevention strategies that successive Governments have introduced in recent years are about. Indeed, the national confidential inquiry into suicide and homicide, NCISH, which I chaired from 2007 to 2010, was set up to inform clinical practice and health policy with a view to reducing suicide rates.

The noble and learned Lord's Bill makes it clear at Clause 6 that it is seeking to amend the Suicide Act 1961. Some may not see the provision of lethal drugs to a seriously ill person as assistance with suicide but in law that is what it is. This leads me to conclude that the Bill is out of alignment with social attitudes to suicide.

The Assisted Dying Bill also fails to provide a strong enough assurance that a person requesting assisted suicide has the mental capacity to make this decision. Capacity assessment must be decision-specific. The more serious the decision, the greater the level of assurance required that the person making the decision has commensurate capacity; that is, a level of capacity appropriate to the decision in question. The key purpose of my amendments is to ensure that there is mandated, at least in outline, a proper process for establishing the absence of mental disorder and for taking positive action to ensure the presence of commensurate capacity.

2.45 pm

Therefore, my proposed steps for establishing the absence of mental disorder and the presence of capacity are as follows. The attending doctor who is assessing a request for assistance with suicide must first be personally satisfied that the person making the request is not mentally disordered and has a level of capacity commensurate with this life-or-death decision. If the doctor is satisfied, he must refer the person for confirmation of this view by a specialist.

Some may ask why I have not chosen to follow Oregon's model of requiring referral for a specialist opinion only in cases of doubt, as proposed by my noble friend Lady Murphy and others. The question might be asked that if the attending doctor has a concern about a potential mental disorder, surely he would ask for an assessment, would he not? If he thought there was a serious mental disorder, surely he would seek to use the Mental Health Act, would he not? But research has demonstrated that many doctors are poor at recognising depression and lack knowledge on how to assess for its presence in terminally ill patients.

Depression is a subtle condition, frequently gaining an insidious foothold in many people with physical illness and many people who are disabled, thus hugely influencing their psychological processes. Studies in terminally ill patients have clearly shown that depression is strongly associated with a desire for a hastened death, including the wish for physician-assisted suicide or euthanasia. This is true for the top three diseases for which patients request physician-assisted suicide—cancer, motor neurone disease and HIV/AIDS—yet even when it is recognised, doctors often take the view that what is sometimes diminished wrongly as understandable depression cannot be treated, does not count or is in some way not real depression.

However, research shows that when depression is detected and treated effectively with medication, psychotherapy or other psychosocial support, most—98% to 99%—will subsequently change their minds about wanting to die. That is an extraordinary statistic, and patients with pre-existing mental illness who then develop a terminal physical disease may receive substandard treatment for psychiatric relapses after requesting assistance to die because doctors struggle to recognise relapse and the need for psychiatric clinical care. The difficulties of spotting depression in terminally ill patients mean that assisted dying will put such people at risk.

According to a large independent study by the Royal College of General Practitioners, 77% of GPs are opposed to a change in the law, so it will be a minority of doctors doing the majority of assessments—doctors who know nothing about a patient beyond their case notes. We know that GPs and physicians are slow to refer to psychiatrists. It seems very unlikely that they will refer, despite our new discourse about parity for physical and mental illness.

There is evidence that Oregon's regime of referral if needed just does not work. Independent research has revealed that some people in Oregon who have ended their lives with legally supplied lethal drugs had been suffering from clinical depression, which had not been detected by the assessing doctors and had not been referred for specialist assessment. We do not want that happening here. Psychiatrists do not want to see members of their own patient group being let down by the lack of a rigorous safeguarding process; nor do they want to be the gatekeepers, so they are in a bit of a double bind. It could work only if the assessment process was in support of a judicial decision-making process, such as that suggested by the noble Lord, Lord Carlile, and I suggest that the independent medical experts called for by him should always include a psychiatrist.

Problems of physical and mental health often coexist. As specialists who frequently work at the interface of such problems, psychiatrists are well aware of the effects of disempowerment, despair, fear of the future and fear of being a burden to others.

The declaration which the Bill of the noble and learned Lord, Lord Falconer, asks the doctor to sign states that the patient,

"has the capacity to make the decision to end their own life; and … has a clear and settled intention",

to do so. That is a not a declaration that I as a doctor and a psychiatrist would be prepared to make without getting to know a patient, and I am not alone in this view.

The noble Lord, Lord Griffiths, asked whose capacity was in question. Research carried out in Oregon found that only 6% of psychiatrists felt confident that they could establish capacity for assisted suicide on the basis of a single consultation, yet this Bill does not require even a single consultation with a psychiatrist. So how many times do I think a psychiatrist should

[Baroness Hollins]
see the person? Since suicidality fluctuates, I propose for the purpose of this probing amendment that there should be two specialist assessments, spaced ideally at least 28 days apart, with offers of treatment for both depression and pain, so that there is time for suicidal ideation to abate. My concern here is to have assurance that all the relevant areas of psychopathology, especially those that may be difficult to explore and/or where highly specialised knowledge of psychopathology is required, are covered.

Medicalising assistance with suicide is a dangerous road to travel. The BMA is very clear that assisting someone's suicide should not be part of any doctor's job description. The 150,000 doctors represented by the BMA have a well established way of achieving consensus through their representative processes.

It is our duty to scrutinise this legislation to try to reduce risk to people who may be more vulnerable than us—indeed, I believe that this is our only responsibility today. I do not believe that this Bill is safe. These amendments are offered to the House to make it a little safer in the unhappy circumstance of it being passed into law. I certainly intend to return to this issue if there is a Report stage.

In case there is any room for doubt, I support the amendments proposed by the noble Lord, Lord Carlile, in this group and the previous group.

Lord Deben: My Lords, I did not intend to speak on this group of amendments, but two interventions lead me to do so. The first was that of my noble friend Lord Mawhinney, who I think is wrong. I do not think that his proposal is necessary. I think that the Bill covers that. What my noble and learned friend Lord Mackay pointed to in that part of Clause 4 is right. It is important that even those of us who are very unhappy about the Bill should be extremely careful not to be presenting things that might be seen as merely holding up or interfering with the process of the Bill. That is why I would not support that proposal. It was the intervention of the noble Baroness, Lady Warnock, which particularly caused me to feel that I should join the noble and learned Lord, Lord Mackay, in his conversation.

Lord Mawhinney: I am grateful to my noble friend for giving way. Would he be willing to accept that there is a difference between an option being available to someone and a requirement to make a decision being available to someone? I am disappointed that my noble friend implicitly accused me of trying to slow down the process when I was, obviously inadequately, trying to draw a distinction which seems to me to be important. The opportunity to be required to make a decision is different, almost in principle, from the option to make one. I hope that my noble friend might on reflection agree that that is a distinction worth considering.

Lord Deben: First, I agree with the distinction. Secondly, the criticism that I made was not of my noble friend but of myself. It was that I would not like to be accused of supporting something merely for the sake of supporting it because it was another part of the debate. That is why I felt it right to say that I did not support this in order that no one should feel that one was elongating. What I would say to my noble friend is very simple: within the Bill it is clearly necessary before the final act takes place for the person doing that act to assure themselves that there has been no change of mind. That is not an option; it appears to me from the Bill that that is a necessity. If it is not a necessity, we ought to make it one. The noble Baroness spoke of the guidance. It would certainly have to be very clear in the guidance. Given those things, I would not want to change it in the way that my noble friend suggests.

I return to the noble Baroness, Lady Warnock, with whom I have had fascinating and interesting discussions over many years. One of the issues that we have not so far considered, but I hope we all have in our minds, is the fear that particularly older people should feel that they are no longer of use when they are of use. Very often, when people say, "I ought to end my life because I am a burden on you", the answer ought to be, "You are not a burden". I have been very fortunate in my life because I have had the ability—I mean by that the size of accommodation—for my wife and I to look after both our sets of parents until they died. It was an enormous privilege. If you asked our four children, they would tell you that it was one of the most important parts, if not the most important part, of their upbringing—to be brought up with aged grandparents and, in one case, with a grandmother who had long lost the power of communication. They would all say that all four of them contributed greatly to them and to their lives. The worry I have of the thought that the noble Baroness put forward is that it reaches to the thing in this Bill that for me is the deepest unhappiness, which is that people should feel that they do not matter because they cause trouble and difficulty and are a burden on others.

One of the things behind all this that leads me to take time and to be concerned is the awful way in which this nation in particular treats its older people in general and the attitude we have towards them. Of course, I suppose at my age I ought to declare an interest. However, I intend to be around, like most of my relations, for very much longer. I hope I will not be a burden, but it is not for me to judge whether I am a burden. That is why I think paragraph (d) of Amendment 65 is so important. I do not believe that people should end their lives because they make a decision that they are a burden. I think that is one bit we have no capacity to decide in any circumstances, however mentally agile we may be. It is utterly impossible for any of us to make that as an objective decision. Therefore, to put this into the Bill is an important affirmation of our belief that a person, even in their last days, may, in fact, far from being a burden, be someone who makes a real contribution to the people around.

It is difficult not to, and I know that sometimes it could become maudlin, but we can speak only from our own experience. I, too, was with my father as he died. We were very close. He died as I said the words of the Nunc Dimittis. He clasped my hand and was gone. I think that his last fortnight of pain and his difficulty in coming to terms with a failed operation, making a

decision that he would leave his death as it would come, has had a bigger effect than almost anything else. I do not think that he knew that; although I believe that he does now. However, I do not think that he was capable of saying that he did not matter and I think that we ought to protect people from being asked to make that decision.

3 pm

Baroness Masham of Ilton: My Lords, I support Amendment 71 in the name of my noble friend Lady Hollins. As in the case of those with terminal illness, we know that identifying depression is particularly challenging in some other groups, such as those with physical disabilities, intellectual disabilities or autism spectrum disorders.

Depression is more common in those with physical disabilities arising, for example, following a stroke, spinal cord injury or as a consequence of multiple sclerosis. Research shows that that is particularly so when factors including chronic pain, reduced mobility and poor social support are present. Identifying and treating depression and attending to contributory factors can improve both mental and physical health, but depression is difficult to detect in those with physical disabilities. That is because symptoms of the underlying disability can overlap with symptoms of depression—for example, fatigue, lack of interest in previously enjoyed activities, difficulties in sleeping and emotional lability. Depression can be missed by doctors who are not experienced in assessing mental disorders in the context of physical disabilities. Specialist assessment is often required.

Similarly, people with autism spectrum disorders may have characteristics such as social withdrawal, impaired communication and sleep and appetite disturbance which can mask symptoms of depression. Depression often manifests differently in those with intellectual disabilities compared to the general population.

Furthermore, detecting mental disorders in people with autism or intellectual disabilities, as well as assessing their mental capacity to make specific decisions, requires an understanding of their communication needs and how they may differ from the general population. For example, some people with intellectual disabilities may find it easier to communicate using pictures rather than words; others may demonstrate acquiescence, or a tendency to repeat the last words spoken to them. A doctor who has not had experience of or training in assessing mental disorders and mental capacity in people with autism or intellectual disability may be unable to identify the presence of disorders such as depression and may struggle to optimise the person's decision-making capacity. Again, specialist assessment is vital.

Those vulnerable patient groups are not adequately protected by the Bill as it stands. That is even more reason to introduce a process to make specialist assessment of mental disorder and end-of-life decision-making capacity mandatory. Disability is very complicated, and everyone is an individual.

Baroness Grey-Thompson: My Lords, I speak in favour of the amendment tabled by my noble friend Lady Hollins. I felt, coming into the Bill, that I needed a much deeper understanding of mental capacity because my only personal experience of dealing with psychiatrists and psychologists goes back to when I was 11 years old. I have to thank my noble friend Lady Warnock for that because of her incredible work on special educational needs. At the time, I was not allowed to go to a mainstream school and my only gateway into it was going through mental capacity tests.

I have read so much on this but one article that I found stood out to me. It was written, I accept from a very particular point of view, with reference to Herbert Hendin MD, who is CEO and medical director of Suicide Prevention Initiatives. He is also professor of psychiatry at New York Medical College. He stated in congressional testimony in 1996 that,

"a request for assisted suicide is … usually made with as much ambivalence as are most suicide attempts. If the doctor does not recognise that ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror".

The article also said:

"Most cases of depression … can be successfully treated …Yet primary care physicians are … not experts in diagnosing depression. Where assisted suicide is legalized, the depression remains undiagnosed, and the only treatment consists of a lethal prescription".

We have heard a lot about the difficulties of diagnosis. My noble friend Lady Hollins mentioned the 6% of doctors who are confident that they can diagnose depression. If we look at the figures from Oregon, which the Bill is based on, back in 1998 31% of patients underwent psychiatric evaluation. In 2003-04 it was 5%, and in 2007 no patients underwent psychiatric evaluation. There is the case of Michael Freeland, who for 43 years had diagnosed mental health issues and suicidal tendencies—this was all recorded. He was able to obtain the drugs.

Several studies have shown that incidences of psychiatric illness, particularly depression, are linked to 30% of people with a terminal illness. We have to make sure that these safeguards are included. In my mind, we must make sure that anyone who wants to go down this route has to be evaluated in a clear manner by people who understand mental capacity.

Viscount Colville of Culross (CB): My Lords, I have put my name to Amendment 66 because, as I said at Second Reading, I am concerned that there are not sufficient safeguards in the Bill to ensure that the mental capacity of the terminally ill person has been correctly assessed.

In subsection (2) of the proposed new clause, the emphasis is on the doctor not to countersign the declaration of intention,

"Unless the attending doctor is satisfied that a person requesting assistance to end his or her own life has the capacity to make",

that decision. I listened carefully to what my noble friend Lady Hollins said about psychiatrists not necessarily being brought in. However, I should like to think that we can rely on the professionalism and training of our doctors and that if they were in any doubt at all, they would call in a psychiatrist to make this assessment to reach that very high level of satisfaction that the patient has the mental capacity.

[Viscount Colville of Culross]

The requirement to call in a psychiatrist if the doctor is concerned about the person's mental capacity was included in the original Bill of the noble Lord, Lord Joffe, but is not in this Bill. As my noble and learned friend Lady Butler-Sloss said, subsection (2) of the proposed new clause points out that the person should not be,

"suffering from any condition, including … depression",

which could impair his or her judgment. Recent medical evidence has revealed that the presence of depression in terminally ill patients is much higher than in other patients. In a report in the BMJ, *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying*, the authors investigated terminally ill patients in Oregon who requested aid in dying and found that more than 50% met the criteria for depression or the criteria for anxiety that they were depressed. Depression can leave a person with unchanged mental capacity; it can also radically change a person's mental capacity. There was rather a good article in the *Journal of Clinical Oncology* entitled "Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients", which discovered that the risk of requesting euthanasia for patients with a depressed mood was 4.1 times higher than that for patients without a depressed mood.

This amendment would put the onus on the doctor assessing the mental capacity of a patient to bring in a psychiatrist if they were at all concerned about this condition. Proposed subsection (3) seeks to set out the criteria for the psychiatrist who is going to be involved. The 2005 mental capacity committee heard from Dr Geoffrey Lloyd of the Royal Free Hospital's department of psychiatry that in more complicated cases only liaison psychiatrists have the expertise to assess a patient's mental capacity correctly. The report said:

"There was a general consensus among our expert witnesses on one point—that the attending and consulting physicians who are envisaged as being effectively the 'gatekeepers' in regard to applications for assisted dying could not be expected to spot impairment of judgement in all cases".

Proposed new subsection (4) asks for the psychiatrist also to be satisfied that the person making the request has the capacity to make the decision to ask for assistance with dying. Patients can be very good at deceiving even trained psychiatrists about their state of mind and can appear to be capable when they are not. The same often appears with people who are suffering from dementia. Psychiatrists may need to make another visit, maybe a month or so later, to make a proper assessment of their capacity. I can quite see that this sort of period can make the delay too long for many terminally ill patients. My answer must be that the most important thing is to get the decision right. I hope that this amendment will do just that.

Lord Swinfen (Con): I support the noble Baroness, Lady Hollins, on her Amendment 71. Given the gravity of the decision to end one's life, ensuring that a person requesting assisted death has the capacity to make this decision is of fundamental importance, yet the Assisted Dying Bill raises serious concerns about how decision-making capacity will be determined.

Furthermore, I think that the Bill is inaccurate from a legal standpoint with respect to the assessment of mental capacity. The Mental Capacity Act 2005 states at its outset that:

"A person must be assumed to have capacity unless it is established that he lacks capacity".

Section 62 of the same Act makes clear that,

"nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961".

Yet Clause 12 of the Bill of the noble and learned Lord, Lord Falconer, states that,

"'capacity' shall be construed in accordance with the Mental Capacity Act 2005".

The Mental Capacity Act for England and Wales has established the legal criteria to be met if a person is to be considered to lack capacity in relation to the matter in question. There is a requirement that,

"at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in, the functioning of, the brain or mind".

Mental capacity must then be functionally assessed, as it is decision specific and time specific.

In the context of this Bill, the person must have the capacity to make the decision to ask for and, if offered, accept a medical intervention, the consequence of which is death. Given the criteria set out for decision-making capacity in the Mental Capacity Act, the person concerned would need to understand and balance knowledge of their existing medical condition and any potential treatments, and the likely benefits of further palliative care, and be able to communicate this choice, being fully aware that the consequence if the doctor agreed to carry out the procedure would be his death.

From April 2007, the Mental Capacity Act has provided the legal framework in England and Wales for substitute decision-making with respect to healthcare treatment when a person lacks the capacity to make relevant treatment decisions for himself. This can be helpful to people nearing the end of their lives. Lasting power of attorney for health and welfare allows decisions to be delegated to one or more attorneys of your own choice. You can also give your attorneys the power to refuse or agree to any medical treatment you may need to stay alive, if ever you are unable to make that decision. This is called an advance decision and is legally binding if the circumstances are the ones you specified. Any action taken must, under the Mental Capacity Act, respect valid LPAs and advance decisions to refuse treatment.

3.15 pm

In the absence of guidance from an LPA or advance refusal, actions taken must be in the patient's best interests. The MCA is very specific in stating, under "Best interests", that, with respect to life-sustaining treatment, such action must not be motivated by a desire to bring about death. Thus, vulnerable people with enduring incapacity to make this particular decision would be protected from physician-assisted suicide, as capacity is required under the Assisted Dying Bill and such action would not be acceptable under the MCA, as I understand it. The MCA is an enabling and much liked act, which vulnerable disabled people look to

with great hope because it has the potential to empower them and they do not want it annexed by legislators with a very different purpose in mind.

Few would dispute that a decision to end one's life lies at the top end of any spectrum of gravity. It would be no exaggeration to say that, for anyone making such a decision, it is the most important decision of their life. It would not be sufficient therefore to authorise such requests simply on the basis that a doctor is satisfied that the person making the request has the capacity to make the decision. In a case such as this, it is necessary to require that the presence rather than the absence of capacity be established.

The amendment tabled by the noble Baroness, Lady Hollins, seeks to make clear that the assumption of capacity underlying the MCA—an Act which noble Lords will remember was not designed for this purpose—does not apply and that the process of assessing a request for assistance with suicide must include positive action to establish the existence of capacity commensurate with the gravity of the decision involved rather than simply that there is no reason to suppose that it does not exist.

Determining that a person has the capacity to make this particular decision is crucial, as it is a necessary and pivotal factor in deciding whether under the Assisted Dying Bill physician-assisted suicide can be considered. Research indicates that it would be inappropriate to take apparently capacitous requests for physician-assisted suicide at face value. If there is concern about the influences and motivations behind a request for assisted suicide, the action should not take place.

The responsibility for assessing a person's decision-making capacity would, as the Bill stands, rest with the physician who would authorise the assisted suicide. It is all very well to say, as the supporters of legalised assisted suicide do, that capacity assessment is part of a doctor's role. Yes, it is, but when doctors assess capacity, they do so with a view to protecting patients from harm, not to clearing the way for assisting their suicide. This Bill is proposing something outside the parameters of clinical practice and, in consequence, different procedures would be needed.

A really experienced, knowledgeable, sensitive doctor may do a very good job, but there are doctors and doctors. We know that the Care Quality Commission has major concerns about a significant number. I would not want some of those to make decisions of this magnitude in assessing a request for assisted dying made by one of my family.

Indeed, the recent report by your Lordships' post-legislative scrutiny committee found that the Mental Capacity Act is not yet fully implemented, especially in clinical practice. Doctors have varying levels of competence in assessing decision-making capacity. Few understand how to assess capacity and many fail to recognise when a person lacks capacity.

In the context of the Assisted Dying Bill, the assessment of capacity must not be thought of as a brief exercise taking place at the end of the bed. Rather, great attention must be paid to how the capacity of a person making the decision can be optimised. Time can and must be spent undertaking this process, particularly given the consequence that, if the doctor agrees with what the person is requesting, the action that follows will result in that person's death.

For a decision of such consequence, specialist assessment of end-of-life decision-making capacity should be mandatory. A myriad of factors, including pain, the effects of medication, feelings of being a burden and poor social support may affect a person's decision-making. While clear diagnoses of psychiatric disorders which may affect decision-making, such as severe depression and psychosis, may occur, more frequently judgment may be coloured by mild depression, mild cognitive impairment and subtle pressure from others. Particular skills will be needed by those required to identify these psychiatric issues in assessing a person's end-of-life decision-making capacity in this context.

If Parliament decides that this Bill should become law, a very high standard of expertise will be required by those involved. They must ensure that those requesting physician-assisted suicide clearly had the capacity to make such a request. If they were considered to have this capacity, the nature of the psychological processes that led them to make such a decision must have been properly explored and documented.

Yet the Bill as it stands does not provide for mandatory specialist assessment of decision-making capacity. It leaves it all to the attending doctor to decide—usually a GP who will almost certainly have had no psychiatric training. I gather that, until recently, many medical schools taught no psychiatry at all. The Bill's supporters argue that there will be codes of practice to guide doctors on how to go about making these assessments—

Lord Faulks: My Lords, I am reluctant to interrupt the noble Lord, but the noble Lord will see the time.

Lord Swinfen: I am sorry; I did not hear what the noble Lord said.

Lord Faulks: I suggested that he look at the Clock.

Lord Swinfen: I have only a very short while to go.

I have no problem with codes of practice and I would expect that, if the amendment in the name of the noble Baroness, Lady Hollins, or a similar amendment is accepted, there will be a need for detailed procedures to be included in codes of practice to give effect to it. We cannot in this House agree to legalise assistance with suicide simply on the basis that others will decide what safeguards there should be. We need to see and to approve at least the outlines of those safeguards before we can responsibly take decisions on changing the law.

Lord Alton of Liverpool: My Lords, I support Amendment 65 and Amendment 71 in the name of my noble friend Lady Hollins. I also support what the noble Lord, Lord Swinfen, has just said. I thought that he made some incredibly important points. We are dealing with capacity, depression, burdensomeness and the ability to communicate. The last point made by my noble friend Lady Masham during her intervention is one that the movers of the Bill need to take very seriously.

[Lord Alton of Liverpool]

I draw the attention of noble Lords to an Early Day Motion tabled in another place earlier this year. It deals with some of the points in these amendments and states:

"That this House notes the results of the Washington State Death With Dignity Act Report 2013, published on 10 June 2014, which concludes that the number of deaths through physician-assisted suicide has tripled since the first year of implementation and increased by 43% between 2012 and 2013; expresses grave concern that 61% of those who received lethal drugs in Washington in 2013 gave as a reason for seeking assisted suicide being a burden on family, friends or caregivers; recalls that those who introduced the law in Washington assured the public that it would only apply to terminally ill, mentally competent patients; and reiterates its belief that a corresponding change in UK law would endanger the lives of the most vulnerable in society".

I agree with the sentiments expressed in that Early Day Motion. As the debate continues in the country at large, I hope that we shall have the chance to hear more voices from those who have been elected and who have had direct contact with their constituents.

It is not just in the state of Washington where we have seen things change from often good intentions—I pay tribute to the noble and learned Lord, Lord Falconer, whose motives in this I have never doubted—so that what comes out at the end is not always so. I draw the attention of the House to the comments of Professor Theo Boer in Holland, who said:

"I used to be a supporter of the Dutch law. But now, with 12 years of experience, I take a very different view … Pressure on doctors to conform to patients' (or in some cases relatives') wishes can be intense".

He admitted that he was,

"wrong—terribly wrong, in fact".

He had changed his mind. Since 2008, the number of assisted deaths in Holland has increased by about 15% every year, maybe reaching a record of 6,000 a year. It is worth pointing out that the law there changed at first simply by turning a blind eye—then voluntary euthanasia was introduced and then involuntary euthanasia. About a quarter of the deaths in Holland every year now are involuntary—that is, without the consent of the patient. These are the facts that we must consider as we consider whether or not we are putting sufficient safeguards in the Bill to safeguard the most vulnerable.

The noble Lord, Lord Deben, was right to point to the often fragile existence that many elderly people have. I saw figures recently that suggested that around 1 million elderly people do not see a friend, relative or neighbour during an average week: toxic loneliness. It is assisted living that we need in this country, not assisted dying. We need people who can help people in that kind of situation.

We have all experienced depression. Winston Churchill experienced the black dog. Depression is prevalent in many of our large urban communities. Certainly, in the areas that I represented, it was not heroin—although you saw heroin on the streets—it was antidepressants on every shelf of every home that you went into in the high-rise blocks, cluster blocks and spine blocks, where people were forced to live in depressing situations. That is why I was not surprised by the remarks of the noble Baroness, Lady Hollins, with all her experience as a former president of the Royal College of Psychiatry. I was not surprised to hear what she had to say, but I was particularly struck by a report published in April of this year by Price, McCormack, Wiseman and Hotopf. They said:

"Before mental capacity can be placed so centrally as a safeguard in the process, discussion needs to take place about what exactly is meant by the term 'mental capacity' in the new Assisted Dying Bill".

The Bill does not require any treatment for depression, although it proposes in Clause 8(1)(a)(ii) that there should be a recognition of its effects on a person's decision-making. It is not clear what that would mean in practice. Would it mean that a patient would have to receive treatment or a psychiatric assessment, or be refused altogether? There simply is no clarity on that key point.

I also draw the House's attention to the evidence given to the noble and learned Lord's own commission when it considered the issue of capacity and judgment back in 2006. It said that,

"in the context of such a serious decision as requesting an assisted death, the Commission considers that a formal assessment would be needed to ensure that the person concerned had capacity. The evidence given to the Commission made it clear that there are a number of factors that might affect an individual's mental capacity, including temporary factors caused by physical or mental illness, and more permanent impairments such as a learning disability. It would be important that such factors were identified and that an assessment was conducted to explore whether the subject's decision-making capacity was significantly impaired … the Commission does not consider that a person with depression, whose judgement might be significantly impaired as a result of this depression, should be permitted to take such a momentous decision as ending their own life".

I know that the noble and learned Lord still holds to that view. I commend it to the House.

Lord Avebury: Does the noble Lord prefer the situation that exists at present, in which several hundred unassisted suicides of terminally ill people take place every year?

Lord Alton of Liverpool: The noble Lord is right—and every one of those deaths is a tragedy. That is why I said that we have to intervene to assist in living, providing unconditional care, support and love. Simply to provide opportunities for people to take their own lives does not seem a wholesome or good way for this country to proceed. I have known the noble Lord for a very long time and I know that he would not support that either. Let us therefore be careful not to institutionalise what he rightly says already takes place. Just because something happens is not a good reason to make it legal or more easily available. That is why I support these amendments.

3.30 pm

Lord McColl of Dulwich (Con): My Lords, can we have some clarity about the length of speeches? Several speakers have been interrupted by comments that they have gone on too long. I understood that the recommended speaking time was a maximum of 15 minutes for each speech—or am I wrong?

Lord Newby: The noble Lord is correct.

Lord Hunt of Kings Heath: My Lords, I sense that the House would like to make some progress. I will put a simple point to the Minister. He will know that the issue of capacity is clearly critical to our consideration of the Bill and he will have heard that we have had a number of amendments that seek referral on the question to a psychiatrist or other appropriate specialist. The noble Baroness, Lady Hollins, raised issues about the interconnection between the provisions in the Bill and the Mental Health Act and the Mental Capacity Act. My simple request to the noble Lord—and I do not suggest that he does it from the Dispatch Box—is that the Government help noble Lords with their analysis of the interrelationship between the two Acts and the Bill. That would be very helpful for the next stage of the Bill.

Lord Faulks: My Lords, it is a fundamental principle of the Bill before us that a person seeking assistance to end his or her own life should have the capacity to make such a profound decision. That is at the centre of the Bill and why it has taken up so much time—quite appropriately—in the course of this debate. Some of the amendments in this group seek to include capacity among the eligibility criteria in Clause 1. Noble Lords may see some merit in that approach, albeit that the issue of capacity is addressed in Clause 3.

It is clear, however, that your Lordships are concerned to ensure that sufficient safeguards are in place properly to assess a person's capacity to make these very difficult decisions. It is of course right, as has been observed during this debate, that capacity can vary over a period of time and that assessment can be complicated where a person has both a physical and a mental illness. We have heard in particular how depression can be both difficult to diagnose and can fluctuate. Therefore, several assessments over a period of time may be necessary adequately to assess capacity. That leaves aside the question of a change of mind, on which certain noble Lords were somewhat at cross-purposes. However, it nevertheless remains an important issue, the answer to which seemed to be given, I respectfully suggest, by the noble and learned Lord, Lord Mackay, which is that the reversibility of the decision is covered by Clause 4(2)(c).

On the question of mental capacity and the relationship between the Mental Capacity Act and the Bill, my noble friend Lord Swinfen correctly reminded us that the Mental Capacity Act presumes capacity. However, that Act emphasises that capacity is issue-specific. As I understand it, the purpose of the Bill is to identify the particular issue in order for it to be determined whether the individual has the capacity to make that particular decision. What we are asking here is: are there adequate safeguards to enable that decision and the capacity to make it to be adequately assessed?

I will of course consider the point made by the noble Lord, Lord Hunt, about trying to give further guidance. However, at the moment I am not convinced that there is any tension between the Mental Capacity Act and what the Bill does. Whether the House generally considers that the safeguards are adequate is a different matter and one on which there can reasonably be debate.

However, it is clear that there are differences of view about who should carry out the assessment, how many people should do it and whether there needs to be input by more than one person across a range of professions. Psychiatrists, of course, have been identified as key in this, but social workers are also experienced in assessing whether coercion or duress is being brought to bear. Increasingly, they are being asked to carry out capacity assessments for the Court of Protection, and they also play a leading role in safeguarding a person who may be at risk of harm from family or friends. The noble Baroness, Lady Hollins, was right to emphasise the importance of an assessment of the absence of mental disorder being critical when considering capacity. Your Lordships will have to reflect on whether there is a need for specialist assessment of capacity beyond that being carried out by the attending doctor and the independent doctor and, if so, what the requirements should be.

Finally, your Lordships may think that the noble Lord, Lord Griffiths, was right when speaking not altogether flippantly of the capacity of decision-makers to remind us that there is fallibility in experts just as there is fallibility in judges.

Lord Falconer of Thoroton: I am obliged to everyone who has taken part in this important debate. Capacity is central to the Bill. May I indicate how the Bill operates, so that we can then address the question of whether the safeguards are sufficient? I completely agree with the analysis given by the noble Lord, Lord Faulks, as to what the question for us is.

What the Bill requires before the prescription can be given is that the attending doctor and the independent doctor have separately examined the person and the person's medical records and each, acting independently, must be,

"satisfied that the person … has the capacity to make the decision to end their own life".

In addition, as a result of Amendment 4, which was made this morning, a justice of the High Court of Justice sitting in the Family Division must confirm that he or she is satisfied that the person has the capacity to make the decision to end his or her own life. Capacity is defined by reference to the Mental Capacity Act, in Clause 12. The noble Lord, Lord Faulks, is right in saying that that gives rise to no tension; how it operates is that, in considering whether the individual has capacity, the doctors and then the court ask themselves whether that individual has a sufficient degree of understanding and judgment to take this obviously very momentous decision. That means an understanding of what the decision is and what its consequences are. That is how the law defines capacity; it is a matter to be considered on a case-by-case basis.

Are the safeguards sufficient? The amendments identify a number of possibilities. First, I take the amendments proposed by the noble Baroness, Lady Hollins. She suggests that there must be a psychiatric assessment in every single case. That should be so, she says, even if the two doctors are satisfied and the judge is satisfied. Then there is the Butler-Sloss/Colville amendment, to call it so colloquially, which says that

[Lord Falconer of Thoroton]
only when you are not sure and there are doubts do you make the assessment. The Murphy amendment also says that only if you have doubts should you have a psychiatric assessment.

My own view on this, although I need to consider it very carefully, is that if you have any doubts at all you could not be satisfied, whether you were the doctors or the court. In those circumstances, you might think that the case was much too doubtful and stop it straightaway, or you might have doubts because you do not know and are not qualified enough, so you should refer it to a psychiatrist. Like the noble and learned Baroness, Lady Butler-Sloss, the noble Viscount, Lord Colville of Culross, and the noble Baroness, Lady Murphy, I am not inclined to say that you have to get a psychiatric assessment in every single case. In my judgment, there will be cases where it is clear that there is no psychiatric element involved and it is the right thing to do because of the particular circumstances —and the idea that someone has to get a psychiatric assessment may look, on the facts of the case, wholly inappropriate.

My inclination is to consider the amendment proposed by the noble Baroness, Lady Murphy, as the right one. I also need to consider whether one needs to put in the Bill the sort of process that I have indicated, which reflects to some extent the approach of the noble and learned Baroness, Lady Butler-Sloss, and the noble Viscount, Lord Colville. On the basis of the debate that we have had, I think that is the right way to go but I will reflect on what has been said and consider the extent to which this needs to be in the Bill.

I ask noble Lords to remember that, subsequent to their tabling their amendments, the Pannick amendment, if I may call it that, has come in, so a judge will consider this issue. He or she will consider not just whether the right process has been gone through but will have to be satisfied—it is a primary question of fact for the judge—that the person applying to get the prescription has the capacity to make the decision, so you have that final safeguard. If the judge is not satisfied or thinks that a psychiatrist should be involved, there is the protection. I suspect that we should adopt something along the lines of the Butler-Sloss/Murphy approach. The question asked by the noble Lord, Lord Mawhinney, was answered by the noble and learned Lord, Lord Mackay of Clashfern. If the noble and learned Lord says what my Bill means, I accept his comments readily and enthusiastically.

The noble Lord, Lord Carlile, drew our attention to proposed new paragraphs (a) and (d) of his Amendment 65. As I understand proposed new paragraph (a), you cannot be satisfied that the person has capacity if he or she is,

"suffering from any impairment of, or disturbance in, the functioning of the mind or brain … which might cloud or impair his or her judgement".

Again, I think that is going too far. What happens if someone has a brain tumour that might impair their judgment but the doctors are satisfied that that person's decision to take their own life is one that they have reached completely aware of all the circumstances? To take another example, suppose someone is depressed because they are going to die imminently but the doctors and the judge are satisfied that, although the person is depressed, which might be an appropriate response to what is happening, they are absolutely clear that that is what they want to do. Therefore, I think that the amendment goes too far. Proposed new paragraph (d) of the amendment states that the capacity of an applicant,

"is not the subject of influence by, or a sense of obligation or duty to, others".

With respect, I do not think that comes under "capacity" at all because capacity is about whether someone can make a judgment. A person can be completely able to make the judgment and conclude that they hate being dependent on other people. You might think that that is inappropriate and be guided by what the noble Lord, Lord Deben, says but you certainly have the capacity to do it, so, although we should consider this under other headings, I honestly do not think that is a capacity issue.

The noble and learned Baroness, Lady Butler-Sloss, indicated three other points. First, she did not like the word "commensurate". I have not used that word; it was the noble Lord, Lord Glenarthur—take it up with him. Secondly, she was keen—in my view, rightly—that the word "satisfied" should be used, as it is in her amendment. The requirement for the two doctors is that they must be "satisfied". The requirement in the amendment of the noble Lord, Lord Pannick, is that the judge must be satisfied, so I agree with her and I think that that point has been met. Her third requirement was that of training. Under the Bill, the second doctor has to be an independent doctor who is,

"suitably qualified if that doctor holds such qualification or has such experience in respect of the diagnosis and management of terminal illness as the Secretary of State may specify in regulations".

I am sympathetic to the noble and learned Baroness's point and I think that it would be appropriate for certain training requirements to be met before you can be an independent doctor in this context. Therefore, I hope that I have dealt with her point.

I have dealt with Amendment 54 in the name of the noble Baroness, Lady Murphy. As regards Amendments 71 and 151, the noble Baroness, Lady Hollins, made a point that I had not seen reflected in her amendments but I am sure that is my fault—that is, what is the position of somebody who has been sectioned under the Mental Health Act 1983? I have assumed that they would not have capacity. It is not specifically raised as I read any of her amendments. However, I will need to consider that important point. My immediate assumption is that, if you are sectioned, you could not possibly have the capacity to make this decision but we need to look at the position in relation to that.

I have dealt with all the specific points made on the amendments. The debate was fascinating, moving and gripping. One of the great temptations in these debates is to veer off from the amendment, because we are all so gripped by this subject, and go into issues that are slightly off piste. I know it is done with the best motives but I am keen that the Committee should give everyone's amendments a proper shot. I am trying

to be disciplined. I ask very respectfully, because the amendments are fascinating, can we try to focus a bit more on the amendments?

Lord Mawhinney: My Lords, while reserving the right to return to this subject on Report, for now I beg leave to withdraw my amendment.

Amendment 6 (to Amendment 5) withdrawn.

Amendment 5 withdrawn.

The Deputy Chairman of Committees (Lord Brougham and Vaux) (Con): As Amendment 4 has been agreed, Amendments 7 to 11 cannot be moved, due to pre-emption.

Amendments 7 to 11 not moved.

3.45 pm.

Amendment 12

Moved by ***Lord McColl of Dulwich***

12: Clause 1, page 1, line 10, at end insert—

"( ) No other person apart from the person who is terminally ill may initiate a request for assistance to end a life.

( ) No registered medical practitioner, registered nurse or other health professional may suggest that a person consider seeking assistance to end his or her own life."

Lord McColl of Dulwich: My Lords, my first concern about the Bill is the risk that has been already mentioned —that one might create a society in which the vulnerable, the dependent and the weak believe that they have a duty to die. My second concern is the risk to the doctor-patient relationship and the fact that the current approach of the medical team is to care and never to kill or assist in killing.

I have therefore tabled Amendment 12 with the noble Lords, Lord Browne and Lord Morrow, to add two new subsections to Clause 1. The Explanatory Notes to the Bill say of Clause 1:

"This clause would enable a person who is terminally ill to request and be given assistance to end their own life. The process is dependent upon a request being made by the person concerned and no other person, including the patient's doctor, family or partner would be able to initiate the process of requesting an assisted death".

We agree that should the Bill become law, it should be the person himself or herself who is making the request. Indeed, the commission of the noble and learned Lord, Lord Falconer, said on page 29 of its report that,

"we do not envisage that it could ever be appropriate for health or social care professionals to offer assisted dying as an option; only the patients themselves should be able to initiate a conversation about assisted dying".

On page 43 of the Explanatory Notes accompanying the draft Bill, published by the All-Party Parliamentary Group on Choice at the End of Life in partnership with Dignity in Dying, it states:

"While doctors would be free to discuss other aspects of end-of-life care, only the patient themselves could initiate a conversation about assisted dying–a doctor could not suggest it and a relative could not make the request to a doctor on behalf of the patient".

I fully agree with the sentiment behind these statements, but as far as I can see, there is nothing in Clause 1 as currently drafted to prevent the doctor initiating the discussion with the patient. There is nothing in the Bill that sets out the safeguard that a doctor cannot suggest that a patient should consider assisted suicide or that a family member could not have an initial conversation with the doctor.

I am operating on the premise that everything is legal unless it is illegal. The claim that only the patient can initiate the process seems unsustainable. I am sure that there are noble Lords who think that I am scaremongering here. However, on the basis of what has happened in Oregon, it seems unrealistic to assume that a doctor will not suggest assisted suicide as an option if the law is changed. A letter from an Oregon resident in 2011 set out how she overheard her doctor suggesting assisted suicide to her husband. She said:

"When my husband was seriously ill several years ago, I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought).

To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said".

Such a suggestion from a doctor is bound to influence a patient's thinking.

I am concerned about this change in the doctor-patient relationship from advocating positive treatment to suggesting to somebody that they end their life. As the noble and learned Lord, Lord Falconer, previously stated, suggestions of this kind should not occur. However, doctors may feel obliged to make such a suggestion to a patient if the Bill becomes law. When the National Council for Palliative Care gave evidence to a House of Lords Select Committee in 2005, it foresaw a situation where:

"Physicians will be under a professional duty to raise it as an option with their patients if they complain of suffering unbearably, as it will be considered to fall in the category of 'best interests'".

The fact is that assisted suicide has been integrated into medical practice in Oregon. For instance, patients have been refused chemotherapy by their insurance company, but offered assisted suicide because it was covered by their insurance plan. They tell me that everything to do with euthanasia and assisted suicide in Oregon is working well. They can tell that to the horse marines. I beg to move.

Lord Browne of Belmont (DUP): My Lords, I rise to speak in favour of Amendment 12, which was tabled by the noble Lord, Lord McColl of Dulwich, and which I have co-signed. Amendment 12 would have the effect of adding two additional subsections to Clause 1. The first new subsection would ensure that only a person who is terminally ill may initiate a request for assistance to end their own life. The second new subsection would ensure that no medical professional can make a suggestion to an individual that they consider seeking to take their own lives.

Like many in this House, I have always opposed a change in the law to allow for assisted dying. I understand the sincere motivations of those who desire to change the law and I have listened to the many eloquent

[Lord Browne of Belmont]
speeches given by Peers from across the House in favour of the change. However, I have never been convinced by the idea that such a law would be the right way forward. I continue to believe, as I said at Second Reading, that this is not a path we should go down. Such a change would have a detrimental impact on the lives of some of the most vulnerable people living in the United Kingdom today, especially those who are disabled, who may feel under enormous strain to take their own lives, even if they do not want to do so.

To that end, I welcome the opportunity presented by this Committee and specifically by Amendment 12 to highlight the fundamental flaws in this legislation. Amendment 12 very effectively helps to highlight the failure of the Bill to guard against the very real possibility of people encouraging others to seek assisted dying. I find it quite extraordinary that those drafting the Bill failed to have regard for such basic, elementary dangers arising from the legislation. While I am sure that no Member of your Lordships' House would countenance such a possibility, unfortunately human nature is such that we must all acknowledge the real possibility of some people encouraging others to end their lives for financial or other gain if the Bill becomes law.

To my mind, it is easy to envisage a scenario where a family member who would perhaps gain financially from the death of an elderly relative or who was tired of having to care for that person could initiate a request for assistance in ending the life of their relative. The person might not want to die but, on seeing that their relative wants them to end their life, they go along with it, perhaps because, as we have heard, they do not want to be a burden. I think that your Lordships will agree that such a scenario is not far-fetched.

The second new subsection proposed in Amendment 12 is also imperative. I am not a medical expert, as I know some noble Lords are, including the noble Lord, Lord McColl, but, as a layperson, when I listen to the opinion of my doctors, I trust their judgment. If a doctor tells me that I should take a particular medication or go forward for an operation, I will do so on the basis of their judgment, although obviously within reason. I believe that I am like many in our society in this respect. We trust medical professionals who look after our best interests, and they are in a position of significant influence as a consequence.

Under the Bill as it currently stands, it seems that it would be legal for a medical professional to suggest that a person considers the option of assisted dying. To my mind, that is deeply concerning. If a medical professional were to suggest to a terminally ill person that they should consider the option of assisted dying, this could have the effect of putting significant pressure on that person to take their own life. This would especially be the case if the patient was not medically informed or trained. If a trusted physician who had been caring for a terminally ill person and had forged a relationship with them was to tell them that they should consider the option of assisted dying or, indeed, if they were to go further and try to sell the idea, it would be easy to envisage a person in that vulnerable state being swayed by the view of the physician. This is not sheer conjecture about what might happen in a doctor's surgery if the law were changed.

An article entitled "Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act", published by the *Journal of the American Medical Association* in May 2001, reported under the section on changes in clinical practice since the law in Oregon came into being:

> "Six percent of physicians had initiated a discussion about physician-assisted suicide with a terminally ill patient, including 10% of physicians who opposed the law and 6% of physicians who supported the law".

Human nature says that doctors will make suggestions to patients and that there will be relatives who discuss the option of assisted dying with a doctor. I believe that we should protect individuals at a time of vulnerability and not bring more pressure upon them. I support Amendment 12.

Baroness O'Cathain (Con): My Lords, I wish to raise a point for clarification. Amendment 12 states:

> "No registered medical practitioner, registered nurse or other health professional may suggest that a person consider seeking assistance to end his or her own life".

It does not mention whether they are terminally ill. That means that anybody could say to a person with a chronic hearing problem or even dementia, "Why don't you seek assistance to end your own life?". That person would not necessarily be terminally ill. I just want clarification on that point in the amendment.

Lord Phillips of Sudbury: My Lords, I rise also to point out what seems to be a flaw in the drafting of the second proposed new subsection in Amendment 12. As drafted, the registered medical practitioner, registered nurse or other health professional does not have to be treating the person referred to. That would mean that if my daughter was a nurse, she would be caught by such a measure if she said to me, "Dad, shouldn't you seek assistance?". That does not sound probable but you never know. I simply draw the Committee's attention to what seems to be a fatal flaw.

Lord Cormack: My Lords, there are clearly deficiencies in the drafting but my noble friend Lord McColl made it quite clear what he was seeking to put across. There needs to be something to replace this in the Bill because we do not want anybody to be able to suggest this. That is the simple point that my noble friend was seeking to make. It is self-evident and I hope we will have a sympathetic response from the noble and learned Lord, Lord Falconer, indicating that he will look carefully at perhaps crossing a few "t"s and dotting a few "i"s.

4 pm

Lord MacKenzie of Culkein (Lab): My Lords, I endorse the points that have just been made. There may be some flaws in the drafting but we need something like this in the Bill.

I will have something to say about nursing ethics later on as we consider the Bill. But for any registered nurse, whether she is the daughter of the noble Lord, Lord Phillips, or anybody else, to suggest to anyone in any circumstance that they should consider ending

their own life should see them being marched fairly swiftly before the regulatory body and struck off. That would be my view as a nurse. I hope that the noble and learned Lord, Lord Falconer, will help us and say that something like this should be in the Bill.

Baroness Finlay of Llandaff: My Lords, the noble Baroness, Lady O'Cathain, raised a question that has exposed drafting flaws in the amendment, but it actually makes a very important point. I say that based on my own experience of teaching junior doctors, particularly in the Netherlands, where they would frequently say to me that they were under pressure from families for a person to have euthanasia or assisted suicide. The requests were not coming from the patients themselves.

The other situation that we really need to be aware of, as has already been alluded to, is the vulnerability of patients to suggestions from their clinicians. I recall going on a house call with a general practitioner. The patient, who had lung cancer, was breathless and finding life difficult, and wanted to start the process of talking about euthanasia. I listened for a time but noticed that the patient was very wheezy. As the consultation went on—and I could understand a fair amount of it—I said, "Has she had an inhaler for her wheeziness?". The conversation had gone so strongly down the route of processing her euthanasia request that the GP turned to me and said, "I had not thought of it". We then had a discussion about how if she was wheezy it was worth trying, and the lady then said, "My grandson has an inhaler and he hates it". I said, "Perhaps if you have one and he can teach you how to use it, it may help him adapt". Her reply was, "Oh, at least I can be of some use again". The request finished; we did not continue with it, but she got an inhaler to try, exactly the same as her grandson had, with the explicit request that she got him to teach her.

I put that in as an example of just how vulnerable people are to suggestion and how easy it is for a consultation to steer down one road and in that process inadvertently forget the other therapeutic options that might be open, might need to be explored and might need a little bit of thinking outside the box.

Lord Falconer of Thoroton: My Lords, perhaps I might I try to short-circuit this. I am broadly in favour of having something in the Bill that says, "You should not be making suggestions". My anxiety is that I do not want to end up in a situation where there is a fine debate in court as to who first suggested it. It may be that somebody would say, "Can anything be done? Can this be brought to an end?", and the doctors would say, "There are these options". Would that be in breach? I do not know and I need to think carefully about the drafting in relation to this to avoid that sort of fine, purposeless discussion in court.

Baroness Grey-Thompson: My Lords, a doctor very explicitly suggesting to somebody that they end their life is one thing. But for me a much greater concern, which has been debated quite a lot already, is about the gentle suggestion that people should consider ending their lives—the arm around the shoulder. I am sitting in your Lordships' Chamber only because many hundreds of thousands of pounds of NHS money have been spent on putting me back together. I have had some amazing doctors with a dreadful bedside manner, and I have had some doctors with a great bedside manner who have performed procedures that I did not ask for. It was recently reported that a young man, Mik Scarlet, turned down a certain procedure several times. When he was on the operating table, the surgeon completely ignored his wishes and carried out the procedure anyway, and it had to be reversed. He is in a better position now than he was previously. It is a very long and complicated story, which is detailed on the *Huffington Post*.

For me, this is about the constant drip-drip of "You're not worth it". I am a very resilient person. If I got upset every time somebody said to me, "I wouldn't want to be like you", I would be depressed. Somebody said to me recently, "Well, I wouldn't want to be incontinent. That's my worst thing in life". I am technically incontinent. If it was not for self-catheterisation, I would probably be dead, because I would have pressure sores; I would not exist. I was having a debate in Central Lobby with somebody who strongly supported my view on where we should go with the Bill. He looked at me and sort of waved at the wheelchair and said, "Well, you must have considered killing yourself hundreds of times". No, I have not, actually, and I think that it was a bit of a surprise to him. It is that sort of tone, where "You're brave. You're marvellous". People do not realise that they are being demeaning. I think that they genuinely think that they are being empathetic, sympathetic and kind, but, actually, you are constantly being knocked down and told that you have no value and no worth. That is what is of much greater concern to me.

The noble Lord, Lord McColl, mentioned Oregon. In 1994, the Oregon medical assistance program cut funding to 167 out of 700 health services. Four years later, assisted suicide started being referred to as a "treatment". On the back of that, funding was cut to 150 services for disabled people. They started limiting funded doses of powerful pain medication and put barriers in the way of funding for antidepressants. Thank goodness we do not have an insurance system like the one they have in the United States. I would be dead because my parents could not afford to keep me alive. For me, the big issue is not the doctor saying that your life is not worth living; it is the arm around the shoulder. It is that constantly being told, "You'd be better off dead". That is what disabled people face every single day. Disability hate crime figures are the worst they have ever been in 10 years of reporting. It is constant. There is not a group of disabled people and a group of terminally ill people; there is a huge crossover.

I am sure that many people have noticed that my noble friend Lady Campbell of Surbiton is not here today. She has a chest infection. She is watching at home on her ventilator. We all know what a chest infection does for her prognosis. It immediately switches her from being okay to fitting in with the category of having less than six months to live. That is not a situation that I am very comfortable with.

The Earl of Listowel (CB): My Lords, the noble Baroness spoke about the young man who was operated on misguidedly by the surgeon. It reminds me that

[The Earl of Listowel]
young people, 18 to 25 year-olds, might be particularly susceptible to this kind of suggestion over time. I am concerned that this particular group, who are not at the end of their lives but at the beginning and who represent a very small group within the group that we are discussing today, should be given plenty of thought, in particular because of issues around their maturity and the trauma that they may have experienced growing up.

We recognise that developmental delay can arise from trauma. We recognise that, while 18 is generally considered the age of maturity, we extend protections up to the age of 25 for young people who are leaving care. That is for a number of reasons, but in part because of the history of trauma that they have experienced. We recognise that it may take more time for them to develop. Where children or young people have not built up such large social networks, they are more dependent on those nearest to them and one should be very careful to avoid a situation in which they are drip-fed the notion that perhaps their life is not worth living and should be curtailed.

Lord Mackay of Clashfern: I wonder whether the noble and learned Lord, Lord Falconer, was referring to the first part as well as the second part of the amendment, although he spoke mainly about the second.

Lord Falconer of Thoroton: I was referring to both. Clause 1 says the applicant has to initiate it, but I want it to cover both.

The Lord Bishop of Bristol: My Lords, I may not be the only one who is a bit confused about what is happening. I stand to speak in support of Amendment 12 tabled by my noble friend Lord McColl, but I would like to address noble Lords' attention to Amendment 77, which stands in my name. I rather hoped it might have been grouped with Amendment 85, but they stand separately grouped now. I would like to reserve the right to come back to Amendment 85 at a later occasion and I hope a later occasion will occur for that to happen.

Amendment 77 deals with something slightly different. Quite rightly, most of our debate today has focused on the decision to apply for assisted suicide and to sign the declaration. However, it is fair to say that the request for assistance with suicide involves two different and discrete decisions: first, there is the decision to apply for it, and then there is the decision to ingest fatal drugs. The Bill makes it clear that there has to be a minimum of 14 days between the application and the actual ingestion of the drugs, except in the case of somebody who is given a prognosis of a month or less and then the time lag reduces to six days.

I want to draw noble Lords' attention to the fact that there can be quite a considerable time lag between requesting assistance and the act of having the drugs administered. I do not like to keep going back to Oregon because, quite clearly, there are some good things about the Oregon experiment. However, it does need to be said that in Oregon the range between the first request and death has been a minimum of 15 days and a maximum of 1,009 days. In Washington, there has been a range of between three weeks and 150 weeks.

Amendments 77 and 85 are an attempt to try at least to give the opportunity to the person, as they come to the moment when they will actually have the drugs administered, to return to that decision to make sure it is robust. In a sense, it asks questions about two things: the settled nature of their decision but also their continued capacity, given that there are two aspects to the decision that is going to be made. Each decision ought to be subject to some level of scrutiny. Clearly, the first one needs to be subject to a very high degree of scrutiny, but we need to give some attention as to whether the second decision also needs a degree of scrutiny.

These decisions will be made, as I say, at the very least after a 14-day interval in most cases, but some will likely occur after a much longer gap. Consequently, it is necessary to reconfirm that the conditions by which assistance was granted still apply. It is also necessary to confirm that the decision to accept assistance is free from,

"pressure, coercion or duress from others or from a sense of duty or obligation to others",

and that there exists a level of,

"capacity commensurate with the decision".

The actual decision to ingest a prescribed dose of lethal drugs should be subject to the same, or very near the same, scrutiny that the initial request for a prescription was.

Baroness Nicholson of Winterbourne (LD): My Lords, I support Amendment 77, to which I have added my name. I am sure that many noble Lords will have had instances in which patients known to them, whom they are looking after or caring for in some way or another, have declared that, yes, they would want to commit suicide and would want help to do it. Then there is a gap. When the decision comes—when the decision is, "Do they actually want to take those drugs? —the decision is frequently no. I have known several instances of that. I therefore firmly support the proposal by the right reverend Prelate in Amendment 77, and I very much hope that the Committee will accept it.

4.15 pm

Lord Falconer of Thoroton: My Lords, I congratulate the right reverend Prelate the Bishop of Bristol on focusing on the amendments, including one that is not even in the group—but I will happily deal with it anyway. As I understand it, he is saying in Amendment 77 that the lethal dose should be delivered only once requested by the patient. I see no difficulty with that. Perhaps I can think about the wording and come back at Report.

Amendment 85 is not in this group, but let us deal with it anyway, as the right reverend Prelate spoke to it—it is in a group of its own. I am against it because, as we discussed earlier, when I had the support of the noble and learned Lord, Lord Mackay of Clashfern, the point is dealt with by Clause 4(2)(c), which provides that the health professional has to confirm that the person has not revoked and does not wish to revoke their declaration.

Lord McColl of Dulwich: My Lords, I thank noble Lords very much for their contribution and for pointing out the errors in the drafting. I am very pleased with

what the noble and learned Lord, Lord Falconer, said. I beg leave to withdraw the amendment.

Amendment 12 withdrawn.

Lord Howarth of Newport (Lab): My Lords, before we proceed any further—

Lord Newby: My Lords, noble Lords will have seen an unusual amount of toing and froing, as there has been a certain amount of confusion about the consequences of the pre-emption of several amendments as a result of the amendment passed earlier. Having spoken to noble Lords who have amendments affected by that pre-emption, or who have amendments that are due to be debated, I propose that for the rest of the afternoon we proceed as follows. First, the noble Lord, Lord Alton, should speak to his Amendment 11 as part of the debate on whether Clause 1 should stand part. If any noble Lord wants to speak to any of the amendments that were dropped, as it were, as a result of pre-emption, I suggest that they do so at the conclusion of that debate.

The amendments covered by pre-emption were the initial amendments in those three groups, Amendments 8, 10 and 11. The later amendments in those groups, Amendment 69 and onwards, Amendment 25 and onwards and Amendment 90 and onwards could be debated later, when we get to them. I propose that when we have finished the debate on whether Clause 1 should stand part, in the light of the fact that, by common consent, the debate on the following group will be very long, I adjourn the House.

Debate on whether Clause 1, as amended, should stand part of the Bill.

Lord Alton of Liverpool: My Lords, given the advice of the noble Lord, Lord Newby, I will take the Committee to the arguments that would have been contained in the group led by Amendment 11. I think that was the guidance that we were just given. Noble Lords will realise that later amendments, Amendments 90, 92, 93, 105 and 122 will be reached when they get there. I will try to keep my remarks fairly short, because I think that the Committee is growing weary.

This is an important question, as are many of those that have been laid before the Committee today. It deals with the title of the clause, which is "Assisted dying". I would argue that that is incorrect; it is assisted suicide. Those who support the noble and learned Lord's Bill are at pains to tell us that assisted dying is not physician-administered euthanasia, whereby a doctor administers a lethal dosage of drugs to a patient, but physician-assisted suicide, whereby a doctor supplies a lethal dosage of drugs and the patient swallows or otherwise ingests them. I invite the Committee to look at the procedures set out in the noble and learned Lord's Bill against these claims.

Clause 4 is perhaps the principal clause in this respect. Its subsection (4)(a) allows a doctor or nurse to "prepare" lethal drugs for self-administration. Presumably this means putting them into a form, such as a liquid, that the person can swallow—in a way, so far so good—but subsection (4)(b) then provides for a "medical device" to be put in place to aid self-administration. Again, I suppose that this is fair enough, although rather more precision is needed as to the object of such a device. That is why I have tabled an amendment to that effect.

Then we come to subsection (4)(c), which allows a doctor or nurse to,

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

Here we really are on the borderline between physician-assisted suicide and physician- administered euthanasia. Subsection (4)(c) raises some important questions. Precisely what assistance, apart from preparing the lethal drugs and perhaps inserting a feeding tube, does "assist … to ingest" include? Does it include, for instance, holding a beaker to the lips of the person? It is not difficult to foresee a situation in which a doctor or nurse supplying lethal drugs under the terms of the noble and learned Lord's Bill could cross the line, however innocently, between giving the patient those drugs and administering them. Subsection (4)(c) introduces a significant and dangerous grey area into the process of assisting suicide.

The noble and learned Lord has, I can see, recognised this ambiguity in subsection (5), which states that neither the doctor nor the nurse may administer the drugs to the patient, but it seems that as long as subsection (4)(c) stands, the ambiguity will remain. Moreover, subsection (5) says nothing about others administering the drugs, which brings me to my next concern. It is not just a matter of the doctor or nurse refraining from administering lethal drugs. There are others who might be inclined to do so, possibly from altruistic motives. It is therefore important that there is oversight by the doctor or nurse of what happens when the lethal drugs are delivered.

At this point, the noble and learned Lord's Bill becomes rather convoluted. It states, reasonably enough, that the doctor or nurse must remain with the person to whom the drugs have been delivered until either they have been ingested and the person has died or the person has decided not to take them, in which case they are withdrawn. Yet subsection (6) defines remaining with the person as being,

"in close proximity to, but not in the same room as, the person".

I understand and respect the noble and learned Lord's wish to allow a person who is self-administering lethal drugs to die without strangers in the room but we have to balance that against the scope for others to intervene in a way that is not permitted in his Bill if the drugs are ingested without supervision.

We all heard the intervention that the noble Lord, Lord Jopling, put to my noble friend Lady Finlay much earlier in our debates about the circumstances in which people might die. I would have thought that the doctor's presence need not be obtrusive. Apart from anything else, we have to allow for the possibility—this sometimes happens, according to the evidence from Oregon—that complications, such as vomiting or distress, arise when the drugs are taken. The doctor needs to be in the room if that happens.

For me, this is an issue that helps to distinguish between assisted suicide and assisted dying. If it is not the wish of this Committee that we should legalise

[Lord Alton of Liverpool]
outright euthanasia—I do not believe that it is—then it is very important that those clarifications are made. While I am unable to move Amendment 11, which was originally on the Marshalled List, that would have been its purpose. I am grateful to the noble Lord, Lord Newby, for providing us with the opportunity while debating the amended Clause 1, which I will not be opposing, to debate some of these questions.

Lord Cavendish of Furness: My Lords, with the leave of the Committee and with the agreement of my noble and learned friend Lord Mackay, I shall speak to Amendment 10 under the new regulation that we have. With that amendment, I would probably include Amendments 52, 164 and 170. When I left Cumbria, Amendment 70 was included in that grouping but it was moved while I was on the train. Before speaking further, I should perhaps declare an interest since, as I told your Lordships at Second Reading, I was co-founder of St Mary's Hospice in Cumbria more than 20 years ago and, although I retired some two years ago as chairman of the trustees, I maintain my involvement as the patron. I have no professional qualifications in the field of palliative care, but my close association with a hospice over a good many years has done much to crystallise my thoughts on the matters under discussion in your Lordships' House today. We have heard many deeply moving personal experiences, and of course I have my own, but nothing has moved me so much as witnessing not only the physical and mental relief of patients of the hospice but the sense of pure joy that the hospice movement sometimes brings through acceptance and the general level of care.

I feel sure that it is a view shared by both sides of this debate that anyone who is provided with assistance to end his or her life must understand clearly what he or she is doing; that much is surely beyond argument. However, as with many other aspects of the noble and learned Lord's Bill, there is a significant gap between saying what should happen and putting in place provisions to ensure that it does. It is to fill such a lacuna in the Bill that I am proposing these amendments. Many of the arguments have been covered by my noble friend Lord Howard.

For a fully informed decision, the Bill as it stands requires simply that a person seeking assistance with suicide must be,

"fully informed of the palliative, hospice and other care which is available".

But what does that mean? It means no more than that the doctor assessing the request must explain to the applicant for assisted suicide what the various end-of-life care options are. Such a doctor may well know little of what modern palliative care has to offer. It is a medical speciality that is making huge advances year by year, and it is unlikely that even a good doctor, with limited experience of end-of-life care, will be able to be sufficiently acquainted with the subject.

There is also a world of difference when making a decision between being told about something and having had first-hand experience of it. I offer this quote from the report of the Select Committee which, under the chairmanship of my noble and learned friend Lord Mackay, 10 years ago examined the Assisted Dying for the Terminally Ill Bill of the noble Lord, Lord Joffe. The committee's report recorded evidence from Help the Hospices, as it was then called, as follows:

"Experience of ... pain control is radically different from the promise of pain control, and cessation of pain almost unimaginable if symptom control has been poor. On this view, patients seeking assistance to die without having experienced good symptom control could not be deemed fully informed".

Specialist palliative care embraces the holistic care of the individual and those around them, considering not only their physical or medical symptoms, such as pain, vomiting or breathlessness, but also their spiritual, social and psychological needs. When distressing physical symptoms overwhelm a patient, they cannot see beyond the pain, the breathlessness, the anxiety or the vomiting. Effective symptom management enables a person to re-emerge and function once more, and to make informed choices regarding their future. Without such experience, my contention would be that the applicant's capacity to make informed choices is seriously impaired.

The chief executive and the medical director of the hospice of which I have the privilege of being patron do not, as far as I am aware, take a position either for or against the Bill. However, they agree with this amendment and have this to say:

"We see every day how very limited is the understanding and knowledge of Palliative care services among both patients and professionals. Most people resort to these services only when they have a need of them".

This view of course contradicts that expressed earlier by the noble Baroness, Lady Murphy, earlier in the debate.

4.30 pm

There is still in some quarters a residual perception of a hospice as a sort of enhanced care home licensed to drug patients to the point of insensibility. Even in your Lordships' House, I make no apology for repeating the very important fact that here in Britain, many people, including the noble Baroness, Lady Finlay, are pioneering a highly specialist care model which I would guess is world-beating—a point also made by my noble friend Lord Howard—and it continues to forge ahead. Progress is made daily in such areas as the enhancing the effectiveness of morphine through the use of co-analgesics, nerve blocks and new drugs. I could go on. Palliative medicine aims to combine sound medical science and exceptional attention to symptom control with the art of giving people support, hope and the ability to plan their future with their illness.

This is the background against which I propose that if a person seeking assistance with suicide has not previously had a consultation with a specialist in palliative care, he or she should be referred for such a consultation. This will ensure, apart from anything else, that the person seeking assistance with suicide will hear about end-of-life care options from the experts in that area of medicine rather than from the attending doctor. The attending doctor referred to in the Bill is very unlikely to be such an expert, given that 90% of palliative care practitioners are opposed to physician-assisted suicide. An important element of such a consultation is to give the patient an opportunity to

hear how modern pain relief and symptom control work. There is a considerable mythology surrounding this subject, with many people believing that increased dosages of pain relief put a patient's life at risk and that terminal illness therefore means increasing pain. This is simply not the case in modern palliative medicine. While it is not possible to give an absolute guarantee of pain relief in every case, proper palliative care can in most cases reduce, if not eliminate, the pain of terminal illness without any risk to the patient's life. A terminally ill person contemplating suicide needs to hear this, and to hear it from an expert in this field of care.

A palliative care referral will also give the applicant an opportunity, if he or she wishes, after discussing end-of-life care options with a specialist, to request a course of palliative treatment to ascertain whether that, rather than suicide, would meet his or her needs. Some may well say, after experiencing such treatment, that they still wish to proceed with assisted suicide. So be it, but if even just a handful change their minds, the exercise will not have been in vain.

I recognise that this is another step in the assessment process and that some will argue that it adds to the burden of ending one's life, but it is crucial that any such decision is fully informed. Even in Belgium, whose euthanasia law has raised serious concerns, there is provision for hospitals to insist on such a palliative care filter, as it is known. In fact, where Belgium is concerned, noble Lords might care to note that well over 90% of requests for euthanasia in that country vanish when applicants experience the palliative care that they need.

I recognise also that specialist palliative care is not evenly available to everyone in this country, but I feel, given the gravity of what is being proposed here, that it is incumbent on us to ensure that a fully informed decision means something more than just a chat in the consulting room of a doctor who, as likely as not, lacks an appropriate level of expertise in end-of-life care. This amendment in its own right has the potential to bring relief to many who face physical and mental anguish, but it goes further: it provides a vital safeguard that certainly needs to be a feature of the Bill.

Lord Harries of Pentregarth: I shall speak briefly to my Amendment 8 which would ensure that any request for assistance is voluntary. The House is agreed on the need for a voluntary decision, but the question is how you ascertain that the request really is voluntary.

I refer to a later amendment in my name, Amendment 69, which says that the person must not be under pressure or duress from others or from a sense of obligation or duty to others. Noble Lords have touched on this once or twice because it is a matter of huge concern, but we have not yet had a thorough debate on this issue. The noble Baroness, Lady Warnock, wondered why it was such a bad thing to have a sense of obligation or duty to others. That is a good question. The trouble is that the remarks we make are never made in isolation; they are always made to other people. If a person says out loud, "I am beginning to feel a bit of a burden", somebody may hear that remark. As the noble Lord and learned Lord, Lord Mackay of Clashfern, and the noble Lord, Lord Deben, said so movingly, you want to give such a response that the person will know that, despite everything, they really matter. Within all the subtleties of a relationship, you might say something like, "You are certainly worth that and a great deal more". In order to ensure that the request really is voluntary and there is not that kind of subtle coercion, Amendment 69 also says that the doctor must have in-depth discussions not just with the person but with the family and people close to them.

The reason why this matters so much was brought home to me a couple of days ago when I received a letter from somebody saying that a relative of theirs had gone into a hospice for temporary respite and one of the nurses said to them,

"Oh, don't you think it would be better for you to stay here instead of going back"

to your daughter-in-law's place.

"She works ever so hard taking care of you; don't you think you are a bit of a burden to her"?

That was a very unfortunate remark, but people do make unfortunate remarks and they weighs on them.

The reason why this is such a key issue can be seen from the figures and research in Oregon and Washington. Both states collect data on the end-of-life concerns behind people's decision to seek assistance with suicide. Contrary to popular impression, the data reveal that inadequate pain control is one of the least common concerns behind a request. In 2013 only 28.2% of those who sought assistance with suicide indicated inadequate pain control as a concern. Alarmingly, and more commonly cited, is a concern about being a burden on family, friends or care givers. In 2012, 63% of those in Washington cited this as a concern. In the same year, only 33% cited poor pain relief. Responses from Oregon reveal the same pattern. Since legislation was passed there, concern about being a burden has increased as a motivator from 13% in 1998 to 49.3% in 2013. This is a matter of huge concern and I hope that the noble and learned Lord, Lord Falconer, will take the concerns of the whole House on board when he looks again at his Bill.

Lord Howarth of Newport: My Lords, I added my name to the amendments in the name of the noble and right reverend Lord, Lord Harries of Pentregarth. I am glad that we have the opportunity to spend a few moments examining this question of the nature of voluntariness in the circumstances for which we are seeking to legislate.

There can be a multitude of pressures on people who are ailing or nearing death; people who find themselves in a situation in which they consider that they may wish to seek assistance in their suicide. I know that my noble and learned friend Lord Falconer, in the drafting of the Bill, has sought very clearly to preclude situations in which anyone is driven by coercion or duress to a decision of this nature. It is going to be very difficult to ensure that those conditions are satisfied, whether in the context of the original Bill or whether in the Bill as modified by the amendment in the name of the noble Lord, Lord Pannick. There are the most overt and obvious pressures coming, perhaps, from family members who are exhausted, angry and grudging, and who may not love the person they find themselves

[Lord Howarth of Newport]
having to care for. There are, as my noble friend Lady Mallalieu mentioned this morning, circumstances in which family members are actually motivated by venal considerations. They want to stop spending all this money on the costs of care and hurry up their inheritance. Although it is most unpleasant to think of these possibilities in human nature, they do exist and we cannot ignore those possibilities.

There could also be pretty overt pressures from professional carers and doctors who are under pressure, working with inadequate resources, impatient, testy and frustrated themselves. We can see a range of possibilities, from inadequate but well intended care, going all the way through to the kind of institutionalised callousness that was reported at Mid-Staffordshire and Winterbourne View—situations of elder abuse. In a sense, it should be easier to preclude people coming to a decision to seek to end their own life with assistance in such obvious circumstances. However, there are then the subtler situations, in which someone has perhaps been pressurised unintendedly by a person whose gesture or facial expression was not meant to be seen by the relative or person for whom they are caring and was interpreted by that person to signify that they were a nuisance or were no longer wanted.

In her speech at Second Reading, the noble Baroness, Lady Campbell of Surbiton, talked of the pressures of pity and how pity can be experienced as contempt and as a signal that your life is not worth living. There are tacit pressures that could arise even from the availability of the remedy that this legislation would make legal—its tendency to normalise the practice of assisted suicide and, going with that, a tendency to diminish trust between patients, sufferers and those who have responsibility for their care. A number of noble Lords have spoken of the risks of an altered ethos in the medical profession. Of course, people who are old and ill and costing the NHS or their families a lot of money may simply felt that they ought to stop incurring such expenditure. If people internalise such pressures and arrive at a sense that their continued existence cannot be justified and they do not have the self-worth they once had, if they feel guilty and that they are a burden on their families and the system, are we to say that these are decisions freely taken? The noble Baroness, Lady Warnock, in her speech at Second Reading proposed to us that people could proudly and honourably—admirably—come to a decision that they should not be a burden on others. Is that a freely-made decision when such pressures have been psychologically and emotionally internalised? It is a difficult question to judge.

Lord Avebury: I wonder whether the noble Lord has ever looked at the Macmillan Cancer Support site, on which there is a forum for people with incurable cancer. If he looks on that site, he will find that no patient has ever expressed the view that they are a burden on the National Health Service. It has never come up at all.

Lord Howarth of Newport: I will certainly look at that site, but I wish I could be as confident as the noble Lord is on that point.

I will conclude by saying that I think it is going to be very difficult for doctors ever to be certain that a decision has been arrived at on a truly voluntary basis, freely. It will be equally difficult for the judge that the noble Lord, Lord Pannick, has brought in to the proceedings. As the Minister, the noble Lord, Lord Faulks, put it to us earlier, there is a risk that pressures and duress will never be wholly eliminated.

4.45 pm

Baroness Howe of Idlicote: My Lords, my Amendment 7 is a very simple one which deals with an issue that might arise as a result of the Bill—what one might call suicide tourism. I am sure that it is common ground between those who support and those who oppose a change in the law that we would not want to see any such law being abused by people from other jurisdictions travelling here to commit suicide. I feel sure that that is what the noble and learned Lord, Lord Falconer, had in mind when he included a requirement in Section 1 that an applicant for assistance with suicide must have been ordinarily resident in England and Wales for not less than one year. I certainly applaud the intention of that provision, but I fear that it does not go far enough.

Let us consider a hypothetical but far from impossible situation of a couple who have lived in England and Wales then retired to the Costa Brava. One of them is diagnosed with a terminal illness and wishes to take advantage of a law along the lines of the one proposed here, so he or she returns to this country and qualifies as having been resident in England and Wales for more than a year, but not for a year immediately preceding the application. And what about Scotland? Returning home from the Costa Brava is one thing; coming south into England is something else. There must be thousands of people who have been ordinarily resident in England and Wales for not less than a year but who, at a time when they may wish to avail themselves of a law along the lines of the noble and learned Lord's Bill, are living north of the border. Are they to qualify for assistance with suicide, too?

It is a simple matter to guard against such suicide tourism by stipulating that the applicant for assistance with suicide must have been resident in England and Wales for a specified period immediately prior to making the application. I feel sure that that is the intent of the Bill, which should make that clear, as well as the stipulation that the specified period required should be not one but two years.

Baroness Royall of Blaisdon (Lab): My Lords, I find this procedure extremely confusing. I realise that when a complex amendment is passed which subsumes other amendments it makes life complex, but for future reference, we would be very grateful as a Committee to have clear procedural guidance from the Whips as soon as possible. This has been a very confusing discussion on an extremely important issue.

The Earl of Listowel: My Lords, I will speak to Clause 1, and in particular to the concern about young people aged from 18 to 25. As I stressed before, this is a very small group within the larger group we are discussing, and one has to be very concerned that they

get the appropriate healthcare and health professional treatment so that they can make fully informed, proper decisions. It is notorious that the transition from children's services to adult services often causes issues in the treatment of young people.

Many young people may have some difficulty in fully appreciating their own mortality. While it is easy for us to recognise, it may be more difficult for an 18 or 19 year-old to realise that ending one's life is absolutely final. Therefore I would appreciate consideration being given to the welfare of that particular group, so that whatever progress is made on the Bill in the future, the welfare needs of 18 to 25 year-olds are taken into very careful consideration.

Lord Mackay of Clashfern: My Lords, my Amendment 10, which was superseded, accords with the amendment moved by my noble friend Lord Cavendish. I just want to explain that all I wanted to do was to put the condition about informed consent into Clause 1, which contains the lists of qualifications. There is of course a reference to informed consent later on in the Bill. That was all I wanted to do, and it goes along with what is done by Amendment 4 in the name of the noble Lord, Lord Pannick, which talks about informed wish. I therefore assume that that would be simply a technical matter of moving it.

Lord Mawhinney: My Lords, I follow my noble and learned friend Lord Mackay. I was thinking along similar lines on Amendment 10 and fully informed decisions. I am sure that all of us want decisions to be fully informed, so I wonder whether the noble and learned Lord, Lord Falconer, could before Report give some thought to whether he is satisfied that fully informed clearly includes, first, being told what the options are and, secondly, on the part of the patient, having some comprehension of what he or she is being told. Running off a list of options does not mean that the recipient is fully informed if he or she does not understand what the options really mean.

Lord Howard of Lympne: My Lords, I support the observations made by my noble friend Lord Cavendish, with respect to Amendment 70, to which he spoke but which he did not move. He spoke about the importance of palliative and hospice care, and I support what he said and endorse what he said for the reasons that he gave and those that I gave earlier today, in our first debate. I was very concerned by the tale related by the noble and right reverend Lord, Lord Harries of Pentregarth, about a remark made by a nurse in a hospice. I was distressed and surprised by that, and if he were to let me have the details I would like to look into it. It is all the more surprising because the greatest growth area in hospice care is hospice at home. Increasingly, nurses and other workers from hospices go out and look after people towards the end of their lives, in their homes. I was really distressed to hear that, but I assure your Lordships that it is very unusual and exceptional.

I should say a word in support of the observations made by the noble Baroness, Lady Howe of Idlicote. Her observations were powerful and speak for themselves, but I confess that I had not expected the issues before the House today to become entwined in the larger immigration debate, which occupies so much space in the press at the moment—but it seems that it has done, as result of the intervention of the noble Baroness, and I strongly support what she said.

Baroness Finlay of Llandaff: I will be very brief. It is admirable how the House has coped with what appears to be slightly confusing. It is wonderful that we have clerks and Whips who understand more than the rest of us do, as it unfolds.

This stand part debate is very important, partly because the two issues of transitional care and the needs of very young adults are critically important, as is the point made about suicide tourism. I am sure that that was never intended by the noble and learned Lord, Lord Falconer, but this was the only place that it could come up in the Bill, and I am glad that my noble friend Lady Howe raised it.

I had sought previously to clarify "assisted dying", and that the first clause should be titled "Assistance with suicide", because this is about assisted suicide—it is not about physician-administered euthanasia. All the debates that we have had are as such, and I hope that when the Bill is reprinted we will be able to have a more accurate title to Clause 1. It is assistance with suicide, not physician-assisted euthanasia.

Baroness Grey-Thompson: My Lords, I apologise, but I would like to speak briefly because I had six amendments that dropped out due to the amendment of the noble Lord, Lord Pannick.

Noble Lords: No.

Lord Taylor of Holbeach: If I can just explain—those amendments that are part of the groups that the pre-empted amendments belong to will occur later on, when we come to them in order.

Baroness Grey-Thompson: I apologise; I did not express myself very well. I thank the noble Lord for that clarification. I agree with the points made by the noble Lord, Lord Howarth of Newport, on coercion. I absolutely endorse what my noble friends Lord Alton and Lady Finlay of Llandaff said about terminology. Terminology is the dress of thought and is incredibly important.

We still have to debate issues such as how, what, when, where and who, which come up in Clause 1. I refer to an issue which I cannot see coming up anywhere else—that is, how somebody who is peg fed may be assisted to die, and where that fits in with what help is actually needed. In the USA, a patient had a peg fitted expressly so that he could be helped with assisted suicide. My noble friend Lady Campbell of Surbiton already has a peg fitted and that is how she is fed and survives. A lot of questions still need to be answered about the administration of drugs. I think it is assumed that a patient may be swallowing some medicine or some liquid, but for some people the situation might be very different.

Lord Faulks: My Lords, this last group has engendered a wide-ranging debate which has called for considerable mental agility on the part of the participants. They have shown themselves well able to do so. I could not attempt to summarise all the issues that have been raised, but well raised they have been, and they have given the noble and learned Lord, Lord Falconer, a great deal to consider.

I shall deal with one point only. The noble Earl, Lord Listowel, was concerned, as he always is—much to the benefit of the House—with those aged between 18 and 25, who have not been the main focus of our attention today. I can tell the Committee that the General Medical Council's core guidance for all registered doctors on good medical practice makes clear that a doctor,

"should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs".

This will include consideration of the age of the patient.

Lord Falconer of Thoroton: The last half hour has been a remarkably focused debate on a series of amendments. I wish to go through each of the points that have been made.

Amendment 11 in the name of the noble Lord, Lord Alton of Liverpool, seeks to insert at the end of Clause 1 that a condition of having a right to an assisted death is that someone,

"is able to administer to himself or herself a lethal dose of drugs through whatever route is normally employed for ingestion of food".

As the noble Lord recognised, that is at odds with the terms of the Bill, which state that,

"an assisting health professional may … prepare … medicine for self-administration by that person … prepare a medical device which will enable that person to self-administer the medicine; and … assist that person to ingest or otherwise self-administer the medicine; but the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed".

The Bill then specifically says with reference to subsection (4) of Clause 4, which I have just read out:

"Subsection (4) does not authorise an assisting health professional to administer a medicine to another person with the intention of causing that person's death",

so it absolutely underlines that it has to be a final act by the patient himself.

I am against the amendment of the noble Lord, Lord Alton, as it would discriminate against weak patients who cannot easily manage medication orally, including weakened cancer patients as well as those suffering from motor neurone disease, where setting up a form of driver would be more appropriate, but leaving the patient to take the final action. Alternatively, a nasogastric tube or even an intravenous drip can be set up and still leave the patient in control of the final action. The key thing here is to make sure that the Bill underlines that it has to be the final act by the patient but gives some degree of flexibility.

Amendment 10, which was primarily referred to by the noble Lord, Lord Cavendish of Furness, and is in his name, seeks to add a condition that the request for an assisted death should be made,

"on the basis of a fully informed decision".

The Bill currently says that the person has to make the decision,

"on an informed basis and without coercion or duress".

The Bill also provides:

"In deciding whether to countersign a declaration under subsection (3), the attending doctor and the independent doctor must be satisfied that the person making it has been fully informed of the palliative, hospice and other care which is available to that person".

As a result of the amendments made by the Committee, moved by the noble Lord, Lord Pannick, the Bill now states that the judge has to be satisfied that the person has,

"a voluntary, clear, settled and informed wish".

As between the Bill and the noble Lord, Lord Cavendish, there is no dispute that the person should be informed. I would be happy to insert "fully" wherever "informed" is referred to.

The noble Lord, Lord Cavendish, also has a further amendment, Amendment 70, supported by the noble and learned Lord, Lord Mackay of Clashfern, and the noble Baroness, Lady Grey-Thompson, in which, in effect, they set out what one would expect to form part of the full information given before the decision is made. It includes what the consequences of the illness are, what palliative care and pain relief are available, and what the prognosis is in relation to the illness—considerable detail like that. I would expect all these matters to fall within the words "fully informed", but I recognise the feelings of the noble Lords, Lord Cavendish, Lord Howard of Lympne, and the noble and learned Lord, Lord Mackay, all of which suggest support for further spelling out of the meaning of "fully informed". Can I take that away and come back with a proposal on Report to spell that out? I should make it clear that the sorts of things referred to in Amendment 70 would have been what I would have expected to include in any event. However, I can see that the Committee would get more assurance if it were set out in the Bill.

The next group of amendments were from the noble and right reverend Lord, Lord Harries, who was keen in Clause 1 to insert a provision that the decision was being made voluntarily. I am sorry to be wearisome, but the Bill currently requires that the two doctors must be satisfied that the person,

"has a clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress".

In addition, as a result of the amendments made this morning, the judge has to be satisfied that the individual,

"has a voluntary, clear, settled and informed wish to end his or her own life".

There is therefore no doubt that the requirement for voluntariness is there at two stages already. With all respect to the noble and right reverend Lord, Lord Harries, legally it will not make much difference to add that provision elsewhere also.

However, the noble and right reverend Lord touched on the deeper issue of whether we as a House would consider a situation whereby, even though one wished to live, one decided, because one was a burden to those one loved, to go down the route of an assisted death. I would say that that was not voluntary because one wanted to live. That may be an oversimplification in

many cases—there may be other cases where the situation is more complicated—but I would not be in favour of putting anything to that effect in the Bill.

Lord Harries of Pentregarth: The noble and learned Lord seems to agree with my point and speaks as though it would automatically be taken into account. Would it not be safer to have it spelled out in the Bill—that one of the marks that the decision was voluntary is that those looking into the person's decision were assured that that person was not acting out of a sense of duress because they felt a burden?

Lord Falconer of Thoroton: My reason for not putting that in the Bill is that so many cases are much more complex than the simple case I gave, where I would not wish for there to be an assisted death—where one's motive for wishing to have an assisted death will be a mixture of "I don't want to be dependent on other people, I don't want the lack of dignity, I don't want to be a burden", a whole mixture of motives that make clear "I do not want to go on living for the last week or month". I am very unkeen to isolate just one factor in what is a much more complex issue than the example I gave. That is why I am against putting that in the Bill.

Lord Howarth of Newport: Will my noble and learned friend say a word or two about how he envisages that the judge or the doctors should know, ascertain and satisfy themselves that the decision has been taken voluntarily?

Lord Falconer of Thoroton: They must conduct in-depth discussions with the patient and the other doctors. The judge must call such evidence as he or she considers appropriate to be satisfied—the burden is to be "satisfied"—that the decision is voluntary. "Voluntary" means "this is what the patient wants": he or she is not being forced into it either by coercion or by the sort of guilt that we referred to earlier. Although that will give rise to complex issues, it is not a job that is beyond judges or, indeed, some doctors.

The noble Baroness, Lady Howe of Idlicote, said that a person should have to be resident for a year immediately before the declaration is agreed. I think that is the Bill's effect, because as it is drafted it says,

"on the day the declaration is made … has been ordinarily resident in England and Wales for not less than one year".

The patient has to have been here for a year. However, she has a second point, which is that it should be two years rather than one. Until the noble Lord, Lord Howard, suggested it, it had not occurred to me that this was about immigration. I had thought it was about a desire to prevent tourism for this purpose, which is how the noble Baroness put it. I think it is quite difficult to judge between one year and two years. My inclination is to stick with one year, but I will take soundings to see whether two years seems right. People coming to be resident for a year before the declaration is made looks like considerable forward planning. I am not minded to accept her amendment.

The noble Earl, Lord Listowel, made a point about the 18 to 25 year-old age group. I completely agree with him that they need especial care, but this right is for anybody aged over 18. I do not think it should be taken away from them. We need to consider what should go into a code of practice to ensure that the particular needs of 18 to 25 year-olds are borne in mind.

I think that has dealt with all of the amendments that were suggested.

Clause 1 agreed.

House resumed.

House adjourned at 5.07 pm.

Written Statements

Friday 7 November 2014

Competition Appeal Tribunal and Competition Service: Triennial Review

Statement

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Neville-Rolfe) (Con): My honourable friend the Parliamentary Under-Secretary of State for Employment Relations and Consumer Affairs (Jo Swinson) has today made the following Statement.

The Triennial Review of the Competition Appeal Tribunal (CAT) and the Competition Service (CS) commenced on 21 August 2013 and I am now pleased to announce the completion of the review.

The CAT was established by the Enterprise Act 2002, which came into force on 1 April 2003, to hear appeals against certain decisions of the UK competition authorities and economics regulators. It is a specialist body with cross-disciplinary expertise in law, economics, business and accountancy. The Enterprise Act 2002 also created the Competition Service: a body corporate and executive non-departmental public body whose purpose is to fund and provide administrative and legal support services to the Competition Appeal Tribunal.

The review has concluded that the CAT has a vital role to play in determining regulatory and competition appeals, which have important consequences for the wider economy and the Government's growth agenda, and should therefore remain as a specialist Tribunal NDPB.

The review also concludes that the functions performed by the Competition Service should be retained but should be merged with those of the CAT to form a single body, a specialist Tribunal NDPB with its own support functions. The merger should be taken forward as soon as parliamentary time allows.

Stage 2 of the review examined the governance arrangements for both the CAT and the CS to assess compliance with statutory accountabilities and confirm that appropriate governance arrangements were in place. The review concluded that overall compliance with recognised principles of good corporate governance was good and should be rated green. However, the review also identified a number of recommendations to improve how the governance functions will operate in the context of the new merged body.

The full report of the review of the Competition Appeal Tribunal and the Competition Service can be found on the gov.uk website and copies have been placed in the Libraries of both Houses.

Council for Science and Technology: Triennial Review

Statement

Thee Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Neville-Rolfe) (Con): My right honourable friend the Minister for Universities, Science and Cities (Greg Clark) has today made the following Statement.

Commencement of the Triennial Review of the Council for Science & Technology (CST) was announced in Parliament through a Written Ministerial Statement on 15 April 2013 and I am now pleased to announce the completion of the review.

The Council for Science & Technology was established in 1993 in response to the Government White Paper *Realising our potential: a strategy for science, engineering and technology*. It replaced the Advisory Council on Science and Technology. It is an advisory non-departmental public body to the Prime Minister but, for administrative purposes, it is sponsored by BIS and was therefore included in the programme of triennial reviews undertaken by BIS.

The review concludes that the functions performed by the Council for Science & Technology are still required and that it should be retained as an advisory non-departmental public body. The review also examined the governance arrangements for the Council of Science & Technology in line with guidance on good corporate governance set out by the Cabinet Office. The review concluded that the council operates in line with the principles of good corporate governance for an organisation of its size, but there are a number of opportunities to improve it functions.

The full report of the review of the Council for Science & Technology can be found on the gov.uk website and copies have been placed in the Libraries of both Houses.

GCSE and A-Level: Religious Studies

Statement

The Parliamentary Under-Secretary of State for Schools (Lord Nash) (Con): My honourable friend the Minister of State for School Reform (Nick Gibb) has made the following Written Ministerial Statement.

In April this year, the Government announced that GCSEs and A-levels in religious studies, design and technology, drama, dance, music and physical education—and GCSEs in art and design, computer science and citizenship—would be reformed for first teaching in September 2016.

The department has already consulted on proposed subject content for art and design, computer science, dance, music and physical education, and is currently consulting on proposed subject content for drama, design and technology and cooking and nutrition. Today, we are publishing for consultation new subject content for religious studies. At the same time, Ofqual, the independent regulator of qualifications and examinations for England, will consult on the proposed assessment objectives for this subject.

These new qualifications are intended to provide students with the knowledge and understanding that will prepare them for further and higher education and future employment. In common with all our reformed GCSEs and A-levels, they will be high-quality, demanding and academically rigorous qualifications.

The revised content for religious studies GCSE and A-level is designed to provide students with a broader and deeper understanding of religion than previous specifications. For the first time, students studying

the religious studies GCSE will be required to study two religions. As well as studying key scripture and religious texts, students will have the opportunity to learn about critiques of religion and other non-religious beliefs through the study of philosophy and ethics. In addition, it will be a requirement for students to be aware of the diverse range of religious and non-religious beliefs represented in this country and the fact that the religious traditions of Great Britain are, in the main, Christian.

For the thousands of church and faith schools in this country these reforms will enable them to build on their strong academic performance and the important role they play in their communities and wider society.

In future, all RS GCSE students will spend at least half their time engaging in an academically rigorous study of two religions. In all, students will have the option to spend up to three-quarters of their time studying one religion. These changes are an important part of ensuring the new GCSE is as broad and rigorously demanding as other GCSE subjects. In the same way that a well educated GCSE history student would be expected to learn about more than just British history, we expect well educated religious studies GCSE students to know about more than one religion. It will also help to prepare students for life in modern Britain, foster an awareness of other faiths and beliefs, and encourage tolerance and mutual respect—key British values that are non-negotiable and a vital part of a secure future for Britain.

At A-level, students will study at least one religion in depth through two of the following three areas of study: the systematic study of religion; textual studies; and philosophy, ethics and social scientific studies. These broadly reflect the main areas of study at higher education and will ensure that students have sufficient breadth and depth of understanding to support progression to higher education.

This consultation is an important part of the reform process enabling all those with an interest in this subject to provide their views. We will consider carefully all responses received in determining the final content. The consultation on reformed subject content for religious studies GCSE and A-level will be available today at https://www.education.gov.uk/consultations/. Ofqual's consultation on assessment arrangements will be available on its website at http://ofqual.gov.uk.

Written Answers

Friday 7 November 2014

Aircraft Carriers

Question

Asked by ***Lord West of Spithead***

To ask Her Majesty's Government when they expect that HMS "Queen Elizabeth" and HMS "Prince of Wales" will each proceed to sea under their own power for the first time. [HL2405]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever) (Con): Final equipment installation and system commissioning plans are currently being developed for both ships. We expect HMS "Queen Elizabeth" to proceed to sea under her own power for the first time in early 2017 and HMS "Prince of Wales" in early 2019.

Armed Forces: Malaria

Question

Asked by ***Baroness Corston***

To ask Her Majesty's Government what factors are taken into account when administering larium as a malaria prophylactic to British troops and reservists serving overseas. [HL2654]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever) (Con): Mefloquine (commercially known as Lariam) is one of a number of effective methods of malaria chemoprophylaxis used by the military in many parts of the world where Service personnel deploy. The exact choice of drug depends on a number of factors, including the region the individual is deploying to, the health of the individual and any history of side effects. Mefloquine and other antimalarial drugs used by the military are licensed in the UK by the Medicines and Healthcare Products Regulatory Agency, based on the expert guidance of the Advisory Committee for Malaria Prevention of Public Health England. The Ministry of Defence reviews its policy on the use of antimalarial drugs in line with advice from the Advisory Committee.

Female Genital Mutilation

Question

Asked by ***Lord Blencathra***

To ask Her Majesty's Government whether they intend to draw to the attention of England and Wales police forces National Health Service statistics about the number of new cases of female genital mutilation; and what recent discussions they have had with police and prosecution authorities about the prosecution rate for female genital mutilation. [HL2333]

The Parliamentary Under-Secretary of State, Home Office (Lord Bates) (Con): The Minister for Crime Prevention is chairing a cross government FGM roundtable meeting on 10 November, to which the National Policing Lead on Female Genital Mutilation, the Director of Public Prosecutions and other key stakeholders are invited. The meeting will take stock of progress in implementing the extensive package of announcements to tackle FGM made at the Girl Summit hosted by the PM on 22 July. This includes the recently published NHS statistics on cases of FGM and how they can be promoted, alongside new FGM prevalence data, part-funded by the Home Office and published by City University and Equality Now in July 2014.

The roundtable will also review current progress on police and Crown Prosecution Service activity to tackle FGM.

Red Arrows

Question

Asked by ***Lord West of Spithead***

To ask Her Majesty's Government what planning assumptions are in place for the Red Arrows when the current fleet of aircraft are due for replacement; and what aircraft type, if any, will replace them. [HL2401]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever) (Con): I refer the noble Lord to the answer given by the Minister for Defence Equipment, Support and Technology (Philip Dunne) in the House of Commons on 7 November 2013 (Official Report, column 307W). As my right hon. Friend the Secretary of State for Defence (Michael Fallon) has recently said, the Red Arrows will continue flying.

This Answer included the following attachment: Hansard Extract 7 November 2013 (Red Arrows.doc 7 November 2013 HL2401.doc)

RFA Argus

Question

Asked by ***Lord Hylton***

To ask Her Majesty's Government whether they plan to expand the instructions given to RFA Argus so as to enable its medical facilities to assist all urgent cases from Sierra Leone or nearby states. [HL2338]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever) (Con): RFA ARGUS is deployed to support the Government's efforts in Sierra Leone. Her primary role is to act as a logistics lift capability and aviation platform, with three embarked Merlin helicopters. RFA ARGUS does, however, have a limited medical capability on board to treat disease and non-battle injury. Treatment of those suffering from Ebola is carried out at separate facilities ashore, the first of which opened in Kerry Town on 5 November and will have the capacity to treat 80 local patients. Also at Kerry Town the UK military is currently manning a 12 bed treatment unit for national and international healthcare workers.

Social Security Benefits

Question

Asked by ***Lord Beecham***

To ask Her Majesty's Government, in the light of the steps they are taking to reduce the cost of benefit fraud, what they propose to do, and how much they plan to spend, to reduce underpayments to claimants due to mistakes by officials or claimants. [HL2398]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud) (Con): The Department takes both under and overpayments seriously and has in place a number of initiatives to address the errors that cause them. These activities address fraud as well as error, and both under and overpayments. It is therefore not possible to separate out the cost of activities focused exclusively on underpayments as a result of error.

Universal Credit will make the welfare system simpler by replacing six benefits and credits with a single monthly payment. This simplification is expected to lead to a reduction in fraud and error due to the fact that information about claimants will be held in one place and updated more frequently and easily.

For claimants that have income taxed under PAYE, Universal Credit will be linked to HMRC's Real Time Information system, which will provide an automatic monthly update of their income thus reducing the potential for both error and fraud.

The Department has invested in compliance activity, so that case correctness is maintained and fraud and error entering the system are detected and resolved quickly. Across all delivery arms there is a focus on accuracy and quality, including a continuous quality checking regime to review claims and check processing accuracy.

We constantly review claims by checking them against data coming into our systems, in order to highlight potential anomalies. We do this by using business rules which focus on potential error to identify both under and overpayments.

The Department is taking steps to encourage claimants to ensure that the information provided to us is accurate and up-to-date. This includes a fraud and error communications campaign about driving behaviour change and emphasising that claimants must report any change of circumstances.

Syria

Question

Asked by ***Lord Lester of Herne Hill***

To ask Her Majesty's Government whether they plan to make representations to the European Commission to ensure that European Union policy and practice enable women and girls raped during the armed conflict in Syria to have access to safe abortions in accordance with international humanitarian law. [HL2400]

The Parliamentary Under-Secretary of State, Department for International Development (Baroness Northover) (LD): The UK is in regular dialogue with other EU bilateral donors and the European Commission to protect and promote women's and girls' access to comprehensive sexual and reproductive health services. This includes safe abortion services in line with our policy on safe and unsafe abortion. The UK remains one of only a handful of international donors willing to tackle this highly sensitive issue.

Type 26 Frigates

Question

Asked by ***Lord Foulkes of Cumnock***

To ask Her Majesty's Government what consideration they have given to naming one of the new type 26 global combat ships after the City of Plymouth. [HL2312]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever) (Con): I refer the noble Lord to the answer I gave on 30 October 2014 to the noble Lord, Lord West of Spithead (Official Report, column WA184).

This Answer included the following attachment: Hansard Extract 30th October 2014 (Type 26 Frigates.doc 30 October 2014.doc)

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