

Bemühungen zur Einführung der Möglichkeit des begleiteten Suizids in Grossbritannien

In Grossbritannien hat die Berichterstattung der Medien über Untertanen ihrer Majestät, die nach der Schweiz gereist sind, um dort ihr Leben risikolos und schmerzfrei zu beenden, zu einem politischen Vorstoss im Oberhaus (House of Lords) geführt.

Der britische Menschenrechtsanwalt Lord Joffe hat dort einen privaten Gesetzesentwurf für terminal Kranke vorgelegt. Ein Select Committee hat in der Folge den Entwurf beraten und sich in vier Ländern, in welchen aktive Sterbehilfe oder begleiteter Suizid möglich sind, durch Gespräche mit zahlreichen Personen kundig gemacht. Das Committee hat in der Folge einen umfangreichen Bericht erstattet.

Am 10. Oktober 2005 ist im Oberhaus darüber ausgiebig debattiert worden.

Protokoll der Aussprache vom 10. Oktober 2005 im Oberhaus

The UNITED KINGDOM PARLIAMENT

Assisted Dying for the Terminally Ill Bill: Select Committee Report

3.9 pm

Lord Mackay of Clashfern rose to move, That this House takes note of the Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill.

The noble and learned Lord said: My Lords, I beg to move that House take note of the Report of the Select Committee that was appointed last year to examine a Bill presented by the noble Lord, Lord Joffe, known as the Assisted Dying for the Terminally Ill Bill.

I was privileged to chair the Select Committee, and I shall open by summarising the way in which the committee went about its work and the conclusions to which it came. All this is set out in the committee's report, which was presented on 4 April this year as *House of Lords Paper 86*. I hope that, in summarising the work that has been carried out, I will be able to provide an appropriate introduction for our debate today. I will focus only on the main issues.

The Bill introduced by the noble Lord, Lord Joffe, which lapsed with the dissolution of Parliament in April this year, sought to provide medical assistance with suicide to adults who had been diagnosed as terminally ill with a few months to live, were suffering unbearably and wished to end their life prematurely. Effectively, it would have authorised a doctor to write a prescription for lethal medication that it would then be up to the patient to take—or not,

should he or she have a change of heart. In the case of people whose physical condition was such that they could not use such medication, the Bill provided that a doctor might administer a lethal drug to the patient at his or her request.

The issues with which the Select Committee had to grapple, being issues of life and death, are awesome and sensitive. They arouse strong emotions on the part of those who wish to see a change in the law and of those who feel that such a step would be dangerous. Clearly, opinion on the matter is divided in the country, and it was divided in the committee. It was not surprising, therefore, that we had some lively exchanges as we proceeded. I take this opportunity to place on the public record our appreciation of the time and effort that a large number of people, in this country and abroad, devoted to helping us understand their views on the issues involved. If I say that the committee saw over 140 witnesses in four countries and that it received over 60 submissions of written evidence and some 15,000 letters and other personal submissions from individuals, the House will appreciate the scale of the task and of the help that we received. We are also grateful for the help that we received from Foreign Office officials, the committee staff and specialist advisers.

We examined the Bill introduced by the noble Lord, Lord Joffe, from the standpoints of ethical principle and real-world practicality. We examined the philosophical or moral principles that underlay its provisions and the practical implications of carrying it out if it were to become law. In terms of principle, we gave close attention to the propositions that assistance with suicide or euthanasia were natural extensions of patient autonomy and that the existing rights of patients to refuse life-supporting treatment implied a corresponding right on the part of those who were terminally ill to receive, if they wished, medical assistance to end their life.

On the other hand, we examined the arguments that patient autonomy, although an important aspect of medicine, cannot override medical ethics—for example, a patient cannot insist on having surgery that is not considered to be in his best interest—and that there is a crucial difference between a patient deciding to die by refusing further treatment and asking a doctor to end his or her life. We did not find a consensus on the relative weightings to be given to the arguments, with some members arguing that patient autonomy should be paramount, and others that it could not justify weakening the law on intentional killing and assisting suicide.

On the practical side, we looked at allegations that doctors were already ending the lives of patients prematurely, though we found no reliable evidence of that. We considered whether advances in palliative care obviated the need for change in the law. We concluded that such care can do much more now than it could 30 years ago to reduce or even eliminate the suffering associated with terminal illness and that Britain was a world leader in that branch of medicine, though we were told that its availability was as yet unevenly spread over the country.

We considered whether there were good grounds for believing that changing the law to allow medical assistance with suicide or voluntary euthanasia was tantamount to stepping onto a slippery slope, with any new law becoming more widely applied than Parliament intended and with medical practice undergoing a subtle but significant shift as a result. As in so many areas of the debate, we heard arguments both directions. On the one side, it was argued that there was no hard evidence of "slippery slopes" in countries that had legalised such acts or of people other than those for whom the law was designed being drawn into assistance with suicide or euthanasia through subtle external pressures; and, on the other side, it was argued that the Abortion Act 1967, which is perhaps the nearest parallel to a law of this nature, had

produced an unintended situation of abortion on demand; that the Bill was seen, as the noble Lord, Lord Joffe, told us, as simply a first stage in relaxing the law; and that in Holland there were already pressures, three years after the passing of the law permitting euthanasia, to extend its provisions to new categories of people.

We looked also at the difficulties inherent in defining such qualifying conditions as "terminal illness", "unbearable suffering" and "mental competence" and concluded that, while a creditable attempt had been made in the Bill to produce workable definitions, the realities of medical prognosis, the problems of separating out depression from mental incapacity and the wholly subjective nature of "unbearable suffering", called for further work in those areas.

In the course of the inquiry, we visited the American state of Oregon, where only medical assistance with suicide has been legalised; the Netherlands, where both assisted suicide and euthanasia are legal and where the latter predominates in practice over the former; and Switzerland, where only assistance with suicide is legal, although it is not seen in a medical context and anyone can give assistance with suicide, provided that he or she does not act from selfish motives. In the course of those visits, we discovered that the death rate from assisted suicide is very much lower than the death rate from euthanasia. One in 714 deaths in Oregon in 2003 resulted from patients themselves taking lethal medication prescribed to them under the law. In Holland, one in 38 deaths resulted from assisted suicide or voluntary euthanasia.

Finally, we commissioned a review of public opinion surveys that have been conducted over the past 10 to 20 years. It found that there appeared to be a groundswell of opinion in favour of a change in the law, although it added that the public opinion research that had been carried out was of a simplistic "either/or" or "yes/no" nature, with little or no attempt to explore the subtleties of the subject and with very little public understanding of the issues involved. Indeed, one of our objectives in presenting our report has been to try to elucidate this complex and emotive subject to provide a basis for intelligent debate.

So what conclusions did we come to after all this work? As I said, there was no consensus in the committee on the acceptability of the Bill introduced by the noble Lord, Lord Joffe. Therefore, bearing in mind that because a Dissolution of Parliament was in prospect the Bill would be unable to proceed, we agreed to present a report that summarised the evidence that we had heard in such a way as to avoid drawing conclusions and provided a readable and intelligible guide to the subject. In that way, we hoped to provide a basis for a reasoned debate in the House and for the development of informed opinion in the country as a whole. I hope that the House will agree that, although we did not succeed in coming to clear conclusions on the Bill itself, we succeeded in that respect at least.

As for the future, we recommended that the House should debate the subject again at an early opportunity in the light of our report, and that is why we are here today. We also felt that, in the event that another Bill was introduced, its author should take account of a number of concerns that had been raised with us in the course of our inquiry. The first and perhaps the most important is the need to draw a clear distinction between assistance with suicide and voluntary euthanasia. We recognised in our report that, while the most careful attention must be paid to the views of the professions that would be in the front line of implementing any change in the law, a decision on whether assistance with suicide or voluntary euthanasia should be legalised was one for society as a whole to take through its legislators in Parliament and that we should give due weight in that process to public opinion. However, we also recognised the corollary: there is a need to look behind the results of opinion polls in order to ascertain the extent to which the views expressed are based on informed opinion and, if we

are to avoid the risk of damage to the ethics of a profession that is vital to all our needs and that is—not wholly, but largely—opposed to a change in the law, we must consider how best the implementation of any change might be managed. We also felt that the qualifying conditions that appeared in the Bill introduced by the noble Lord, Lord Joffe, would need to be revisited in any future Bill.

As a lawyer, I feel that I should say something about the existing law on the subject before I conclude. I must pay tribute to the advice that was given to the committee by the noble and learned Lord, Lord Goldsmith, the Attorney-General, who did so in his capacity as legal adviser to the House. The position may be summed up as follows: the law does not forbid suicide, although those institutions that have in their care persons with suicidal tendencies, such as prisons or hospitals, must take reasonable care to prevent them giving effect to those tendencies. However, the law forbids helping someone to take his or her own life and ending someone's life at his or her request, although the law is not implemented in such a way as to visit the maximum sentence on anyone who acts in that way. Every case that comes to notice is considered on its merits by the police and by the Director of Public Prosecutions to assess whether a crime has been committed, and, if so, whether the circumstances justify a prosecution. If a prosecution is successful, the court must consider whether a custodial sentence or some other sentence is called for. That flexibility in our law was recognised recently and commended by the European Court of Human Rights.

In the circumstances, as chairman of the committee, I have refrained from expressing a personal opinion, either in the committee or in the House; and I do propose to express any such opinion now. We have tried to produce a report on which all the committee could agree as a basis for today's debate.

Moved, That this House takes note of the report of the Select Committee on the Assisted Dying for the Terminally Ill Bill [HL] (Session 2004–05, HL Paper 86).—(*Lord Mackay of Clashfern.*)

Lord Ackner: My Lords, before the noble and learned Lord sits down, will he confirm that, first, suicide has never been a crime in Scotland and, secondly, that as far as he is aware there has never been a prosecution for aiding, abetting, counselling or procuring suicide?

Lord Mackay of Clashfern: My Lords, I think that I am right in saying that suicide has never been a crime in the law of Scotland. I believe that the reason for that is the same as that which ultimately persuaded the authorities in England to take away that position in England. The difficulty is that for a crime one normally expects some form of sanction to be available; in the nature of suicides, such a thing is not possible. I do not feel able to answer the second question immediately, and I do not think that the committee's report necessarily contains an answer to it.

Lord Joffe: My Lords, it was a privilege, and, indeed, an education, to be a member of the Select Committee, chaired by the noble and learned Lord, Lord Mackay of Clashfern, who has so meticulously summarised the report. I should like to express my appreciation to the noble and learned Lord, Lord Mackay, and the other members of the Select Committee, all of whom gave up so much of their valuable time to consider my Bill which lapsed at the end of the last parliamentary Session.

In my view, three key recommendations were made by the committee. First, that if a Bill similar in nature to the existing Bill were introduced, it should, following a Second Reading,

be sent to a Committee of the Whole House for examination. Secondly, that while the most careful account must be taken of expert evidence, at the end of the day the acceptability of assisted suicide or voluntary euthanasia is an issue for society to decide through its legislators in Parliament. The evidence to the committee was of an apparent groundswell of public agreement with the concept of euthanasia and a shift from opposition by many professionals.

Thirdly, that in England and Wales there is a small but significant number of terminally ill patients who, given the choice, would wish to avail themselves of assistance to die in order to bring an end to their unbearable suffering. These were generally patients with strong personalities and a history of being in control of their lives who, to quote the report,

"are unlikely to be deflected from their wish to end their lives by more or better palliative care".

It is only for these patients that assisted suicide was proposed as an option, which they may wish to exercise, and I and other supporters of the Bill have made it crystal-clear in our evidence to the committee that we are totally supportive of palliative care for the overwhelming majority of terminally ill patients and it is misleading for opponents of the Bill to infer otherwise.

In the evidence given to the committee, concerns were expressed about the possible adverse effect of the proposed legislation on vulnerable people and on the medical profession. Inevitably those concerns could only be speculation about what might happen. From the evidence the committee received in Oregon and the Netherlands, it was clear that the same concerns and predictions of abuse of the legislation had been expressed in these countries prior to legislation. Yet, after many years of practical experience, there was no credible evidence that vulnerable people had been put at risk, or that there was a slippery slope, or that the medical profession had been disrupted, or that the ethos of medicine had changed for the worse. It was also clear that, far from palliative care having been undermined, it had flourished since the legislation was passed.

The system that most impressed the committee was that in Oregon, where only assisted suicide is permitted and which is working well. The noble Earl, Lord Arran, will in his speech outline in greater detail why the majority of the committee was impressed with the Oregon system. I will accordingly restrict my comments on the Oregon system to a talk at Westminster by Dr or Professor Stevens from Oregon given subsequent to the publication of the Select Committee report. Many of the views expressed by Dr Stevens were repeated in an article by the noble Lord, Lord Alton, in a Catholic publication called *The Universe* and by the noble Baroness, Lady Finlay, in a number of public talks without even a reference to the fact that those views were in most respects diametrically opposed to those of all the responsible organisations and researchers who gave evidence in Oregon. In weighing the value, if any, to be placed on Dr Stevens's views, I invite your Lordships to study the evidence given to the committee by Dr Stevens and his close colleagues Drs Hamilton and Toffler and particularly their responses to questions 991 onwards.

I draw attention to the principle of personal autonomy upon which the Bill is based; namely, that competent adults should have the right to make decisions on their own lives, which naturally includes the decision as to when and how they should die. Nobody else—including doctors—should have the right to make such decisions. There is one limitation to this right and that is that in making such decisions, vulnerable members of society should not be placed at risk. The Bill recognised this and incorporated an array of more than 20 interrelated

safeguards and was itself far more restrictive and tightly drawn than the legislation in the Netherlands or Belgium and had even more safeguards than that in Oregon. I realise that I am fast approaching the end of the recommended time for speeches. However, I have been advised by experienced Members of your Lordships' House that, as it is my Bill which is the subject of the committee's report, it would not be unreasonable for me to talk a few minutes longer. I hope that your Lordships will bear with me as this is not a timed debate.

Much of the passionate opposition to this Bill is based on religious beliefs. I naturally respect the religious beliefs of those who express or share those beliefs, although I should add that public opinion surveys show that a massive majority of both Protestants and Catholics do not share the views of their religious leaders on this issue. The question that arises is whether a relatively small minority of society has the right to impose its beliefs on members of society who do not share them. In contrast, this Bill does not seek to impose anything on anybody. It simply provides another end-of-life option which terminally ill patients can accept or disregard as they choose.

I am aware that there is a divergence of opinion among those suffering from disabilities. Public opinion surveys of the disabled show that the majority would support the Bill. I cannot agree with the view of the Disability Rights Commission that although it has no objection in principle to the Bill, it should be delayed until all disabled people have equal rights with the rest of society. I personally totally support the battle of the disabled for equality and I greatly respect and admire the courage of those with disabilities, in this House and elsewhere, battling for equality for the disabled. But I say to them that this Bill is not about disability in general, nor about that crucially important battle for equality by the disabled. It is about terminally ill patients only, all of whom will be fully protected, to the extent that protection may be necessary, by the safeguards in the Bill.

In the Select Committee, reference was made to evidence given by me to the committee to the effect that the Bill was a first stage and that there was the possibility of subsequent amendment to widen its scope. That evidence was correct. However, when further questioned on that evidence, the report records my answer as,

"a first stage and possibly the final stage, but there could be subsequent stages"—

an answer, incidentally, that has been carefully overlooked by opponents of the Bill. Naturally, the question of future stages will be a matter for future legislators.

I carefully listened to the evidence given at the Select Committee. During its course, I gave notice of a number of amendments to meet concerns that were expressed, including that there will be no obligation on physicians to raise the possibility of assisted dying with patients and no duty on hospices or hospitals to permit assisted dying on their premises. I will include those amendments in a new Bill which I propose to introduce after this debate. When drafting my proposed Bill, I, naturally, will consider all the matters raised in the Select Committee report, the speeches that are made in this debate and any other feedback that I receive.

In conclusion, the Select Committee report recommended that in any future Bill a clear distinction should be drawn between assisted dying and voluntary euthanasia. Having discussed this recommendation with seven of the 13 members of the committee—a majority—I established that all seven would support the principle of a Bill which limited its application to assisted suicide where the patient takes responsibility for the final stage of ending his or her life. Extrapolating from experience in Oregon, that would be likely to result

in about 650 deaths a year. Accordingly, I am minded to recast the new Bill to provide only for assisted dying. I will make a final decision after considering what is said in this debate.

Lord Carter: My Lords, I congratulate the noble and learned Lord, Lord Mackay of Clashfern, and the Select Committee on an excellent report. Having served on four Select Committees examining Bills—chairing two of them, including the Joint Select Committee on the draft Mental Capacity Bill—I know how hard it is to keep to the terms of reference, which is the Bill itself, and to examine the principles of the issue. The committee did that admirably.

Your Lordships will have seen the briefing from the leaders of the British faith communities. But the "sanctity of life argument"—perhaps I may call it that—is not my reason for opposing this legislation. As legislators our religious beliefs are bound to inform our deliberations, but our overriding concern and responsibility should be to consider the best interests of society as a whole; that is, for those with religious beliefs and those without.

In 1990, according to one survey, 35 per cent of people surveyed thought that there was always a clear distinction between right and wrong. By 2000, that figure had shrunk to 20 per cent with 75 per cent believing the exact opposite; namely, that there can never be universal standards of what is right and wrong because each judgment must always depend on circumstances. We live in a pluralist society and we must legislate accordingly.

My reason for believing that this legislation would not be in the best interests of society is based on a genuine concern about the fundamental change in attitudes and belief regarding the end of life that I am convinced would result from a change in the law. In the real world, end-of-life decisions would inevitably move from the moral to the utilitarian.

If the law changed, the extent or compass of euthanasia would change. The noble Lord, Lord Joffe, and others have made it clear that this Bill is only a first stage. The logical extension of the argument can be found in Appendix 6 of the report, which is the Euthanasia Statement of the Dutch NVVE. It sets out the Criterion for requesting euthanasia. The medical conditions that would come within the Criterion are quadriplegia, dementia, blindness and/or deafness, motor neurone disease, multiple sclerosis and other crippling but non-terminal conditions. I am not exaggerating when I say that there are many older and disabled people who are genuinely fearful of the change in the attitude of society towards them if assisted dying is legalised.

One aspect of disability is rarely mentioned. There is an unspoken fear, except to each other, among parents of disabled children, whatever the age of the children may be. They ask, "What will happen if we die first? Who will take life and death decisions if we are not there?". Last week, at the RADAR conference which debated assisted dying, one mother described the concern expressed by her son who had a progressive and terminal condition that stretched over 30 years until he died. He required 24-hour care for most of his life. When he died he was fully competent, but, for a long time, had been concerned about the burden that he placed on his parents. Of course, they were there to reassure him.

What would his attitude and that of those who cared for him have been if his parents had died first and assisted dying was an option? I know of one couple, both of whose disabled children died. Their only consolation was that their fear of dying first had been removed.

I turn to what may seem to be a technical point, but is very important. The noble Lord, Lord Joffe, has indicated that he would amend his Bill to exclude Scotland. This would raise

exactly the same dilemma that faced the Government when considering whether abortion should be a reserved or devolved matter in the Scotland Act. It was reserved to the Westminster Parliament on the ground that it would not be in the best interests of society to have different regimes for abortion in the two countries. The same argument applies to euthanasia. We have heard of suicide tourists to Switzerland. I imagine that we would not wish to have suicide tourists crossing Hadrian's Wall.

The Select Committee received a vast amount of evidence, but if time allows me to quote from only one submission, it should be that of the National Group of Palliative Nurse Consultants at pages 85 and 88 of Volume III:

"It is well known in the caring professions that nurses, not doctors are the clinicians who look after patients as they die. There is absolutely no recognition of this in the Bill . . . We firmly believe that the law needs no change to allow for euthanasia or any form of therapeutic killing to meet the needs of people approaching the end of their natural life. It is our view that no suffering is unamenable to relief when a patient and family and expert practitioners work together to tackle its complexities. It is our opinion, based on many years of clinical and personal experience that this Bill is fundamentally flawed and sets a dangerous precedent.

That is the opinion of professionals who, unlike most of us, spend their working lives helping the terminally ill.

In conclusion, I have one important question about the progress of the Bill that I wish to put to the Minister and about which I have given him notice. We all know that Private Member's Bills which start out this House have no chance in practical terms of reaching the statute book unless the Government co-operate over the allocation of time when the Bill reaches the Commons. If the Bill the noble Lord, Lord Joffe, intends to introduce is agreed to by this House—and that is by no means certain—and it does reach the Commons, will the Government help to find time for it there? I am sure that noble Lords will agree that the attitude to the Bill of this House as it passes through its various stages would certainly be influenced by knowing whether, to put it bluntly, it is going nowhere or whether it has a chance of reaching the statute book.

Baroness Thomas of Walliswood: My Lords, I start by paying tribute to our chairman, the noble and learned Lord, Lord Mackay of Clashfern, whose qualities of sagacity and discretion combined with the saving grace of humour are well known to this House. I do not believe that we could have had a better leader when considering this difficult and controversial subject.

I came to the work of the committee as one who generally supports the objectives of the Bill, a point of view I acquired—if that is the right word—from my mother, who was born in 1909. I mention that merely to indicate that the ideas set out in this Bill are not new. I should like also to draw attention to the support for some of the ideas in the Bill of the noble Lord, Lord Joffe, expressed outside Parliament. That is in sharp contrast to the views within Parliament, particularly in the House of Commons. While our chairman has highlighted the less than ideal sophistication of some of the polling methods used, nevertheless the general trend of opinion polls shows increasing support for the ideas set out in the Bill. Interestingly, 47 per cent of people might be prepared to break the current law to assist a suffering terminally ill patient to die. Over recent years, sentences in the courts seem to show understanding of the difficult choices which some people have faced in this respect.

Turning to opinion within the medical profession, it is clear that support for some form of assisting terminally ill patients to die has risen over past years among both nurses and doctors. The attitude expressed to us by the BMA in its evidence was neutral on the grounds that it was for society as a whole to determine such matters. Obviously it recognised the difficulties that such legislation might pose for some professionals, in particular those frequently involved in end-of-life care. Any new Bill would need to provide a watertight conscience clause.

The Royal College of Nursing gave evidence against the Bill but it is fair to say that this approach may have represented the feelings of the council rather than of the membership as a whole. An independent survey of nurses by the *Nursing Times* in 2003 showed that two-thirds of nurses supported a change in the law.

One of the aspects of the Bill—to which the noble Lord, Lord Carter, referred—which I found unsatisfactory was the lack of attention paid to the of nurses in end-of-life care. Their role might need more recognition in a new Bill. The evidence from Oregon and the Netherlands does not suggest that nurse-patient relationships have been damaged or changed by legislation in those countries.

My third point is the apparent conflict—at least for some—between palliative care and the approach taken by the noble Lord, Lord Joffe, in his Bill. I am aware that the noble Baroness, Lady Finlay of Llandaff, a distinguished practitioner and teacher of palliative care—who, I believe, follows me in today's debate—may well express different views, but I can see no such conflict, and nor do we find evidence of it elsewhere. It may be that palliative care is less well developed in Holland than in the United Kingdom—that may be connected to the fact that most people there die in the care of their GP—but Dutch doctors are certainly working hard to acquire palliative care skills. Meanwhile a most welcome development in the UK is the increased training of GPs in end-of-life care of their patients. A wide spectrum of alternative treatments is highly desirable.

Fourthly, I want to address the frequently expressed fear that any legislation along the lines of the Bill of the noble Lord, Lord Joffe, would be a danger to disabled people or to those who might think they ought to die so as not to be a burden on their families. Again, I think that the case is quite the contrary. Evidence given to us suggests that some severely disabled people who need to go into hospital already fear that doctors may assume, for example, that the disabled person would not want to be resuscitated in the operating theatre—a totally unfounded assumption made in a lordly fashion on behalf of patients—whereas the whole point of these proposals is that it is the patient who decides these matters, not the doctors or the families, who are excluded by the Bill from playing any part in the process which might lead to assisted suicide or voluntary euthanasia.

That leads me to my next point—namely, the character of those who seem to choose to take advantage of legislation giving patients choice in the manner and timing of their death. They tend to be people who have always exercised a high degree of choice in their manner of life and wish to do the same in respect of their manner of death, particularly where death by self-administered medication is involved. It pains me to be at odds with the right reverend Prelate the Bishop of Oxford, speaking on this point this morning, but in a secular society people of all walks of life value the freedom to choose how they live their lives. Apparently they are also willing to grant to others, or to claim for themselves, the same freedom to end those lives if they become intolerable by reason of terminal illness or unbearable pain. After all, suicide is not a crime.

My last point is a simple one. The Bill considered by the committee forces no one who disapproves of it to take advantage of it. Experience elsewhere suggests that not many people would take advantage, but it does give some people in specified and desperate circumstances the freedom to choose to die, even if they are not able to commit suicide unassisted. I hope that the House agrees the Motion before us today and that, in due course, we may return to debate a new Bill which will change the law. I would prefer that the Bill contain provision for both assisted suicide and voluntary euthanasia, if only to test the opinion of the House of Commons and to make it think as hard as we have thought on these matters. It is time for Parliament to face up to these issues.

Baroness Finlay of Llandaff: My Lords, I had the honour to serve on the Select Committee. Those pressing to change the law tell us that what they euphemistically call "assisted dying" encourages the development of good palliative care. Let us look at that claim. One of the many letters I received during the course of our inquiry was from two consultants, who described a 31 year-old woman, living in Holland, with an advanced cervical cancer.

She chose to return home to Newcastle because, she told them, she was being offered euthanasia on every doctor's ward round, like a treatment option, and had felt pressured to accept the offer. In Newcastle, they dealt with her problems of pain and incontinence, and she was able to spend several weeks with her three-year-old son before dying peacefully from her illness.

The evidence that our committee heard in Holland illustrates their lack of specialist palliative care. We heard that 84 per cent of those requesting euthanasia are in pain, and 70 per cent have difficulty breathing—not good palliative care by any standards. One in 32 dies by such means there, not the small numbers of which the noble Lord, Lord Joffe, has spoken. Volume III of our report has evidence from Dutch physician Bert Keizer, who wrote:

"I would rather die in a country where euthanasia is forbidden but where doctors do know how to look after a dying patient in a humane manner than I would in a country where palliative medicine is ignored but euthanasia can be easily arranged".

And increasingly, Dutch doctors feel that economic measures in healthcare will increase the pressures on physicians to provide assistance in dying.

But what about Oregon? As in Holland, palliative care in Oregon is not an accredited medical specialty. Last year, the *Journal of Palliative Medicine* reported that, after seven years of legalised assistance with suicide, palliative care in Oregon for people in the final week of life had actually worsened. Three years ago, another report on end-of-life care in the US found that less than 20 per cent of Oregon hospitals had palliative care programmes, and it gave Oregon a Grade E for end-of-life care. However, we are being told that Oregon is the model to follow, and that the take-up rate of assisted suicide is small. Well, every annual report into the working of the law by the Oregon health department has the caveat:

"Our numbers are based on a reporting system for terminally ill patients who legally receive prescriptions for lethal medications and do not include patients and physicians who may act outside the [law]".

Its annual report data are based entirely on interviews with prescribing physicians. In 1999—two years after the legislation—it candidly admitted that,

"the entire account could have been a cock and bull story. We assume, however, that physicians were their usual careful and accurate selves".

The report ends with an interesting warning:

"Again we remind all our physician readers that prescriptions written under the Death with Dignity Act must be reported".

All this was clarified in a letter I have received in the past few days from the Oregon health department, confirming that,

"there is no central register of prescriptions written by doctors in Oregon".

It goes on to say that the Oregon health department,

"would not be able to detect a prescription written for physician-assisted suicide but not reported to us".

The latest Oregon health department report confirms that the percentage of patients referred to a specialist for psychological evaluation has declined from 31 per cent in 1998 to only 5 per cent now. Yet excluding depression, which occurs in more than one in five such patients, is key to assessing competence. And Oregon's data indicate "doctor shopping". More than two-thirds of patients changed their doctor to get a lethal prescription written, so the doctor writing the prescription knew little about them beyond the case notes.

Why do people seek death? Overwhelmingly, people who ask to die are confused, depressed, feel that they are a burden, feel unconnected to the world around them, and are fearful. The great majority of ill people go through this as they grieve for their health and the life they used to have. I have had the honour of caring for many thousands of such patients, but the present law protects them from harming themselves.

Even the most determined can have a change of heart. In 1991, a GP referred a young dying man to me, asking for help because the man only wanted euthanasia; he was refusing all care and his GP did not know what to do. With a prognosis of weeks, he was desperate to die, but pain and immobility gradually improved. Ten years later his wife died of pancreatic cancer, leaving him lone parent of their three children. Now he says to me, "Ilorra, don't go there. I cannot bear to think what would have happened to my kids if I had been able to have euthanasia". But he fulfilled every criterion of every assisted dying Bill I have ever seen, and there is no doubt that he would have gone ahead with it.

Palliative care is advancing rapidly. New drugs are emerging, as are better ways of using the ones we have. Doctors who care day in, day out for dying patients know that, whatever was the case 30 years ago, you no longer need to kill the patient to kill the pain.

Let us be crystal clear about what "assisted dying" really involves. It is not giving a little more morphine or sedative so the patient can relax and let go of life. No, it is a massive overdose of barbiturates—50 times the therapeutic dose—and, in the case of euthanasia, the Dutch protocol advises an injection of curare to paralyse the patient completely to prevent breathing. Where the overdose is taken by mouth, as in Oregon's assisted suicides, those who ingest it sometimes do not die for more than 30 hours and a few even wake up again.

This is a Rubicon that we must not cross. When I was a newly qualified doctor, I thought that we should allow euthanasia, but now I am certain that even physician-assisted suicide is too dangerous to adopt and that the words of the Hippocratic Oath are as true today as they ever were. They state:

"I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect"

Baroness Jay of Paddington: My Lords, I have been passed a note which states that the list of speakers has been changed. With the permission of the House, I shall therefore speak now instead of my noble friend.

It was a great privilege to serve on the committee under the absolutely exemplary chairmanship of the noble and learned Lord, Lord Mackay of Clashfern. His leadership enabled us to produce this unanimous report and to reintroduce the subject of assisted dying into this new Parliament. As has been said, everybody who served on the committee learned a great deal from our extensive inquiries. I found it an enormously educative experience. I remind the House that I was a member of the previous committee, which, 10 years ago, recommended that the legal prohibition of assisted dying should remain. However, I have been convinced both by the ethical arguments of personal autonomy and by the practical issues of patient choice in 21st-century medicine to change my mind. I now believe very strongly that the law must change.

In the brief time allotted to us all today, we are bound to make points about a complex subject in headline terms. My first headline is that it is extremely important for Parliament to listen to public opinion. After all, this is a difficult legal and ethical issue, but everyone has personal experience of death and of dying. Polling evidence can always be challenged, but no responsible survey that I have seen has shown less than 70 per cent support for a change in the law. Would it be that many of the measures which we pass in this House had that level of approbation.

I remind the House of what was said by the noble and learned Lord, Lord Mackay of Clashfern. He said:

"A key finding of the committee was that while the most careful account must be taken of expert evidence—

I bow to no one in my respect for the position of the noble Baroness, Lady Finlay of Llandaff, and of the other doctors we have listened to—

"at the end of the day, the acceptability of assisted suicide or voluntary euthanasia is an issue for society to decide through its legislators in Parliament".

Expert medical evidence quite rightly played a large part in our inquiries and medical opinion appears to be changing. One eminent doctor who gave us evidence told us that he hoped that opposition to the Bill of the noble Lord, Lord Joffe,

"wouldn't become the last bastion of medical paternalism in this country".

I shall briefly address some of the concerns of palliative care which the noble Baroness, Lady Finlay, has just raised. I believe that doctors in her specialty remain more adamantly opposed

to the change in the law than many of their colleagues. I shall précis their arguments, again in headline terms. They argue—and the noble Baroness argued this most articulately throughout our hearings—that their specialist services can solve all the concerns of a dying person and therefore remove the need for assisted suicide or voluntary euthanasia.

Like the noble Baroness, Lady Thomas, I see no dichotomy at all between supporting, extending and improving every type of palliative care and supporting the Bill of the noble Lord, Lord Joffe. As a health Minister and through my very long associations with the National Health Service, I have always supported the hospice movement and palliative care in all its forms, but this is not an either/or question.

One of the most telling lessons we learnt as a Select Committee was that for some terminally ill patients—and we should not argue on the basis of particular anecdotes—palliative care, however expertly given, is just not the solution. For such people, who are probably always in a minority and perhaps a small minority, the loss of independence, control and dignity—which is what one might call a much more existential form of suffering—is what makes them seek assisted suicide. We saw that vividly illustrated during our visit to the state of Oregon; personally, I would hope that our legislation would closely follow the Oregon Death with Dignity Act rather than the experience in the Netherlands. A recent research report, written by our committee's special adviser, Dr Farsides, noted:

"There was nothing to suggest that the Act had had a detrimental effect on end-of-life care . . . it would appear that change has taken place in parallel to concerted efforts . . . to care for dying patients".

So in practice it is not an either/or situation.

Also in her review, Dr Farsides noted that there was no evidence of the so-called slippery slope—the increased demand made by the availability of assisted suicide in Oregon. Since the legislation for physician-assisted suicide, the numbers of people using the provisions of the Act has remained stable and small for eight years.

I give a final headline. The experience of Oregon shows that far more people ask for a lethal prescription than actually use it. For many, it is seen as a comforting insurance policy against unbearable suffering. Most importantly, it gives the patient ultimate personal control over when and how they die—over the end-of-life decision. In our very civilised secular society, I do not believe that we can deny that final right to our citizens. This Government have a proud record in social policy of extending and improving human rights. The Select Committee has indicated a clear way forward. A new Bill, to be introduced by the noble Lord, Lord Joffe, can provide an historic opportunity to add to that record. I follow my noble friend Lord Carter in asking the Minister to receive this report favourably and for the Government to give the Bill a fair wind.

Lord Patten: My Lords, I have four main points to make. First, if a Bill such as the one proposed by the noble Lord, Lord Joffe, were to pass into law, in future years it would come to be viewed as an event rather like the discovery of nuclear power when used for weapons of mass destruction, or the passage of legislation that made abortion possible. In other words, we are in the foothills of one of history's possible "no turning back" moments, if we proceed down the route that the noble Lord wishes to take.

Your Lordships will well remember the arguments when the Abortion Bill 1967, known as the Steel Bill, was first debated in another place—that it would affect very few people, that there would be very strict conditions, and so on. The exact opposite has turned out to be the case, with more than 5 million deaths of pre-born children since 1967. So, too, the arguments in Holland and Oregon over euthanasia and assisted dying have run. Once the laws have been passed, contrary to the stated aims of those legislators when the legislation was debated, the recognised duration of terminal illness has been unofficially extended, according to evidence of which I have been made aware. New reasons, such as dependency or isolation, have been introduced and then accepted as reasons for legitimately offering people the opportunity to hasten their own death.

The problem with the Bill proposed by the noble Lord, Lord Joffe, as the noble Baroness, Lady Finlay, reminded me on a previous occasion, is that it assumes that if strict conditions are prescribed, they will be followed in practice. Good law-making cannot assume that people will behave according to the prescription of the rubric of the law so that the vulnerable will be protected. As the organisation RADAR put it succinctly in its briefing for this debate:

"Without protection, people cannot exercise true autonomy".

I say "hear, hear" to that.

That brings me to my second point. The proposals in this Bill are not only concerned with private morality or utilitarian matters but are matters for the wider community. A positive choice sometimes has to be made in favour of protecting the interests of our most vulnerable members, even if that means limiting the freedom of others to determine our end. As your Lordships know, I am one of the simpler sorts of Peer; I make no claim to be a philosopher, although I am broadminded enough to have had philosophers among my circle of friends in the past and at present. We all know that, beat the thickets of philosophy well and hard, and it can be guaranteed that out will pop some hedgerow philosopher, willing to grease any slippery slope that your Lordships care to name. However, I have yet to find one philosopher—if they are present, perhaps they will stand up; I would be happy to way—who does not recognise that the exercise of personal autonomy always has to be limited, if only to some extent, to enable us to live together in reasonable harmony.

Baroness O'Neill of Bengarve: My Lords—

Lord Patten: My Lords, I should not have said it.

Baroness O'Neill of Bengarve: My Lords, I do not need to make the point.

Lord Patten: My Lords, I think that His Holiness Pope Benedict rather makes the right point when he warns against the dictatorship of relativism. I warn the noble Lord, Lord Joffe, that he may be mistaken if he tries to corral those who do not care for his Bill as being just a few religious persons and the leadership of the Churches. I have one very close friend—I wish that I had asked his permission to quote him today—who I can describe only as a High Church atheist, so passionate is his disbelief in God, who feels exactly the same as many people who do not care for the Bill of the noble Lord, Lord Joffe.

That brings me to my third point, which is the need not to destroy our trust in the medical profession, for patient autonomy can oh so quickly give way to medical and to state power. I trust my medical advisers, at least at present. I think that they will never harm me and that

they will do their best, although, of course, everyone is fallible and mistakes can be made. However, that trust comes about not because of my belief that doctors have some superior moral quality but because of their tradition of doing no harm, held by those of faith and of no faith. In the face of that, and with great respect to the Select Committee, I would have wished that the committee, which quite properly considered the conscientious objections of doctors and nurses, had addressed the conscientious objections of patients and the rights of patients to know about the attitudes of their doctors. That is an oversight. Should the Bill of the noble Lord, Lord Joffe, reach the statute book in some form, we would *de facto* have to make provision for patients who wished to know what kind of doctor was going to treat them: a doctor who cared to preserve life and a doctor who, in shorthand—or in "headline terms", to borrow the excellent phrase of the noble Baroness, Lady Jay—was really a "vet" doctor prepared to take part in the end of life. There would need to be separate training, and separate registers of the two classes of doctors would have to be made public. The Select Committee might have usefully considered a little more the pragmatic and conscientious feelings of patients themselves as well as those of doctors.

Fourthly, should a Bill like that of the noble Lord, Lord Joffe, ever see the light of the statute book, it surely cries out for a sunset clause after five years, or whenever. If there was ever such a case, it is this Bill.

Finally, I admire no one more than the long-running Minister who will reply to the debate at about midnight. I have a couple of questions for him, as I have sensed a certain amount of news management in the air from sources quite close to sources that are close to government saying that, should a Bill like that of the noble Lord, Lord Joffe, come forward, the Government are minded to give it government time. I should like the Minister to say specifically what the Government's intentions are in this matter. I am hopeful that he will answer that question. If his answer is that the Government intend to give the Bill time, I ask him and his colleagues to pause, first, because I think that it would cause amazement among the public that a government led by the right honourable gentleman the Prime Minister—this particular Prime Minister—should go down that route and, secondly—I hasten to add that I myself make no accusations in this regard—that it will raise fears among many that extending government time for this Bill means that the Government wish to save money on the National Health Service in future months and years if it becomes law. I do not know that that is the case and I am not suggesting that it is, but those arguments will run. The Minister can set those arguments to lie now or later in his winding-up speech, if he wishes.

Lord Russell-Johnston: My Lords, my views are not the same as those of the noble Lord, Lord Patten. The substance of the argument was made in the debate on 6 June 2003, to which I made a brief contribution. I do not believe that that substance has been diluted by the Select Committee report, which was so well and so fairly chaired by the noble and learned Lord, Lord Mackay of Clashfern. In the short time that I have, I shall inform the House about a debate on a report on this subject held in the Parliamentary Assembly of the Council of Europe on 27 April. I shall use the words of others to express my opinion.

The Council of Europe report was presented by a Swiss called Dick Marty. It did not recommend euthanasia, but recommended that in all member states a debate should be opened to consider how best to approach a very real, deep problem, which at the moment in most countries is unregulated or covered up. The *rapporteur* said that he was especially pleased that his report was supported by the international committee of nursing staff in the European Union.

First, I quote my liberal Dutch colleague, Dick Dees. He said:

"There are many arguments to support Mr Marty's report and recommendations. Evidence-based scientific studies prove that euthanasia and other end-of-life decisions are practised in many, if not all, countries. In *The Lancet*, a study of the position in six European countries confirms that doctors' assistance to patients at the end of life is practised in all of them, including those where it is currently illegal. One of the study's most important conclusions is that a natural dying process occurs in only one third of all death cases. The proportion of deaths that were preceded by medical end-of-life decisions ranged between 23 per cent in Italy to 51 per cent in Switzerland. A scientific study in Australia shows the same picture as Europe".

Secondly, I should like to quote another Dutchman—this time not a liberal—Erik Jurgens.

Baroness Knight of Collingtree: My Lords, while the noble Lord is talking about that particular debate, he should tell the House that the Council of Europe turned down the Marty report.
Lord Russell-Johnston: My Lords, I shall come to that. Noble Lords might like to know that those opposing the report put down 50 amendments about two days beforehand as a blocking measure, the like of which had never been seen before. I am quoting from Erik Jurgens, who said:

"I am a social democrat, but also a Catholic and a strong supporter of the hospice movement in my country. I therefore voted in favour of the law that has been criticised today by quite a few speakers. The report by Dick Marty is eminently reasonable. Why? Because he asks that public debate be fostered".

How can anybody be against such a thing? I now understand a bit better. In the view of many religious people, it is simply a sin; it is wrong, and we cannot discuss the pros and cons of that which is fundamentally wrong. I do not believe that faith concepts should be imposed on those who do not share them. That was epitomised by the circular letter from leaders, which has already been referred to. Erik also made an important second point:

"The European Convention is saying that the right to life should be protected by law, but that in no way puts any barrier to the two other ethical principles involved. One is compassion. I call on my Christian colleagues here: compassion for fellow human beings is the very basis of Christian values. That is what is involved today—compassion for a suffering human being who is terminally ill, but wants to die in dignity. The second value is the right to personal autonomy and self-determination. They are both ethical values of at least equal worth to the right to life".

I had a letter that I intended to read to the House, but somehow I mislaid it. It was from a young woman in her late twenties. I hope that perhaps she will read this and write to me again. It was such a sad letter. She suffers pain, misery and indignity, and there is no cure or palliative.

Erik Jurgens, my socialist friend, asked the Christians to show compassion. Muslims have signed the letter too; perhaps they should direct their attention to the practice of honour killing, which kills thousands of young, healthy women all over the world. According to the Metropolitan Police, it killed about 100 in London last year. They are people who want to live and find happiness.

I congratulate the noble Lord, Lord Joffe, on his initiative in raising this question. I assure him that, if in time he introduces a Bill—I hope that he does—I will certainly support it.

The Lord Bishop of St Albans: My Lords, I had the privilege of being a member of the Select Committee and, with other members, I put on record my gratitude, particularly to the noble and learned Lord, Lord Mackay of Clashfern, who chaired us with remarkable and judicious fairness and wise good humour. As a committee, we were all agreed about one thing—that no one should suffer unbearably. We all recognised that, in circumstances where someone is suffering unbearably towards the end of their life, we would want medicine to intervene. But it was at that point that some of us parted company.

I cannot go so far as the noble Lord, Lord Joffe, and the Bill would wish. Why not? Because I believe that the philosophical basis for the legislation is profoundly flawed. It is based on the notion that the exercise of personal autonomy is the highest moral good. However, a moment's thought will reveal that the exercise of personal choice is not what gives life value. What gives life the highest value is being in a relationship of love with another person, and one's family, children, grandchildren, friends and neighbours. All those songs about love through the centuries, from the Song of Songs to the winsome songs of Kylie Minogue, exist because they are a celebration of what life is all about. Apart from Frank Sinatra's "My Way", and nothing could be more kitsch or self-centred, when did you last hear a song or read a poem about the joys and importance of personal autonomy?

What is the personal autonomy demanded in the debate? It runs in a very curious syllogistic form: "One—medicine exists to cure illness and relieve suffering. Two—I am ill and suffering, and have personal rights. Three—therefore, I demand the right to demand that purveyors of medicine kill me". But that argument has very serious holes in it. First, you can give the patient that right only by then infringing the rights of doctors. As we have already heard, it is no answer to say that any law would contain a conscience clause whereby physicians would opt out; just mention the Abortion Act 1967. Yes, a minority of doctors would be prepared to carry out euthanasia, but the great majority—especially those actively involved in care of the dying—do not want it foisted on them. Imagine, if the Bill went through, that you were terminally ill and in hospital. The first caller comes round with a little sheet and says, "Do you want cornflakes or porridge?". The next caller is your physician, who would be required, if logic has anything to do with it, to offer you a series of options—palliative care, euthanasia or assisted suicide. Just thinking about it is chilling. To call that a therapeutic option, as some proponents have done, is to see language and values twisted out of all recognition.

Secondly, there are the rights of other terminally ill people to be considered. It is simply naive to suggest that, because any law would allow assisted suicide or euthanasia for volunteers only, that is what would happen in practice. In those circumstances, who is a volunteer? The figures from Holland really should give us considerable pause. We need to think, therefore, of the autonomous rights of those who do not wish to go down that route. Perhaps I may, *en passant*, deal with this public opinion argument. I have not noticed that Parliament is rushing to fulfil public opinion's desire that capital punishment should be back on the statute book. If not that, why this? It seems to be special pleading.

Thirdly, whose autonomy would be exercised here? If you imagine someone, as we leave this Chamber, about to jump off Westminster Bridge, would we not all automatically seek to prevent them doing so? Then we would all be intervening, and rightly so. But what about the patient who wants to commit suicide and we agree to that? Surely, we are making a value

judgment between two people who are suicidal. We are saying to the person who wants to jump off the bridge, "Your life is of enormous value", but to the one that does not, "Actually, we agree with you". The minute you say that, you are then influencing their autonomous decision.

A story in the scriptures has shaped the civilisation of our country ever since it was first heard. It is the story of Cain and Abel. As your Lordships will know, after Cain killed Abel, the Lord asked Cain, "Where is your brother Abel?". Cain replied, "I do not know. Am I my brother's keeper?". I do not want that question to be swept aside as describing only those who take "a minority religious view", because that is not just. The answer to that question has shaped our society and it challenges every generation. Because we have recognised the authentic moral force of that question, we have answered it with a resounding, "Yes, I am my brother's keeper". If we allow this Bill to proceed, we shall overturn one of the most cherished and profound values by which we as individuals and a society have lived and ought to live in the future.

5.4 pm

Debate resumed.

Baroness David: My Lords, I congratulate the noble and learned Lord, Lord Mackay of Clashfern, and his committee on producing an excellent report. It is a very thorough report and very helpful to all of us who understand the difficulties inherent in the subject. Nevertheless, it seems to come down fairly strongly in wanting the Bill of the noble Lord, Lord Joffe, to be reintroduced into the House this autumn and for it to go to a Committee of the Whole House with the safeguards and amendments that the noble Lord, Lord Joffe, has agreed to make. I hope that the Bill will go through and finally become law. I have been a member of the Voluntary Euthanasia Society for a long time. I am delighted that, at its AGM in November, it will vote for a change of name to Dignity in Dying, removing the word "euthanasia", which tends to alarm people. My proxy vote is already in. Compassion for those who are terminally ill seems of primary importance.

I strongly believe in personal autonomy and the right of individuals to decide when and how they die. As somebody aged 92, I think it is patronising for opponents of the Bill to suggest that elderly people are unable to make informed decisions about their lives, as the noble Baroness, Lady Thomas, has said. If I were terminally ill, I believe that I would be the only person with the right to decide how I die and whether I preferred palliative care to assisted dying. It would provide me with an additional option on how to end my life, which I would find tremendously reassuring, whether or not, in the end, I decided to exercise that option.

I note that in paragraph 52, a consultant in palliative care, on the basis of his own experience, felt that patients requesting assistance to end their lives tended to be people who wished to be in control—people who are not willing, or prepared, to engage the issues that may underlie the problems that arise. I resent that, although I have to admit that some of my children sometimes refer to me as a control freak.

The Earl of Arran: My Lords, I, too, express my appreciation for the manner in which my noble and learned friend Lord Mackay so skilfully led our very lengthy consideration of this highly difficult issue. His Scottish canniness in retaining his neutrality as chairman was quite remarkable, while his diplomacy and sensitivity have helped to produce a report which should

ensure that the quality of debate, both inside and outside your Lordships' House, is greatly improved.

Death is not a pretty affair, and it was a most humbling experience, and a great privilege, to have been appointed to this Select Committee. I would like to say how impressed I was by the dignity and the compassion of the witnesses who came before us, both here and abroad.

My consideration of the Bill benefited greatly from travelling to Switzerland, the Netherlands and the state of Oregon in the USA. All those jurisdictions permit some form of assisted dying, and these visits enabled me to consider the concerns and proposed benefits of changing the law in the context of what happens in practice. While the models used in the first two countries seem to be working satisfactorily, the system used in Oregon impressed me the most, and I intend to concentrate on their experience.

The law emerged as a result of a people's initiative in 1994, and is similar to that set out in the Bill of the noble Lord, Lord Joffe, with the exception of not allowing voluntary euthanasia for those unable to ingest the medication. The legislation has been in force for seven years and the take-up is very low. Only 208 terminally ill adults have taken the medication, which equates to 0.13 per cent of all deaths in the state. But a significant number of patients who were provided with the medication did not take it, and died of natural causes. However, as the noble Baroness, Lady Jay, said, the fact that they had it available and accordingly remained in control removed an enormous load. It gave them comfort and allowed them to come to terms with their impending death. As the committee noted, if the Oregon experience were replicated in the UK, on a pro rata calculation it would result in around 650 deaths per year.

Perhaps the most interesting information that we gained in Oregon was from Ann Jackson, the director of the Oregon Hospice Association, who was the primary spokesperson for the hospice movement there. She confirmed that the Oregon legislation had not adversely affected the hospice movement. In fact, since legislation, the number of Oregonians dying under hospice care had continued to increase. In 2003, all patients who were assisted to die were offered hospice care. Of those, 89 per cent were actually in hospice care and the rest had left or refused it.

Many of the negative predictions about what would happen when the legislation was passed, such as that patients who used it would be more likely to be the poor, the uneducated, the uninsured or depressed, had turned out to be unjustified. Furthermore, there was no abuse of the system. The committee held 10 sessions in Oregon at which evidence was given. In nine out of the 10 sessions, it was agreed that the system was working effectively and that there was no evidence of abuse or a slippery slope. This was the view, among others, of the Oregon Medical Association, the Oregon Board of Examiners—which is responsible for controlling the conduct of doctors—the Oregon Nursing Association and Oregon's equivalent of the Department of Health, as well as a number of researchers.

In only one session, comprising three doctors, a politician and a nurse, was evidence given against the legislation. However, when challenged, these witnesses were unable to explain why they had not taken up their concerns with the relevant authorities. Since our visit, one of these witnesses, Dr Kenneth Stevens, has made a presentation to Members of your Lordships' House. Unfortunately, he made a number of statements which are totally inconsistent with the evidence we heard from all of the reputable organisations to which I have just referred.

I also asked the chief operating officer of the Oregon Medical Association whether there were any common characteristics among the doctors who opposed the Oregon Act. He replied, "Yes. Dr Toffler"—who was one of the witnesses—

"is perhaps the most devoted religious Catholic I have ever known and I think it is fair to say that his abhorrence of not only physician-assisted suicide but abortion is based on that".

This was not uncommon. Opposition to the Bill was often based on strongly held religious beliefs, but these were not always explicitly stated. Your Lordships may be asking why, if assisted suicide has existed in for seven years, other states have not adopted it. Here it is interesting to note that Oregon has one of the lowest levels of church attendance in the USA. This would appear to be a key determinant of why this type of legislation has yet to be introduced in other states.

I would like to make one suggestion. A majority of the committee members who travelled to Oregon, as well as a majority of committee members more generally, thought that the Oregon model was working well. As a result, should the noble Lord, Lord Joffe, decide to reintroduce his Bill, he may like to consider amending it to reflect the Oregon Act even more closely by dropping his voluntary euthanasia provision.

It is my belief that society will, in its own time, eventually push such a Bill forward until the clamour for action becomes too great for Parliament to resist. Thus it was with homosexual reform and abortion, both of which at that time became unstoppable. When and if this happens with assisted suicide, it is essential that this House gets the Bill right and, above all, that we ensure that the safeguards are sensible, secure and workable.

In closing, I quote, very briefly, from one letter among so many from a gentleman with motor neurone disease. It states:

"It would be a great comfort to me . . . to know that if I reach a point where, having lost my dignity and control of my physical faculties and I cannot endure my illness any longer, I would be able to ask my doctor for help to die. Society appears to agree that patients like me should be given this fundamental choice and our laws should reflect this".

I suggest that that time is now approaching.

Lord Taverne: My Lords, perhaps I too may say what a pleasure it was to serve on the committee chaired by the noble and learned Lord, Lord Mackay of Clashfern, who presided over our proceedings with such skill, charm and fairness.

I accept the present inclination of the noble Lord, Lord Joffe, to promote assisted suicide only, but I want to put the case for euthanasia, based on the evidence we heard in the Netherlands. The Dutch experience is often referred to and often misrepresented. Indeed, I am not entirely satisfied that the summary of it in our report gives an altogether balanced picture, because, in trying to be as fair as possible in representing both sides, it perhaps gives undue weight to critical witnesses who are part of a small minority and did not reflect general opinion.

In the Netherlands, euthanasia has overwhelming support among the public and the medical profession. Dutch experience shows that there is no conflict with palliative care; it has in no

way undermined trust in doctors; there are fewer cases of involuntary euthanasia than in other countries; it has not led to a slippery slope; and there is not a shred of evidence of danger to vulnerable groups.

More than 90 per cent of the public and doctors in the Netherlands support the law. The official government study shows that 85 per cent of doctors believe that helping their patients to die improved the quality of their dying considerably. The noble Baroness, Lady Finlay, gave the example of one doctor who was vehemently opposed to the Dutch law. Of course there are doctors who are vehemently opposed to it, but it would be quite wrong to suggest that they were part of a majority opinion. There is no doubt of the overwhelming support of the Dutch medical profession for the law there as it stands.

On palliative care, the Dutch Ministry of Health and the Dutch Medical Association told us that, since the law came into force, interest in palliative care has grown and has led to a boom in the training of GPs and others. I refer to the passage in questions 1304 and 1396. The respondents saw no conflict. A Dutch palliative care consultant at a Catholic hospice told us that they were happy with the possibility of providing euthanasia in the hospice and added—Catholics and reverend Prelates please note:

"It does not create a conflict with our religious background".

On trust in doctors, in 2002 a BMJ survey of 11 European countries, including Britain, showed that trust in doctors is highest in the Netherlands. There is much more open discussion there of end-of-life decisions with patients and families—far more than in any other European country. The actual experience of the law in the Netherlands in no way upholds the contention that a change in the law would undermine the relationship between patient and doctor.

It is often mentioned that there are 1,000 cases in the Netherlands of active ending of life without explicit request, amounting to 0.7 per cent of all deaths. However, the available evidence suggests that involuntary euthanasia occurs much more frequently in countries without legislation. Professor van der Wal, the person who led the official study into the practice of euthanasia, told us that in the Netherlands there is no association between enacting the law and the number of cases of involuntary euthanasia; see question 1683. Indeed, his research showed that these were examples of alleviation of symptoms rather than deliberate ending of life—all of them cases of people who were incompetent and suffering severely. Doctors estimate that in 33 per cent of those cases, life was shortened by less than 24 hours, in 58 per cent by less than a week and in 6 per cent by less than six months.

Lastly, it is often alleged that changing the law leads to a slippery slope and endangers vulnerable groups. The Dutch evidence explodes those myths. There has been no significant increase in the number of cases since the law was passed. One of the witnesses, a hospice director who opposes the law, agreed that there was no evidence of growing laxity in the use of the rules. Here, he said, there is no slippery slope; see question 1510. Of course, it is somehow alleged that the Netherlands does provide evidence of that, because there are now demands for a change in the law, but that is not what is normally meant by a slippery slope. There are always demands for a change in the law—some for making the law more restrictive and some for making it more relaxed. But that is not the same as the question about whether there is a laxity in the use of the rules. That is what is normally meant by a slippery slope. One witness, who conducted the official study, told us that there was no evidence that disabled groups were affected more than others. Indeed, most euthanasia cases in the

Netherlands do not involve the very old but relatively younger people; see questions 1664 and 1666.

To sum up, the evidence shows that in the Netherlands the law works well. It provides far more dignity in dying than we allow, and shows far greater humanity than we do towards those who experience unbearable suffering at the end of their lives. Unless one is obsessed with theological principle, that is surely what matters. When it comes to what we allow some people to suffer when they die—well, you would not do it to an animal.

Lord Patel: My Lords, I, too, thank the noble and learned Lord, Lord Mackay of Clashfern, for his outstanding chairmanship of the committee. It was a privilege and a pleasure to be a member of a committee chaired by him and an added pleasure to witness his incisive questioning of the witnesses. All the credit for what turned out to be a balanced report, despite the polarised views held by the members of the committee, goes to him, for it was not easy to get a consensus report. The noble and learned Lord achieved that, and I thank him for all his efforts.

As noble Lords are aware, I am a doctor, but I have witnessed thousands more first breaths of life than I have last breaths of life. My experience of dealing with patients at end of life is limited, and I draw my conclusions from evidence as presented to the committee—unbiased.

During the months of the committee's deliberations, we heard from many doctors, as representatives of professional organisations and as individuals, generalists and specialists. Subsequent to the publication of the report, I also wrote to the presidents of all the Royal Colleges and faculties in the United Kingdom to seek their views on the report.

Assisted dying is an issue that increasingly divides the profession, and the views of the professional organisations seem to change. The British Medical Association opposed any change in the law when its representatives gave evidence to the committee, but more recently it has changed its mind and now holds a neutral position, feeling that it is for society and Parliament to decide, as do many of the Royal Colleges, including the Royal College of Physicians of England, the Royal College of Surgeons, London, and the Royal College of Psychiatrists, to name but a few. On the other hand, the Royal College of General Practitioners now opposes any change in the law, in contrast to the view expressed by its representatives when they gave evidence to the committee.

The greatest opposition comes from some of the doctors more closely involved with the care of patients near the end of life. We do not have the results of surveys carried out involving all the doctors in the United Kingdom to be able to know the views individual doctors, particularly on clearly defined legislation. All we can say for now is that the views of the profession on assisted dying are divided. Although the medical profession is divided on the issue, there is wide consensus that any change in the law must be accompanied by wider availability of good quality palliative care, strong safeguards in the legislation for patients, training and support for health professionals, a robust monitoring of the law and clear conscientious objection clauses, all of which I would strongly support.

I agree with the view expressed in the report that at the end of the day the acceptability or otherwise of a change in the law on assisted dying is a matter for society as a whole to decide and not for any groups of health professionals. I do not, however, believe that the implementation of any change in the law could be placed outside the current system of

mainstream healthcare. I say that because of the strong doctor/patient relationship that exists in our healthcare.

In a previous debate on the original Bill introduced by the noble Lord, Lord Joffe, I said that I could not see myself supporting any change in the law, although I recognised that the medical view was divided. My main concern then was how any change in the law would affect vulnerable groups such as the elderly, the disabled and others. During the deliberations of the committee, we heard from many individuals and organisations representing so-called vulnerable groups, and again their views were divided.

Although I was not there to listen to the evidence, I refer to the views expressed in the light of their experience by Professor Raymond Tallis, a respected geriatrician and an ethicist, who gave evidence to the committee on two occasions; Dr David Cole, a clinical oncologist; and Dr Carole Dacombe, a medical director of St Peter's Hospice, an organisation providing hospice care to a wide community. They gave evidence to the committee regarding a small number of individuals for whom legislation related to assisted dying would be appropriate.

Dr Carol Dacombe described her experience,

"of consistently and persistently encountering a small number of patients who despite the whole range of services available to them . . . have felt a need to express a wish to see their life ended".

As she said, they are often people who have a long life history of seeking control over their own destiny and who do not find help and support—as most of us do—in faiths and spiritual concepts. They feel their suffering through illness to be unbearable and wish it to be ended.

All the evidence presented to us, including that from the state of Oregon, suggests that the number of individuals seeking such a course will be quite small. The evidence presented to the committee suggests support for a Bill limited in scope, much in line with death with dignity legislation—which would be a much better title than the one used in the Bill proposed by the noble Lord, Lord Joffe. It suggests support for a Bill as enacted in Oregon, with all the safeguards for individuals and robust monitoring of the law in place, allowing patients to take charge and decide for themselves. Such a Bill would have wider society and health professional support. At least it would allow for a debate that is more focused and confined to a tighter Bill.

Baroness Hayman: My Lords, many noble Lords have spoken of the quality of the chairmanship of the noble and learned Lord, Lord Mackay of Clashfern. I echo that which has already been said. It was a privilege to sit on the committee and a real education. Our thanks go to him and to all the staff who supported us.

Like the noble Lord, Lord Patel, when I joined the committee I was uncertain as to the way forward and whether to support the Bill and the provisions being put forward by the noble Lord, Lord Joffe. The reason for my doubt was that I did not have a fundamental, faith-based approach that gave a simple answer to this question, such as is manifested in much of the correspondence that we have received on the subject. If you simply believe that when you live or when you die is in the hands of someone else, it is not a matter of debate whether we should envisage legislation such as this Bill. If you do not believe that, and if you believe that living an ethical or moral life and trying to legislate in the best interests of society is often a

matter of justifying your inconsistencies rather than of total consistency, it is a difficult question.

I need no persuading that more people at the end of their life would be helped by improvements in palliative care and the availability of those services than would be helped by implementing the Bill as outlined by the noble Lord, Lord Joffe. But, like others who have spoken, I do not find those objectives irreconcilable. Nor is it impossible to believe that passionately; to campaign for it and be willing to work for it, and to understand that for most people their suffering—existential and physical—can be helped by excellent palliative care such as is being developed in this country. That is a given.

Equally, I cannot accept the assertion that has been made today in the Chamber that all suffering is amenable to relief. That was not the evidence that we received on the committee, either from patients or doctors. It is not the evidence that many of us have seen in our own lives among those for whom we have cared very deeply. Some suffering is not amenable to relief. Many professionals will accept that, even with the best palliative care.

Sometimes the perceptions of doctors and patients differ in that area. I always remember a lovely story about the late Queen Mother, who said that she had never appreciated the strength of the sense of humour that her orthopaedic surgeon demonstrated until she read, the day after she came round from an anaesthetic in hospital, his comments to the press that she was comfortable recovering from her operation. Doctors have to accept that people vary. My noble friend Lady David said that we should not say that all those seek such assistance are controlling personalities, as though that were in some way wrong. Some people find some parts of the symptoms and experience of dying more difficult to cope with than other people do. Some symptoms are more amenable to relief than others.

If we are to accept that that is so, I have to ask myself whether there is a greater danger, in moving the line a little so that those people could gain assistance, that we would prejudice more—that we would create greater harm in society. That was the issue on which the noble Lord, Lord Patel, has just spoke. Would we necessarily cause fear and concern that pressure would be put on patients to die? That was not the experience that we saw in any jurisdiction that we visited. In fact, we heard lots of evidence of families persuading people or trying to persuade people not to take that course of action, but that they in the end did.

I bored the committee rigid by constantly questioning whether we really were crossing a Rubicon if we changed to physician-assisted suicide. For me, the difference between physician-assisted and physician-administered suicide was not clear when I embarked on the matter and became much clearer later. It is important to the medical profession, and I could support one but not the other. From the perspective of a patient who wants to die, what is the difference—what is the Rubicon—between being able to say, "Turn off my life-support machine" and having that enacted, or being able to say, "I don't want to take this medication", and leaving an advance directive to say, "I don't want artificial hydration and nutrition"? From the perspective of the patient who wants to end their life prematurely, what is the difference in being able to say, "I want to do this in a considered, controlled way with the assistance of doctors, when I know that it is going to happen, so that I can say my farewells"? I could never answer that question satisfactorily. I could not see a great danger to society, so I support the sort of Bill that the noble Lord, Lord Joffe, intends to introduce.

Baroness Cumberlege: My Lords, in the past, medicine was simple, relatively ineffective and safe. Today it is very complicated, effective and potentially dangerous. We have moved

from the time when the family doctor, with great kindness, prepared us for the inevitable. Today, for many, the attitude is quite simply negligent. Curing what was thought to be incurable, successfully operating on the inoperable and striving to achieve what is still unachievable is considered a triumph of progress. But in the end we all die. This evening, we are being asked to consider whether it is right to terminate the lives of those people beyond the extremities of medical progress. Fortunately, we have the excellent report, which is not only beautifully written, but well researched and finely balanced. The skill, wisdom and integrity of the committee's chairman shine throughout.

The committee, through the evidence of the noble and learned Lord the Attorney-General, heard that the Director of Public Prosecutions, when asked whether he should in future publish prosecution guidelines, had decided not to do so but to consider each case on its merits. That values the individual and recognises that every life is different, so three cheers for the DPP. During the summer, at the invitation of the noble Baroness, Lady Finlay, I visited Velindre Hospital in Cardiff. It was one of the most memorable and inspiring days of my life. If ever there were a case for human cloning when it comes to palliative care, it is Professor Finlay. Sadly, I do not have the time to describe that visit and what I learnt. If I have a criticism of the committee, it is that it as a body did not take up the offer to visit a hospice. I am sure that for some it would have been enlightening, and might have modified their support for the Bill.

Once a year, I have the joy of presiding over the graduation ceremony of 100 newly qualified doctors. Those young people are some of the brightest in the land. They are well motivated, see medicine as a vocation and cannot wait to start their real work in healing, treating and curing patients. In unison they make a pledge—it is much too long to recite today; anyway, I did so when we debated the previous Bill. That pledge means a great deal to those aspiring young doctors and their tutors, friends and families—and to me—for it is their contract with society. But we are told, in the section on the outline to the Bill, that,

"medical staff who comply with the terms of the Bill [are] to be immune from both prosecution and breach of any professional oath or affirmation".

Are we to jettison so lightly oaths and affirmations? For some of us, they are important. They guide our lives, behaviours, marital status and thinking. Do the oaths and affirmations made by judges, magistrates, and your Lordships in this House mean nothing?

According to the Bill, an oath or affirmation is simply a matter of words—a mere trifle to be discarded. That underlines one of my deep concerns with the Bill, both in its intention and in its practicality; namely, that inconvenience is to be jettisoned. A life which is deemed inconvenient and to have no value is to be cut short, not by the individual, as is allowed by law, but by others—by physicians.

At the moment, I am chairing a working group at the invitation of the Royal College of Physicians to define the nature and role of medical professionalism in modern society. It is tough. Getting a definition has consumed hours of debate and discussion. We have ended up with a long description and a short definition which states that,

"medical professionalism signifies a set of values, behaviours and relationships that underpin the trust the public has in doctors".

Doctors recognise that it is only by maintaining trust that they can help people to ease their way out of this world with dignity, and their families to be free from anger and guilt. In the report, we are told that,

"the majority of letters received from doctors expressed serious reservations about the impact of the Bill".

They are right. They are, in common parlance, the fall guys—the people to shoulder the burden of the execution of any Bill. Of course a conscience clause is proposed that allows doctors to opt out. But how is a patient to know whether they are dealing with a doctor who has opted out or opted in? It is hardly an appropriate conversation to have at such a vulnerable time.

Finally, I return to the DPP's remarks. Here is a lawyer saying that each case must be taken on its merits—do not try to define what is indefinable. I believe that a law will cause many legal battles adding to confusion, anguish and distress. It will start surrounded with good intentions but will end up being a charter to be exploited by venal relatives, determined to take the waiting out of wanting. A Bill, however well intentioned, will cause more harm than good.

Lord Carlile of Berriew: My Lords, I, too, join in the applause for the chairman of the committee, the noble and learned Lord, Lord Mackay of Clashfern. His wisdom, his judgment and just occasionally his Scots instincts made possible a task that most of the rest of us would have found wholly impossible.

In the evidence before the Select Committee in this House and elsewhere, I have heard abundant repetition of a proposition—that death by choice somehow provides a more dignified end to life than death by the process of nature, a process which, of course, includes disease. To that proposition, I for one am unable to subscribe. I take that view not from any religious viewpoint—if anyone detects my religious viewpoint, would they please kindly let me know what it is, because I have been struggling to find it for the whole of my life. If I ever find it, it will probably be on my deathbed, if I am given the opportunity. My viewpoint on this matter is framed, to an extent, by 10 years' experience as a lay member of the General Medical Council—hardly a religious experience; possibly a paradigm utilitarian experience; certainly an experience which, if you were on the road to Damascus, would make you likely to turn off into the nearest service area.

My view is that a new law on this subject, whether it relates to voluntary euthanasia or assisted suicide, must achieve two ends if it is to stand the test of being a good law. First, it must have ethical integrity for any profession that is involved, whether they are doctors, lawyers or, possibly, a new profession of thanatologists—why should doctors be involved in this? Secondly, it must have legal certainty.

I turn to the first of those, ethical integrity. I do not believe that any ethical framework concerning voluntary euthanasia or assisted suicide could be accepted other than under the heading of "therapeutic benefit". Therapeutic benefit can be judged objectively. It commonly is judged objectively in the everyday work of doctors by their peers, and occasionally even the doctors will allow their therapeutic benefit to be judged by us, the patients. As between human and human, therapeutic benefit in carrying out death by a deliberate act can never be justified objectively if there is an alternative available. I have read all the evidence and I have listened to some of it. In every case—and I mean every case—there is a therapeutic alternative available. It may not be a perfect alternative, but there will be an alternative. I am

told that the alternative may not be one that we would choose, but I do not seem to remember being given the choice of being born. We do not exercise true choice in many things that happen in life although we may often delude ourselves that we do.

So in therapeutic benefit, at the very least, in every case there is some type of end-of-life therapeutic medication that can remove the pain. We have to face that. If once in a million cases there is a case in which the therapeutic benefit cannot remove the pain, is that the hard case that makes for a bad law? I do not believe so.

Secondly, I turn to legal certainty. If these cases are allowed to proceed under even a modified version of the Bill of the noble Lord, Lord Joffe, they will from time to time lead to homicide trials. I am basically a criminal law practitioner. I know that we are regarded by our commercial practitioner colleagues rather as the physicians sometimes view the orthopaedic surgeons in the medical world. However, we wrestle on a daily basis with asking ordinary people—juries—questions that can be difficult to address. What is the question that they would have to address in this area? It would not be, "Are you sure that this is homicide, before you can convict?". Rather, it would be, "Are you sure that there is not some therapeutic benefit that could be given before you can convict?". It is inevitable that many cases of homicide would be allowed to slip through the net if this kind of Bill became law.

I turn to the question that I have asked myself many times—why do people want death in the way that is prescribed by this type of legislation? Can we be sure that they are exercising their free will? How on earth can we be certain that there is not undue influence? I found that the Dutch evidence, which I heard in the Netherlands, extremely unconvincing. One of the figures that comes from the Dutch evidence, from research that was published this year, is that 50 per cent of cases are not reported by doctors who carry out voluntary euthanasia although they are obliged to report every one. Why do they not report about 50 per cent of the cases? Because they know not what they do in many of those cases. We cannot brush those figures aside. I fundamentally agree with my noble friend Lord Taverne when he asserts that the Dutch experience is not one in which we have confidence. Having heard the evidence there, I have very little confidence not only in what doctors do in Holland, but in the way in which the Dutch authorities seek to ensure that the practice is carried out carefully.

I would add this on assisted suicide. Some noble Lords, some who are present today, have a particular interest in mental illness. Some of us, unfortunately, have had to deal with mental illness in our own families. It is a very troublesome thing when you come across it for the first time. It becomes a very important issue in your life once you begin to understand it. It leads me to ask myself, why do people assert that they wish to have their life ended by voluntary or assisted suicide? My belief is that in many cases it is because they are ill that they are not able to make the essential judgment that is required for the decision to be one which is governed by sound medical ethics and certain law.

If we enacted legislation along the lines suggested by the noble Lord, Lord Joffe, we would send a completely false message about the state of the law in this country and the ethical judgments that we would wish to impose on doctors. I am against it.

The Lord Bishop of Oxford: I very much respect the serious intentions of the noble Lord, Lord Joffe, and the care that he has taken with the Bill to try to limit any possible damage. I should also like to say to the Select Committee, as a person who was not a member of it, how valuable the report was. It was a model of clarity and helpfulness.

It has been suggested or hinted a number of times that the main arguments against the Bill are on religious grounds. There are some religious arguments, and it may be that some of them will strengthen arguments of another kind. But I know that the right reverend prelates the Bishops of St Albans and of London, and myself, believe that these are rational arguments that can be considered by rational people whatever their religious views.

A leading article in the *Guardian* this morning said that the bishops,

"should be listened to with respect—and then ignored".

I feel like writing to the *Guardian* and asking if it would please assess the rationality of our arguments. That is very much what I hope your Lordships will do.

I believe that there is a fundamental philosophical flaw behind this Bill which, indeed, would be behind any successor Bill. It concerns autonomy, which cannot be taken as the overriding principle. In some respects all noble Lords would accept that. But Professor John Harris, who has been very influential and been quoted in the Select Committee report, stated:

"It is only by the exercise of autonomy that our lives become in any real sense our own. The ending of our lives determines life's final shape and meaning . . . when we are denied control of the end of our lives, we are denied autonomy".

What worries me about that quotation is that there is a sense that if we are denied autonomy—the ability to make a choice at the end of our lives—our lives somehow lose shape and meaning. I suggest that our lives have just as much shape, meaning and value when we are in positions of total dependence on other people. For much of our lives we are dependent on other people and may not be capable of making significant choices at all—in the womb, as a child, through periods of sickness, and perhaps for quite a long period at the end of our life. A loss of autonomy does not signify any loss of meaning or value from our lives.

Here, we need to face the fact that, as was once put rather brilliantly, mind is a social reality. We become persons in relation to other persons. There is a western idea that has been with us since certainly the 18th if not the 17th century: we are essentially human beings only if we are standing on our own and making heroic choices. That is a totally flawed understanding of what it is to be a human being. We are interdependent, there is mutuality, and our meaning and value are discovered just as much through other people's attitudes to us when we are dependent as they are in the choices that we make.

I know that the noble Baroness, Lady David, felt rather insulted by the reference to people with strong personalities wanting to be in control of their lives. I point out to the noble Baroness that that was in the Select Committee report as evidence of the kind of people who are seeking this measure. In contrast to that, we need to pay attention to the point in our lives when we are dependent on others. We should realise that at those times we in no way lose meaning or value.

There is time for only one other point, which is in reference to the well-known "policeman's dilemma". A motor accident leaves a lorry driver trapped in his burning cab. He cannot be freed and he asks a policeman to shoot him before he agonisingly burns to death. Many of us here—I am certainly one—would not judge a person in that situation to be wrong. But Professor Harris says:

"If we concede this case, then we concede the principle of assisting death in extreme distress and where the condition, as the lorry driver's was, is clearly the terminal one".

I do not believe that to be true. There are certain boundary situations where agonising choices have to be made. There are certain exceptions. But you cannot take from those exceptions general principles of prescriptions and laws. St Thomas Aquinas gave a well-known example. He said that if a person who is starving to death steals when there is no other way of obtaining food, he is not guilty of theft. That is a similar boundary situation but we would not dream of legislating for that. The fact that we concede the policeman's dilemma should not bemuse us into thinking that we should therefore legislate. The point about exceptions is that they really are exceptions, and we do not want to legislate for them.

Lord McColl of Dulwich: My Lords, before the right reverend Prelate sits down, does he agree that if, under those conditions, the policeman is asked to shoot the driver of the petrol tanker, he would refuse not for any ethical reason but simply because he would know that to fire a gun in those circumstances would blow the whole thing up?

The Lord Bishop of Oxford: My Lords, I shall just note that point and ponder on it.

Baroness Gibson of Market Rasen: My Lords, I, too, congratulate the noble and learned Lord, Lord Mackay of Clashfern, and his committee members on their well-balanced report.

There is no doubt that those who support and those who oppose the Assisted Dying for the Terminally Ill Bill introduced by the noble Lord, Lord Joffe, hold genuine and sincerely held views upon it, and that, as usual in your Lordship's Chamber, the debate is being conducted with respect for each other's views.

Many of us know people who believe their lives to be painful beyond tolerance, and we all wish such suffering to be alleviated. Where we are divided is on whether, and how much, help should be given to terminally ill people to end their lives, should they wish to do so. I put my name down to speak in this debate before our long summer break began. I believed in the proposals in the Bill then and I believe in them now.

During the summer, a number of events strengthened my support for such legislation. I watched a television debate on the Bill. An intelligent and articulate woman, with an equally intelligent and articulate brother, explained why she helped him to die peacefully and, as they put it, with dignity. A key reason was that the brother, whose intellect remained, was slowly losing his ability to articulate, and his misery and frustration at his illness and loss of faculties was almost tangible through the television set.

The brother and sister travelled abroad to achieve his aims—to end his life in what he described as a dignified manner at a time of his choosing with those he loved most with him. His quiet determination shone out of the film that the family had made of his illness and of the decisions he took about it.

Almost on the same day, I received a letter from a young woman with a terminal illness. Indeed, it may be the same letter as that received by the noble Lord, Lord Russell-Johnston, who mentioned it in his speech. The young woman is 28 years old and has heart and lung problems, causing her to deteriorate slowly. She uses oxygen constantly and is severely physically limited. She has been told that she will continue to deteriorate. She wrote:

"Because the current law forbids assisted dying, I have had to make the decision to starve myself to death. This could take some time and may cause even more physical pain. I have, however, come to the conclusion that starving myself to death is more favourable than living as I do".

She does not want to travel abroad; she wants to die in her own country. She pleads with us to listen to our public and to hear their voices. The Bill, which is the subject of this report, would allow her to die in the way she wishes at a time she chooses. I do not believe that we have a right to deny her that.

I also received a moving letter from a young woman about her father's death. He had wished to be helped to die. She wrote:

"Having the right to decide the time to die would give the patient control at the end and make the process less frightening because the terminally ill person is the only one who knows when he or she wants to pass away. It is their perception of dignity which is important".

I believe that that is true.

Obviously I have received letters both for and against changing the legislation, as I am sure we all have, from individuals and associations, and I shall mention just one or two. I was particularly grateful to the BMA and the GMC. They both clearly set out their stance on future legislation, which in both cases is neutral. I had heard from doctors for and against the proposed legislation, with both sides claiming the backing of the BMA and the GMC, and so I was relieved to have this issue cleared up. I understand that both organisations have said that, if such a Bill became law, they would be able to publish guidelines to underpin the practice.

A further letter came from the disability committee of the National Union of Students. The committee members are elected representatives of students who have various disabilities, both seen and hidden. They support such a Bill, believing that it will protect vulnerable disabled people more than the current law does. On the other hand, RADAR, for which I have a great deal of respect and with which I have worked in the past through my work at my union, Amicus, sent a very thoughtful briefing in which it explained why it cannot support the introduction of the proposed legislation at this time. But it stressed the need for better and increasing palliative care—a point with which I agree wholeheartedly.

As do others in the Chamber, I believe in the expansion and extension of palliative care. I believe that those who choose to receive it must have the best treatment possible and that equitable access to palliative care for all should be provided. That is in line with the response of the National Council of Palliative Care to the report on the Bill. I differ from the NCPC in that I do not believe that this must be provided before pursuing assisted dying for the terminally ill. It is possible to press for better palliative care at the same time as allowing the assisted dying option for those who choose to take that route. Palliative care and assisted dying are not mutually exclusive. Both are needed, and should be allowed.

Finally, I am sure that if a new Bill is introduced, it will be discussed in depth in this House. I am also sure that improvements will be made during those discussions and amendments. I support the noble Lord, Lord Joffe, in his efforts to bring forward well-constructed legislation in this difficult area.

Lord Gilmour of Craigmillar: My Lords, we have heard strong speeches on both sides. I shall look briefly at the arguments against the Bill.

The strongest argument against the Bill, of course, is that assisted dying may enable jealous and tiresome relatives, or others, to persuade old people to agree to be killed because they think that they have become an intolerable burden to their children and friends. However, the Bill provides stringent safeguards against that happening. It has not happened in Oregon, as my noble friend Lord Arran made clear, and, as the noble Lord, Lord Taverne, said, it has not happened in Holland. Moreover, the Joint Committee on Human Rights decided that the safeguards in the Bill were adequate to protect the vulnerable.

Secondly, there is the slippery slope argument, which maintains that, if the Bill is passed, all sort of dreadful Bills or actions will be passed in future. We are always on the slippery slope; it is not necessarily a bad slippery slope—it may slope in the right direction. The slippery slope argument has probably been used against almost every measure for some 200 years. It is often a favourable slope, as the history of the Reform Bills in this House well shows. In any case, the view that we should not do the right thing today because somebody else may do the wrong thing tomorrow is surely not a compelling argument.

Then there is the argument that committing suicide, or helping somebody to do so, is wrong because of the sanctity of life. Since 1961, however, suicide has not been illegal—though assisting suicide is, of course. If the terminally ill person is incapable of doing what he wants because of the illness, however, different considerations should surely apply. The sanctity of life is a difficult concept. It is evidently not known or followed by Messrs Bush and Blair, who are killing thousands of innocent civilians in Iraq. According to President Bush, it is not even known to God, since God told him to launch the invasion.

The idea that it is God's will that an old and weak person should spend a month or so dying in agony and dissolution, to the anguish and distress of his family, rather than being allowed to die with dignity a few weeks earlier as the result of an assisted suicide seems extraordinary to me. The most reverend Primate the Archbishop of Canterbury and the right reverend Prelate the Bishop of Oxford put that argument separately in the papers on Sunday—the right reverend Prelate put it again today—and it seems explicit in both articles. I quote the article of the right reverend Prelate:

"a person in extreme distress as a result of a debilitating illness is in a very different situation. But does their life not still have value? Do we not want to say to them: you are still of worth, we still want you with us, we don't want to empty our lives of your presence?"

If I were in a state of terminal illness and extreme agony and somebody came along and said that to me, I hope that I would convey my displeasure—I probably would not be well enough to hit him—and make him leave that room pretty soon. It seems to me to be well beyond the reach of any form of reality, although, as the right reverend Prelate said, it may still be rational.

We know that doctors, hospitals and nurses allow terminally ill people to refuse life-preserving treatment or drugs, a practice that the most reverend Primate the Archbishop of Canterbury supports. The fact that that is permissible but that doctors are not allowed to administer a drug or medicine that will kill patients quicker and more mercifully is equally extraordinary and reminds one irresistibly of the famous words of Arthur Hugh Clough:

"Thou shalt not kill; but needst not strive,
 Officiously to keep alive".

I appreciate, of course, that some doctors have strong views and would not want to participate in any such process. They should obviously be allowed not to do so. Other doctors would do the job, and their feelings should be respected.

The arguments against the Bill introduced by the noble Lord, Lord Joffe, do not stand up. I strongly support it

Phillips of Sudbury: My Lords, I thank the committee for the wonderful report that it has produced, and the noble and learned Lord, Lord Mackay of Clashfern, for his chairmanship of it. Beyond and above that, however, I thank the noble Lord, Lord Joffe, for the hugely important role that he has played in bringing this most important of subjects before the House and the public, his indefatigable pursuit of the issues and his sensitivity to views other than his own. I cannot speak too highly of what he has done.

I am a solicitor very long in the tooth. I have had nearly 50 years in the profession. At different times in my career, I have dealt with old and frail people, both in the making of their wills and acting as an executor of their estates, dealing with applications to the Court of Protection. I spent four years as a coroner's assistant, an extremely educative phase of my life, where you come very close to the realities of what we are talking about. I am going to make a few practical observations.

My first is that legislation is never better than a crude instrument. We deceive ourselves if we believe that we can load on to the shoulders of legislation all the refinements and subtleties that we would wish to see in legislation allowing assisted dying. It cannot be that subtle or calibrated.

Modern legislation, I suggest, is honoured in the breach: 14,000 pages of new statute law a year, most of it remaining on the shelf. What is implemented is implemented unevenly and with undue discretion on the part of those enforcing it. How can we be sure that this most complex legislation would have the quality of enforcement and policing without which it could be wholly counterproductive?

The evidence from Oregon and Holland has been presented to us by several speakers as justifying the proposed legislation. I cannot see that. The law was changed in Oregon only in 1998 and in Holland in 2001. The most important aspects of the evidence that I would want to see are the most difficult to find. For example, there is the whole question of undue influence or pressure on old people from relatives, beneficiaries and the like: how does one go about getting evidence for or against that? I suggest to your Lordships' House that we are not remotely in a position of having adequate evidence one way or the other.

The draft Bill itself is full of ambiguities and flexibilities. I do not blame the noble Lord, Lord Joffe, and his helpers for that because we have a cruel choice in legislation. You either have something that is so fixed and certain that it is inflexible or you have something that, being flexible, is full of movement and ambiguity. I pick out a few such key words: "capacity"; "competence"; "fully informed"; "temporary relief". At the heart of the Bill, is the phrase "a few months". "Unbearable suffering" is defined as, "suffering whether by reason of pain or otherwise".

There is no suggestion of what "otherwise" that might be. All that would lead to a position that we have seen pursuant to the Abortion Act: specialist firms of doctors offering their services as an assurance to find a way through the complexities to the result that an old person or, more likely, the relatives wanted.

Above all, we cannot have it both ways in the Bill. We cannot liberate the terminally ill suffering unbearable pain—in the way that, I understand, people want—and simultaneously protect the vulnerable old from abuse by pressure or undue influence. We cannot straddle those dual objectives. There will be the age-old problem of people saying, "I'm a burden on my family. I've had a good life. I can't afford it". That is a commonplace, and we have all seen it. I am afraid that, whether one wishes for it or not, undue influence will be the necessary handmaiden of the Bill, however unintended.

In Oregon, the research by A D Sullivan and others shows that, whereas in 1998 only 12 per cent of those requesting physician-assisted suicide felt themselves to be burdensome, a mere two years later that had risen to 63 per cent. In the 1987 MORI survey annexed to the report, 71 per cent agreed and only 12 per cent disagreed that people permanently dependent on others for medical or nursing care might request euthanasia in order not to be a burden on others. Even among geriatricians, a survey done by the universities of Sheffield and Charleston in 1999 shows that 84 per cent of them believe that legalisation of patient-assisted suicide might put pressure on vulnerable patients to request just that, and 53 per cent feared that the social process of dying and grieving might be undermined.

The balance of harm has not been weighted sufficiently for my practical view in favour of the proposed Bill. Lastly, I would call into my speech the words of the right reverend Prelate the Bishop of Oxford and my noble friend Lord Carlile.

Lord Ackner: My Lords, I join in the congratulations so elegantly expressed by the noble Lord, Lord Phillips of Sudbury.

I have a clear recollection of the Suicide Bill, because it occurred in 1961, which was the year in which I got silk from Lord Kilmuir. The Bill seemed to be very soundly based. I decided I would look back at the Second Reading debate to see whether there was wisdom to be found there; and I think there is. On 2 March 1961, at col. 261 of the *Official Report*, Lord Silkin said that, as a result of what was being suggested, society would no longer regard it as its business to preserve life. That seems to indicate that society was rejecting the sanctity of human life, because if such sanctity were maintained, it would be impossible to legislate to make suicide no longer a criminal offence. The Bishop of Carlisle was of the view that it was contrary to law to take one's own life, and he founded that upon the sanctity of human life. In the same debate, Lady Wootton of Abinger said:

"The early Christians were, I think, very much disposed to suicide; and perhaps they were so disposed through excessive rationality. They assumed that by an early departure from this life they could escape not only its miseries, but also its temptations, and that they would thus equip themselves with a clean passport to the blessed state of the next world. It was, I think, because of this tendency to favour suicide that St. Augustine felt himself called upon to discourage the practice".—
[*Official Report*, 2/3/61; cols. 266-67.]

Lord Denning, not then Master of the Rolls, said that suicide had been a crime for nearly 1,000 years:

"The reason for that law was stated by Blackstone to be founded, as it was, on our religion. The law of England, he said, wisely and religiously decreed that no man had power to destroy life except by commission by God, the author of it".

That was clearly a religious backing to the foundation of suicide being a crime. He went on to say:

"But what about . . . Clause 2 of the Bill, aiding and abetting suicide? If we do away with suicide as a crime, logically we do away with any aiding and abetting, because you cannot aid and abet a crime when it is no longer a crime. Indeed, it is illogical to have this clause in here, but it may be needed".—[*Official Report*, 2/3/61; cols. 262-5.]

However, he pointed out that suicide had never been a crime in Scotland, and said that Scotland had not apparently found it necessary to have any aiding and abetting provision.

Several years before the Bill was passed, Professor Glanville Williams, at whose feet I tried to learn, had written a book entitled *The Sanctity of Life and the Criminal Law*, in which he said:

"The religious objection is principally the familiar one that killing falls under the ban of the Sixth Commandment. This theocratic morality is, however, no more successful in the present application than in those previously considered. The true translation of the Sixth Commandment is not 'Thou shalt not kill', but 'Thou shalt do no murder', as the Book of Common Prayer has it; and it is only by a stretch of words that a killing with the patient's consent, to relieve him of inexpressible suffering, can morally be described as murder".

Of course there must be safeguards, and these, I submit, have been properly and fully considered by the noble Lord, Lord Joffe.

In conclusion, I ask your Lordships' forgiveness if I leave soon after completing this speech. The lift in my block of flats is out of order, and I have gone down six flights of stairs to get here. It is easier getting down the stairs because, if you do it backwards, the prospect of doing any real injury is remote. Going upstairs, though, requires some assistance, and I have got someone to stand by to assist me, provided that I am not too late. I am much obliged.

Baroness Morgan of Huyton: My Lords, when people ask what the point of the House of Lords is, we should point to this debate and to the quality of the committee's report. Whatever the eventual outcome of our discussions—I should say that I support a change in the law—the time is clearly right for this debate. I pay tribute to the noble Lord, Lord Joffe, for bringing forward his Bill. We cannot ignore this matter because it is being debated in the country, in the media, in pubs, in churches, at school gates, over the kitchen table and in many families. The public followed the Diane Pretty case in detail day by day and watched its tragic outcome. This is an issue that touches, or will touch, many of us. It is not the preserve of professionals, nor can it be the preserve of those with strong religious beliefs. It is the preserve of all of us.

We have received particularly strong statements from practitioners of palliative care and from hospices that their relationships with the terminally ill could be affected. Of course we have to listen to and respect that. But we should recognise with the greatest respect that their views may not be the views of their patients. It is their patients' views that must be paramount. The Bill offers independent choice to those who are denied it at present. Of course we all wish to

see palliative care improve in future and hope that the Bill will not be necessary. But the Bill does not deny the improvement in care that we all seek. This is not an either/or situation. This is an issue of independence and equality. It is about an extension of human rights to those who are at present denied them.

I welcome the amendments outlined today by the noble Lord, Lord Joffe. They deal with several concerns raised by the committee. It is clear that a lot more detailed work will be needed to get the Bill right. But in the end the public know in principle what this debate is about. Like many noble Lords, I have received lots of strongly argued letters with passionate views from both sides. Like my noble friend Lady Gibson, I found one particularly poignant and I shall read a section of it. The young woman argues that she has a very cruel choice between starvation or hard suffering and a very unpleasant end. Her other choice is to go abroad with her husband to help her. The reason that she feels unable to do that is her fear of what her husband's legal position would be when he returns. She wrote:

"I cannot plead with you more, to listen to your public. Hear their voices. A change in the law to make assisted dying legal in this country is not only the right decision, but also a necessary step forward, so that people, who often have their dignity taken away from them by their illness, can at least have a dignified death at a time of their choosing. Bring an end to the unnecessary suffering felt by many. Given patients their voices back".

I hope that we can fulfil her wishes so that in future others will not suffer in the same way.

Earl Ferrers: My Lords, this is a sensitive subject that combines compassion and understanding with the basics of life and how to deal with death. You cannot get more complex and sensitive than that. If one is not a professional or a cleric, one walks on this bed of nails with care although, as the noble Baroness, Lady Morgan, said, one does not have to be a professional or a cleric to hold views on the subject. It is not surprising that views are fairly diverse.

I wish to raise four points, but before I do I shall refer to two speeches. The noble Baroness, Lady Finlay of Llandaff, made a most astonishing speech that was clear and full of knowledge and understanding. Then she referred to a person who had wanted to be assisted to die, but did not have that assistance, and was alive 10 years later. If that had happened, one wonders where the rectitude and the rightness and wrongness would have been. It was a remarkable speech. The other speech, among many enormously impressive speeches, was made by the right reverend Prelate the Bishop of St Albans who put a complicated situation clearly and asked since when personal choice has been the highest moral value. I had never thought of it like that, but most religions would say that personal choice is not the highest moral value because whatever one does one has to operate and co-operate with other people.

The four points that I wish to make are stark and simple. They are unencumbered by any natural explanation. The first is the remark made by the late Lord Soper, who used to come to this House dressed in his black cassock. I can see him sitting just behind where the noble Lord, Lord Phillips of Sudbury, is sitting. We used to sit on the other side of the House because we were in government in those days—it feels like about a hundred years ago. I remember Lord Soper speaking without a note, as he always did, in a most beautiful voice. He said that in his experience the closer people come to death, the more they want to hang on to life. Those who are in favour of the Bill of the noble Lord, Lord Joffe, may say that that may be so but the Bill refers only to those who are about to die and are suffering terrible pain so it

expedites an inevitable process. But one wonders whether we are entitled to expedite an inevitable process. What is an inevitable process? Death is an inevitable process and the only uninevitable things about it are how and when. Therefore I question whether we are right to expedite it.

Secondly, most doctors want to be seen as the savers of life, not the extinguishers of it. Savers of life would not like to be thought of by some as possible extinguishers of it. When an old lady sees her doctor, whom she trusts, will she feel that maybe this time he has come to extinguish her? Thirdly, the old lady—of course, this refers just as much to an old gentleman, a position some of us are rapidly approaching—may not wish to die, but may feel that she is being a burden on her children and that she ought to ask to be removed. Those would be intolerable pressures. My fourth point is closely connected. The old lady may think that her children probably wish her to be assisted to die in order to relieve them and her of the desperate misery that they see her going through. She may feel that she ought to do it for her children's sake.

I feel that the pressure on the elderly and the infirm to do that which they do not want to do because they feel that they ought to do it would be immense. These matters are never black and white but are varying shades of grey. No one person will slot into any one category. That is the danger of legislation: as soon as it categorises people there are arguments as to whether a person falls into a category or not. The wonders of modern science and modern approaches enable us to do remarkable things but I cannot believe that convenience dying is ethically, morally or religiously correct.

Baroness Warnock: My Lords, it has become abundantly clear from all that has been written spoken on the subject of today's debate that there are two different kinds of argument against what the Bill would permit. The first is absolutist and the second is consequentialist. We have not heard very much about the absolute argument this afternoon. I shall say very little about the consequentialist arguments. They focus mainly on the slippery slope, at the bottom of which lies non-voluntary euthanasia, or they concentrate on the supposed fact, which I by no means accept, that the passage of the Bill would mean an erosion of trust between doctor and patient. These are empirical arguments, based on what is thought likely to happen. As such of course they ought to be based as far as possible on evidence.

I want to concentrate instead on the absolutist argument that it is morally wrong to allow assisted death for those who seriously request it because it would violate the principle of the sanctity of human life. That issue has already been mentioned and came out very well in the quotations that we were referred to by my noble and learned friend Lord Ackner. Those whose objection to the Bill is based on this principle have no need to invoke the consequentialist arguments against it, although they often do—and although it may well be true that, as the right reverent Prelate the Bishop of Oxford said, many in the Church actually rely more on the empirical than on the absolutist arguments.

It is clear that most people—I would say everyone in your Lordships' House—believe that human life is a value that has enormously high priority among all the things to which we attach value, and that one must be extremely cautious in giving other values priority over it. But those who literally believe in life's sanctity, argue, as the Church of England and the Roman Catholic bishops and the Chief Rabbi did in their written submissions to the Select Committee, that this sanctity derives from the fact that:

"God himself has given to humankind the gift of life".

Or, in the more explicit words of the Chief Rabbi, that,

"life is a precious gift from God . . . whose value is absolute and not relative to factors such as age and health".

That was the fundamental basis on which those men of God founded their evidence to the committee.

I want to suggest to your Lordships that, in matters of legislation especially, it is crucially important to distinguish moral arguments from religious or theological arguments. That is true despite the undeniable fact, which I certainly would not deny, that our morality has been hugely influenced by the Judaeo-Christian tradition. But the law cannot be based on the literal interpretation of religious beliefs of some, but not all, Members of Parliament, or of some, but not all, members of society. There are many people, even many people who, like me, are church-goers, who cannot take literally the proposition that being God's gift confers on human life a special sanctity regardless of its quality and regardless of whether the person living it wishes to preserve it. Life is not an abstract thing; it is not a separable non-concrete entity. A human life is always being lived by somebody. Someone in the extremity of suffering, knowing that his life is in any case drawing to a close, and begging to be allowed to die, will not be comforted by the thought that another person, not he, places the value of his life above every other conceivable value. And indeed, he may wish, as has been pointed out, to point out that we do not always apparently regard human life as having to be preserved at all costs. Not everyone, as the noble Lord, Lord Gilmour, suggested, who is opposed to this Bill has refused to sanction the deliberate sacrifice of human life to other values in time of war, for example. I would argue that in certain limited cases, as outlined in the Bill, we should forget the theological arguments defining life itself as possessing an intrinsic sanctity. I turn instead to that separate moral argument; namely, the argument from compassion.

Compassion will of course lead us to try to make any human being's life when it is coming to its end as tolerable as possible. But by any moral standard is it good to prolong that life against his express wishes? Is it better by any moral standard to keep him alive if in some extreme case he is reduced by our efforts to actual unconsciousness, rather than to allow him to decide that now is the time to go? I cannot myself regard this as a rational or defensible morality, upon which the law must in my opinion be based.

Lord Beaumont of Whitley: My Lords, I am, as most of your Lordships will know, a priest of the Church of England and, I hope, a theologian. I have never understood why some people think that the only theologians are those who are academics. I once attended a conference of clergy and committed laity of the Church of England at which, in his summing-up, the chairman said:

"Next time we meet we must invite a theologian".

In my book all thinking human beings are theologians because we all, like Jacob, wrestle with the idea of God.

I find nothing in the teachings of Jesus of Nazareth, which I attempt to follow, which would exclude from the free will which God has given us the right to decide on ending my life responsibly. That being so, I have signed a so-called "living will" detailing the circumstances in which I want to be allowed or even assisted to die.

As I do not want to be a hypocrite, all rights which I claim for myself I wish also to claim for others. Whether or not they wish to exercise them, they should have those rights. Of course I hope that I shall never have to exercise them myself. I believe that this Bill, which gives people the right to make their own decisions, is the right one. I—like, I am told, the majority of clergy—am an ardent reader of crime novels. The reason for that I believe is that we need to be reminded, against all the superficial evidence, that Easter Day does follow Good Friday and that the Texas Rangers will eventually breast the hill, and that when they come over the hill they will be better than the Texas Rangers who might come over the hill today.

I therefore am more aware than most people of the ingenuity of those who wish to kill others for their profit. And I will be as concerned as anyone to make sure that all the necessary safeguards are in place. But about the principle I have no doubt at all; this Bill is long overdue and it is time we got on with it.

Baroness Greengross: My Lords, I add my congratulations to the committee for the wonderful and thoughtful work that it has carried out. I have worked with older people for almost all my adult life. It took me many years to decide how I feel about the issue. In the end I feel very strongly that most of the older people I have known are very scared of the process of dying, not of being dead and not of death itself, and want an assurance that whatever happens they will not suffer intolerable pain and lack of dignity when they die.

We are not talking here about prolonging life or giving people life rather than killing them off, we are talking about people who are very near death; they are all dying. I think that the six-month period suggested in the Bill is too long for the prognosis of death. Perhaps it should be reduced.

We must recognise that part of the dignity of an older person's life is that, when they are mentally competent, they retain a degree of autonomy. We are talking about people who often in our society do not have their views listened to when they are alive and well, let alone when they die. People's fears about losing even more autonomy and the will to make decisions are very real. We are talking here about love and care at the end of life for as long as people are alive, not about killing people off. This is about how we treat people when they are still alive, and being alive is very important until you take your last breath. Luckily, in our society, because of medical and social care developments and advances, most people who die are older people, so this is terribly important. Of course, our respect for people must continue until the last moment of life.

We are talking about how we spend the remaining very short time that we have left to us. Death is inevitable; critical, intolerable pain is something that we all want to avoid. I am a tremendous admirer of the palliative care movement, of the doctors who practise palliative care, of the hospice movement and of our country's reputation in this field. My father died in a hospice. I was absolutely overwhelmed by the care that he received, as I have been in many other cases of people who have died in that way with good palliative care. We are here talking only about the few cases where palliative care does not work, where people suffer intolerable and dreadful pain and the only way to control that is to knock them out completely. I have difficulty saying that one is all right but the other is some sort of murder. That is untrue and rather hypocritical. We are here talking about good care.

Surely a dying person should not have to plead for his or her wishes to be carried out. Just knowing that, whatever happens, your wishes will be carried out so that you have control over those last moments of your life is very important. It is important that that person's wishes to

die in the way that he or she wants are carried out because as competent adults we want to be respected, to say our farewells and to finish any outstanding business with which we need to deal.

I would like to talk about disability, the disability movement and the many Members of this House who are shining examples of the courage of many disabled people. Those who I have known have very much enriched my life. I admire people who manage to make a life, often while suffering terrible disabilities. The fact that many disabled people are undervalued and feel that the Bill would add to that undervaluing is something that I do not understand. I work with disabled people and believe that discrimination against them is unacceptable in whatever form we discover it. We must deal with that where it still exists. It is absolutely nothing to do with the Bill. We must deal with any forms of discrimination as such, not muddle them up with the Bill.

In fact, discrimination against disabled people is reflected if we do not let the Bill pass in some form because under English law an able-bodied person is not committing a crime if he or she commits suicide, but if a person needs a bit of help to take the appropriate medication, they are discriminated against because of their disability. So we deny disabled people the ability to take their own life as able-bodied people can under our legal system.

We must deal with abuse wherever it exists. It is another form of discrimination. I support the Bill and the decision of the noble Lord, Lord Joffe, to restrict it to assisted dying and to drop the voluntary euthanasia part of the Bill at this stage.

Safeguards to stop abuse of any person who is dying, or anyone else, are essential. If further safeguards need to be built into the Bill, I know that the noble Lord will be very willing to incorporate them. I support that view. This is about how we die, not how we live. People's wishes—your wishes, my wishes, everyone's wishes—must be respected. This is about common humanity, not about killing people.

Baroness Wilkins: My Lords, I spoke in opposition to the assisted dying Bill that the noble Lord, Lord Joffe, introduced in 2003, and after careful reading of the Select Committee's excellent report—I join other noble Lords in congratulating the noble and learned Lord, Lord Mackay, and his committee on it—I remain fundamentally opposed to any change in the law on assisted suicide or voluntary euthanasia.

I believe that to make that change would cross a threshold in the safety of our respect for the value of human life which could never be recrossed. We must not cross that boundary. As the noble Lord, Lord Walton of Detchant, who chaired the Select Committee on this subject in 1993-94, stated in his evidence:

"society's prohibition of intentional killing is the cornerstone of law and social relationships . . . It protects each of us impartially, embodying the belief that we are all equal".

My personal autonomy has to be outweighed by that greater claim of a just and equal society where no one is given cause to fear that their life has less value than others.

However many safeguards are put in place to ensure that an assisted dying Bill was used only for those for whom it was intended, it is impossible to create a safeguard against the wider,

unintended consequences of changes in society's attitude to the value of life. Again to cite the report of the noble Lord, Lord Walton, who, by chance, is following me in this debate:

"the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death but should assure them of our care and support in life".

For me, one of the most striking elements of the Select Committee's report is the evidence of the very small number of people who would actually take advantage of any change in the law. It states:

"There was general agreement among our witnesses that the number of people who might be regarded as serious about ending their lives, who are not psychiatrically ill and who are unlikely to be deflected from their purpose is very small indeed".

Are we really to jettison that fundamental safeguard that our lives have value—the bulwark that killing is a crime—to satisfy the personal autonomy of a small, albeit tragic, group of people? I am convinced that satisfying that small group of people would mean that thousands live in fear. As the report states:

"There is a concern that . . . others will find themselves pressured in one way or another into taking a course of action which they would not have sought if the law had not allowed it".

The report goes on to discuss those "hidden pressures", which many noble Lords have cited today on elderly people who begin to feel themselves to be a burden on their families and whose care is eating into their children's inheritance and who may begin to feel that they should tidy themselves up and dispose of themselves. I have had many conversations with my disabled friends, who genuinely fear going into hospital if they have an acute period of illness and need intensive medical care, and that they will meet the prejudice of doctors who are imbued with society's prejudice that their lives are not equal to others and that it would be better to be dead than to be disabled.

As the law stands, it provides protection for such people. It proclaims to all of us that our lives have value. The current law protects the vulnerable and we remove it at our peril.

Lord Walton of Detchant: My Lords, I echo the congratulations expressed from all sides of the House to the noble and learned Lord who chaired the Select Committee. I also congratulate the members of the committee on producing a thoughtful and balanced report. In giving evidence to that committee, I said that I wholly appreciated and understood the sincere and compassionate reasons why my noble friend Lord Joffe had introduced the Bill. As the noble Baroness, Lady Wilkins, said, I chaired the House of Lords Select Committee on Medical Ethics, which reported in 1994. We produced a unanimous report dealing with issues of exactly this nature. I have not changed my mind, even though I now realise that three members of my committee who, in the end, subscribed to a unanimous report, have done so: the noble Baroness, Lady Jay, and, I believe, my noble friend Lady Warnock and the noble Baroness, Lady Flather.

Having said that, I endorse Clause 15 of my noble friend Lord Joffe's Bill:

"A patient suffering from a terminal illness shall be entitled to request and receive such medication as may be necessary to keep him free as far as possible from pain and distress".

That is the motivation of the hospice movement in the UK, which is increasingly influential in treating individuals with terminal illness of all kinds. Palliative care, of which my noble friend Lady Finlay is such a noted exponent, is not just delivered in hospices, but it is a philosophy of care that extends into a community and is practised by many general practitioners.

The principle of double effect has not been mentioned today. The noble Lord, Lord Russell-Johnston, suggested that many doctors in this country already practised euthanasia. I do not believe that they do. They practise what we in our committee report endorsed as double effect. In effect, it means that, if it is necessary in order to relieve pain, distress and suffering, to give such doses of medication as may have—not invariably—the secondary consequence of shortening life, that is perfectly acceptable in law and in medical practice. I admit that some philosophers regard that concept of double effect as hypocritical, but it has been practised widely for very many years. I believe that the use of that double-effect principle produces death with dignity.

Perhaps I may now raise one or two points from the report produced in 1994. We totally accepted the concept of informed consent to medical treatment and endorsed the right of a competent patient to refuse consent to any medical treatment, even if that ultimately resulted in death. We also confirmed that there was no obligation on the healthcare team to embark on or to continue with futile treatment that added nothing to the well-being of the individual as a person. We endorsed advance directives. I have signed an advance directive, which makes it clear that, if I become incompetent or terminally ill, I would not wish to be subjected to certain forms of life-prolonging treatment.

As the noble Baroness, Lady Wilkins, said, many of us had experience of relatives or friends whose dying days or weeks were less than peaceful or uplifting, or whose final stages of life were so disfigured that the loved ones seemed already lost to us. However, we did not believe that those arguments were sufficient reason to weaken society's prohibition of intentional killing, a prohibition that is the cornerstone of law and of social relationships. It protects each one of us impartially in the belief that all are equal. We did not wish that protection to be diminished, and we therefore recommended that there should be no change in the law to permit euthanasia or physician-assisted suicide. In fact, we found that it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law would not be abused. I appreciate that many Members of your Lordships' House have expressed concern about the concept of the slippery slope, but the possible erosion of any such legislation, whether by design or by inadvertence, or by the human tendency to test the limits of any regulation—as has clearly happened with the Abortion Act—gave us concern.

I was gravely concerned by what I found in Holland 14 years ago. The situation was that euthanasia was not legal—it was legalised in 2001. Every year, more than 1,200 individuals were subjected to voluntary euthanasia under certain conditions, but more than 1,000 were subjected to non-voluntary euthanasia because they were neither competent to withhold or to give consent. The Royal Dutch Medical Association now says that doctors can help patients who ask for help to die, even though they may not be ill but simply suffer through living. That is a situation and a recommendation that goes far beyond what I would regard as acceptable.

As others have said, our committee was concerned that vulnerable, elderly, lonely, sick or distressed people would feel pressure—whether real or imagined—to request early death.

This is a carefully phrased and well-balanced report, but, having considered it carefully and having looked in detail at my noble friend Lord Joffe's Bill, I have to say, after almost 60 years of medical practice and having looked after many dying patients in the course of my professional career, that even with amendment to remove the voluntary euthanasia section, I cannot support it. In all conscience, I would have to oppose it.

Baroness Knight of Collingtree: My Lords, I, too, begin with a tribute to the Select Committee, which did a difficult job extremely well, but there can be no doubt of the validity of the comments of the National Council for Palliative Care in its responses to the report. It says that much more evidence should be sought and lists eight crucial areas that have not been properly examined. Even one of those eight could be enough to stop the Bill in its tracks.

Euthanasia seems quite cosy and humane when it is first suggested: "Let's stop suffering. Let's get doctors to help us out of this vale of tears when things get rough. We put down dogs, cats and horses. Why not humans?". Humans are not dogs, cats or horses. Doctors are not killers. Suffering can be ended without ending life. In Oregon, where euthanasia is legal, palliative care is now regarded as unnecessary. What about that for a slippery slope? Apparently, in Oregon, they do not bother to make palliative care available at all—because killing is.

The more evidence that one receives and the more thought that one gives to the actuality of euthanasia, the more one turns against it. Certainly, legalising it puts elderly and helpless people at terrible risk. They know that, which is why so many of them are afraid of what our conclusions may be. Some people say that doctors already kill and have done so for years. Where is the firm evidence? Surely we can all agree that there is no more grave matter than bringing about the death of a human being. Hearsay evidence is not enough when deciding whether, how or in what circumstances killing should be allowed. Not nearly enough is known about palliative care, the extent to which suffering can be contained or how advances in medical techniques and expertise are changing and improving life for sick people all the time. Surely, it is far better to recognise and encourage research into all of that, rather than to forget it and kill people, as is happening in Oregon.

There has been no attempt to answer fears that the Bill could lead to the widespread killing of people who have neither asked nor wanted to be killed. The evidence from Holland shows another slippery slope that has been slipped on well and truly. Surely, no one can say that it has been in a good direction. Doctors in Holland openly admit that legalising euthanasia has led to the killing every year of 1,000 people who never asked to be killed. That may save money, it may empty hospital beds and it may get rid of troublesome people, but, unless Harold Shipman was right, it is wrong. No wonder more than 10,000 people in Holland now carry cards in their wallet saying, "Do not kill me".

Something else is very sinister in the Dutch law, and we have not heard about it yet: it permits children aged between 12 and 17 to ask for euthanasia and to get it. That cannot be either ethical or logical. As many of your Lordships surely know from experience, teenagers are often plunged into moods of black depression by the most trivial things: a football team loses, a love affair goes wrong or an exam is looming. "I just want to die!", they wail. To take them at their word is wicked. To allow such children to be legally killed when they have their whole life ahead and have no experience of how wonderful life can be and no understanding

that all disasters end is wrong. They are often immature, emotional and sad little souls who need love, care, help and hope—not death.

We should look more closely at how legalised euthanasia is working elsewhere: at the many examples of the dangerous slippery slope that it opens up; at the denial of human rights that it involves and the terrible fears that it heralds. Nowhere in either the report or the Bill can I find any surety that we could avoid the experience that other countries have faced before us.

Finally, I worry that doctors who fundamentally objected to killing their patients would be forced to do so or would have to leave the profession if the Bill were passed. The Select Committee worried about that too. How could such doctors be protected? In this country, we have huge numbers of Muslim, Hindu, Christian and other doctors whose faith directs them only to cure. We could not staff either GP surgeries or the hospital service without them. How can we pass a law that would give patients the right to a procedure that so many doctors object to carrying out, while giving doctors the right not to carry out that procedure? Will we have official lists of doctors who will kill and those who will not? Oh, please not.

Viscount Craigavon: My Lords, I strongly support this prospective Bill and warmly congratulate the noble and learned Lord the chairman and his committee on producing such a report, one that enables those who want to do so to understand all sides of the present debate. The report and, in particular, its volumes of evidence, make up a valuable and readable account of where this evolving debate has reached. The changes it highlights since the 1994 Lords report on medical ethics are stark.

I shall touch on just a few aspects that seem important to me. Various opinion polls have been quoted and put into context, but I should like to emphasise the very recent *Daily Telegraph* YouGov poll which showed what was called huge popular backing for legislation for assisted suicide. Some 87 per cent of those questioned agreed with the statement that people who are terminally ill,

"should have the right to decide when they want to die and to ask for medical assistance to help them".

That is a trend and direction in public opinion which should be taken into account even if the exact figure might not be accepted. Reading it in the *Telegraph* makes it even more persuasive.

We should be grateful that the various royal colleges and societies seem to be moving from a monolithic view to reflect that in practice their members tend to be significantly divided. In my opinion, there is no loss or shame in that. We should welcome this relatively new attitude taken by these various organisations which, in necessarily different ways, have allowed themselves to be much more neutral in this debate. Reading their oral evidence is almost essential in order to understand the rationale and nuances of their position, although I realise that not all the colleges have changed and that they all have slightly different remits.

As has been mentioned, one of the key concepts influencing this is "patient autonomy". The Select Committee report provides throughout a great amount of detail on how in practice this is balanced in making decisions. I hope that anyone trying to relegate the importance placed on patient autonomy in this context will first at least have read the extensive evidence in the report. Indeed, the speech of the right reverend Prelate the Bishop of St Albans sought to set up what was almost a straw man in order to knock him down, while the speech of the right

reverend Prelate the Bishop of Oxford was a slightly more sophisticated version of the same. At the very least, patient autonomy should allow for some form of feedback from the patient. I was under the impression from both the right reverend Prelates that whatever the patient said would not be taken into account because they had a better and more authoritative idea of what would be good for him.

We have been told that the recent remarkable BMA decision and vote was completely within its rules. As has been said, the BMA's decision is,

"not to oppose legislation which alters the criminal law, but should press for robust safeguards for patients and doctors who do not wish to be involved in such procedures".

Whatever pleadings are made about the figures of the vote, it is a remarkable change of attitude.

I realise that the different organisations collect and report on the views of their members in different ways. I read the oral evidence of the Royal College of Nursing, to which the noble Baroness, Lady Thomas, also referred when making a similar point. Some members of the committee asked the representatives to justify why they were reporting as official policy their "collective" and what were called "themed" views against the thrust of the Bill when it was held to be known that a significant proportion of their members might not agree with that position. I understand that my noble friend Lord Joffe, despite being given assurances of further information and figures from the RCN about the basis of its claimed "themed" position, has still received nothing. One can only guess that this is the way it chooses to show so-called "leadership" to its members.

Another, alternative voice on this subject in the report comes from a nurse. It is set out on page 95 in Volume III. The nurse, the elected chair of the RCN Ethics Forum Steering Committee, submits a most reasoned submission; one made, as she rightly has to say, in her personal capacity. She states that she believes that,

"the submissions received during the RCN's formal consultation process were overwhelmingly in favour of changing the law".

In the first sentence of her conclusion she states her belief that:

"The vast majority of UK nurses support assisted dying for the terminally ill".

Whatever the percentages on either side, I believe that the present RCN approach is counterproductive.

Finally, perhaps I may point out a slight paradox. We are told by opponents of this Bill that the uptake of what might be available is likely to be on a considerable scale. Given that the nearest parallel will probably be the Oregon system, if I may use rather round figures, it is remarkable that out of around 30,000 deaths a year in Oregon, about 60 people are given the prescriptions they request and only 40 actually use them. On such a scale, that is not likely to cause a major change or upset in our attitude to death. The significant proportion of people who ask for the option but then do not use it points to the additional benefit for an even larger number who have the reassurance that a "back-up" system is there and is available to be called upon if they need it. That is a recognised phenomenon and was described very well by

the noble Earl, Lord Arran. When my noble friend Lord Joffe brings back his revised Bill, I strongly hope that this House will follow the recommendation made in the committee's report that it should have a formal Second Reading before going before a Committee of the Whole House, where I sincerely hope that we can have a rational and considered debate on the details of the Bill.

Lord Puttnam: My Lords, a couple of weeks ago a close friend of mine, a former Member of your Lordships' House, died surrounded by his large family in precisely the way that every one of us, given the choice, would wish to breathe our last. Sadly, that is far from being the common experience.

I think that this is the first time that I have tested the patience of the House on a subject on which I can offer no professional background whatsoever. We have been fortunate to hear from a great number of experts, those whose background as doctors and care workers have made them remarkably well versed in this most difficult of areas. The voice that I have found missing has been that of the patient; the desperately, terminally sick human being whose principal concern is to minimise their suffering and end their lives with some semblance of dignity. That voice does exist, but for the most part it has been left to the artist to convey it. My purpose here today is to ensure that this most important voice at least gets a hearing.

Like many of your Lordships, I have a personal story to tell. The death of my mother last December, aged 93, was a travesty of natural justice. I cannot fault the excellent care she received, but the final three months of what had been an active and healthy life were simply grotesque. As she slipped away, week by week, the person that my sister and I visited rapidly ceased to have any resemblance to our mother. This once energetic woman was reduced to little more than a confused, skeletal "living cadaver".

Did your Lordships know that those approaching death very commonly experience acute nightmares? No, neither did I. The closest my mother and I came to a "conversation" in those final few weeks was her all-too-vivid descriptions of being abducted—"kidnapped", as she believed—by those who appeared only to wish her harm. Every scrap of dignity was stripped away as she was simply—kept alive.

I would not wish any Member of your Lordships' House to suffer as my mother did in her final weeks. The belief that under our present arrangements pain and suffering can be kept at bay is, in too many cases, simply not true. It is not, as the noble Lord, Lord Carlile of Berriew, would encourage us to believe, a one in a million chance. Far from it.

A number of contemporary artists have taken a stab at depicting the personal experiences of people like my mother and, given my background, it would be odd were I not to draw your Lordships' attention to the cinema. It may be worth pointing out that artists, down the years, have tended to anticipate the future rather better than lawyers, doctors or even bishops. Like Alan Bennett, they are a voice well worth listening to. Three films at least should be compulsory viewing for anyone wishing to share what I would best describe as an experiential viewpoint. "The Sea Inside" has rightly been highly praised, but I suggest that your Lordships might find even more illuminating the French-Canadian film, "The Barbarian Invasions", along with the magnificent Japanese production, "The Ballad of Nayarama". All of these films, in their different ways, take you on a difficult but thoroughly educative journey.

I have touched on my own experience but I should like to offer another testimony from, as it were, the "front line". Alan Rusbridger, the distinguished editor of the *Guardian*, wrote earlier

this year about the death of his father. Here is a short extract from what I found to be a very moving account:

"My father was, so far as we could tell, quite often in agony. And my brother and I were placed in the awkward situation of begging, cajoling and—in the end—demanding that he be given ever higher doses of morphine.

Different members of the medical team appeared to have different views about what was an adequate, or even an appropriate dose. The 'night' team countermanded the 'day' team. The palliative care team didn't work at weekends!

I had a tense conversation with one Macmillan nurse to whom I had suggested raising the dose. 'I'm afraid we have ethical and legal difficulties with sedation' she said.

'I'm not asking you to sedate him', I replied. 'I'm asking you to do what he was promised—to be allowed to die without pain'.

My brother and I visited every day, spending hours by his bedside, But, as luck would have it, de-hydration finally took its course at a time when neither of us was there. So my dad died alone.

Why is withholding nourishment and treatment, as an old man withers away from dehydration, more ethical than intervening to help him die at the time, and in the manner, of his choosing?"

Are we honestly to accept that this is simply "God's will"? Was it God's will that some 20,000 people died in Kashmir at the weekend? Not my God. My God will be weeping. Is it entirely beyond us to navigate our way towards something altogether better— not "either/or" but "and"—a choice that might perhaps, at the end of our lives, dignify the human experience?

The Earl of Northumberland is reported as saying:

"It becomes not a valiant man to die lying like a beast".

That was almost 1,000 years ago. He was right then and he would be equally right today. Surely the time has come finally, seriously and humanely to address the manner of our parting. I unreservedly support the need for this Bill or something remarkably like it.

Baroness Howe of Idlicote: My Lords, I join other noble Lords in congratulating the noble and learned Lord, Lord Mackay, and his committee on such a knowledgeable and balanced guide to this very difficult subject. No one who heard the dramatic and sad account of the noble Lord, Lord Puttnam, could be other than sympathetic and very concerned about the conditions in which those whom he described died. However, if the Bill introduced by the noble Lord, Lord Joffe and not the Select Committee report were before us today I should be unlikely to support it. Apart from the concerns of the healthcare professions, to which I shall return, my reasons for caution fall mainly into the "slippery slope" category, which I think both exists and is very relevant. There is also the risk of masking the need for a huge improvement in the availability and quality of palliative care for those with terminal illness.

On the slippery slope concept, I am concerned that such a Bill could all too easily increase the risk of legalising assisted dying and euthanasia well beyond the three currently named

qualifying groups. The report rightly draws attention to the need for those categories to be much more clearly defined, but would that be enough?

There are, I fear, also some economic factors at work. We are an ageing population, and that means higher costs as well as benefits. Most citizens have little need of healthcare so long as they are young and healthy, but when and if they reach the point of being unable to care for themselves they deserve proper and, above all, pain-free—I insist on that—and, inevitably, increasingly expensive healthcare. Yet we know that they do not always get it. Indeed, far too often they do not get it.

Inevitable pressures exist—have always existed—on NHS budgets. Concern about delays in securing rapid enough approval for the latest cancer drug, about which we have heard over the past month or so, is just one example. The postcode lottery aspect of whether the health services needed are available in your area is another. So I share the concern, for all those reasons, that the basic human rights of the elderly and other vulnerable groups could all too easily slip still further down the priority list.

I turn now to the concerns of the caring professions. There is, rightly, much discussion of the role and responsibilities of doctors. That is entirely reasonable, for they are the people who would be prescribing lethal drugs or administering lethal injections. As the Select Committee made clear, hospital doctors would bear the main burden of euthanasia requests. Even so, I was disappointed to see how little emphasis there was in the report on the position of nurses.

Many years ago, I served on the commission, under the distinguished chairmanship of the noble Lord, Lord Briggs, on the future of the nursing profession. Its membership included every kind of medical, nursing and manpower expert. Being none of those, I gave myself the title of "Patients' rep", and from the patients' viewpoint, and in so many other ways, I came away with a profound admiration and respect for the nursing profession.

In the context of this report, nurses, in some respects, occupy an even more central position than doctors. They are generally the member of the healthcare team to whom patients feel most able to speak freely; they are usually with the patient all the time. The doctor, by definition, is generally a visitor and, albeit under the doctor's supervision, the continuing burden of patient care falls inevitably on the nurse. Of course, it is exactly the close relationship which develops between patient and nurse that is so critical in today's debate.

As the RCN has pointed out,

"there is a real danger that the proposals in the Bill could undermine the nurse-patient relationship, leading to a culture of fear amongst vulnerable people at a time when they most need to feel supported by their clinical team".

Many of your Lordships have raised that point. Yet, despite that, nurses seldom appear in the noble Lord's Bill either. Almost the only reference to the nursing profession is the general phrase "member of a medical care team". That is a serious deficiency.

Finally, let me say a word about palliative care—others have touched on it as well. The Bill would enable an applicant for euthanasia to ask for a palliative care consultation, but, as the committee wisely observed, experiencing good pain control is different from being told about it. To have reached the despair of requesting euthanasia, a patient is likely to have received inadequate care and to be completely worn down, unable to conceive of anything that would

really improve quality of life. It is therefore insufficient for any Bill that purports to see palliative care as complementary to euthanasia simply to offer the option of a consultation. We should not agree to end the life of patients who have not experienced good palliative care.

All that begs the question: why have those dying people not received good care? After all, the report tells us that Britain has the best palliative care in the world, so why are people still dying in despair? The answer, I fear, is simple. As with so much else in the NHS, Britain leads on quality but is deficient on quantity and, sadly, distribution. Up to now, the gap has been filled, to a large extent but by no means sufficiently, by the voluntary sector's Herculean efforts. Where there are specialist palliative care centres, as has been so brilliantly argued by my noble friend Lady Finlay, and doctors and nurses who have had specialist training, the ability to alleviate the suffering of terminal illness is little short of dramatic. The problem is that such centres of excellence are too few and far between, with the result that many people who are dying do not receive the end-of-life care that they deserve. Yet, we are debating assisting patients to commit suicide or giving them euthanasia, when, with some reallocation of NHS resources, we could solve the problem without changing the law and putting people at risk. Would it not be much wiser to concentrate on that vitally important second alternative.

Baroness Flather: My Lords, in spite of the dismissive way in which my noble friend Lady Knight spoke of dogs, cats and horses, I submit that in this country we adore our pets and give them the best care possible, we tolerate our children and are not that bothered about older people. The culture I come from is not quite the same. Older people are respected and cared for by the younger people, children are ever with the family and pets take a very low position. In this country, we spend money on pets and take advice from vets. If we want to keep a pet alive against a vet's wishes, we are told that we are being selfish. Yet we do not want to allow a person who can ask for help to have it. We do not want a person who is capable of making his or her wishes known to be allowed to do so. I find that very strange indeed.

We have heard a lot about the Netherlands. Different people have spoken about different things. I worked with a very good friend from the Netherlands who in the very early 1990s told me that her father was very ill. When I said "You will have to go and see him frequently", she said that she had met with her sisters and brothers and that they had decided that their father should have an early termination of life. In the Netherlands, euthanasia was practised before the law legalising it existed. When the law was introduced in 2001, it was not the first time euthanasia was used. I am sure that my noble friend Lord McColl will talk about his experiences in the Netherlands when we served on the committee chaired by the noble Lord, Lord Detchant.

The situation in the Netherlands is very strange: they were practising general euthanasia, not voluntary euthanasia, long before any law came into being. They are now moving back towards regularising the position. That is a fact. I heard it from my friend and noble Lords will hear more about it in a while.

It is interesting to hear from people of deep faith. It is not possible for anybody who has a deep-seated faith to acknowledge or accept that any patient should be helped to die by a family member or doctor. It is clear that if you believe in God, how and when you go must be God's will.

I was a little surprised by the comments of the most reverend primate the Archbishop of Canterbury in the *Telegraph* yesterday that we were sleepwalking towards a breaking of trust between doctor and patient. I did not think that we were sleepwalking. Given the number of

debates that we have had on the subject and the wonderful report that has been produced, I would not call it sleepwalking. Our eyes are wide open; some of us feel one way and some feel another way, but we are not sleepwalking. Nobody should be in any doubt that we have considered this matter personally and deeply.

I was very much taken with Win and Jan Crew, whom I met at one of the meetings of the noble Lord, Lord Joffe. They took Mr Crew to Switzerland to die. It was absolutely amazing to see those two women, and how when you love someone, you would do that for them—but you cannot do it in this country. Having heard the speech of the noble Lord, Lord Puttnam, I do not think it can be moral to let somebody die by millimetres—I do not want to go into inches—and use the double effect. I find double effect to be hypocrisy, whether others do or not.

This is a very personal issue. Each of us should try and put ourselves in that position and ask how we would feel and what we would want. We cannot speak for anyone other than ourselves, but many people in this country want some provision. Social legislation does not come out of the ether; it follows public demand. I congratulate the noble Lord, Lord Joffe, on being so persistent. It is very difficult to take on something as controversial as euthanasia.

I do not think that assisted suicide is the way forward. Assisted suicide should be available if one wants it but it should also be possible to have voluntary euthanasia. As the noble Baroness, Lady Finlay, said, it can take 30 hours for a person to die after taking pills. Unless a magic pill is produced, we need voluntary euthanasia in this country.

Lord Cavendish of Furness: My Lords, before my noble friend sits down, and for the purpose of clarity, will she confirm whether, in the example she gave, it was the Dutch family who were going to decide the fate of the father?

Baroness Flather: Yes, my Lords.

Lord Cavendish of Furness: I am much obliged, my Lords.

Baroness Flather: My Lords, I was trying to show that we are not in the same situation as the Netherlands—it is completely different. The Dutch have been practising non-voluntary euthanasia for a long time.

Baroness Masham of Ilton: My Lords, this mammoth debate shows the interest that there is in this very complex matter. It is obvious that the committee, under the chairmanship of the noble and learned Lord, Lord Mackay of Clashfern, worked very hard to produce this report.

Everyone should have the right to refuse life-prolonging treatment if they so wish, but I cannot support the belief that terminally ill people should have the right to medical assistance to die—pain relief, yes, but not killing. It would be impossible to ensure that any safeguards were not abused, and I agree that the law should not be changed to permit killing, whatever the motive.

As a disabled person with a long-term, permanent condition, and also having a husband who now has multiple, complicated illnesses, I rely on advice from specialist doctors. Above everything, I want to be able to trust them, in the hope that they will preserve life and not give up and kill us.

I am glad that the General Medical Council wrote to the committee to say that a change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities of doctors and their relationship with patients. If the Bill has done anything useful, it has highlighted the need for good palliative care for all who need it.

Many people to whom I have spoken, or who have written to me, have said that it is sad that the BMA's decision appears to leave the medical profession in the position of washing its hands of the clinical responsibilities for preserving life. Naturally, it is understood that there will be cases where some medical support has been applied to prolong life where easing pain might have been more appropriate. The use of painkillers with the intention of easing suffering would be considered morally acceptable by all, even where this may have the unintentional effect of accelerating death. Is it not the action of giving treatment with the intention of accelerating death that is not acceptable to many people? Such a change in the law to permit euthanasia would be a step over a moral boundary irrevocably with long-term consequences which cannot be foreseen.

I shall quote Jane Campbell, who is a disability rights commissioner. Jane is severely disabled, but works hard. She says:

"The impetus behind calls for assisted dying is fear. People find severely disabled people so difficult they want to pity or tidy them away. They see facilitating death as an ultimate act of pity. No wonder people who fear death see euthanasia as a possible escape. Before considering assisting people to die, should society not assist them to live?"

I hope that all your Lordships have seen and read the open letter from the British faith communities expressing grave concern at continuing and renewed efforts to legislate for euthanasia. I thank all the faith leaders who have signed the letter and I associate myself with their concern that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death. The so-called right to die would inexorably become the duty to die. Economic pressures and convenience would potentially come to dominate decision-making.

I was reminded the other day that I had once officially opened a GP surgery/health centre in South Yorkshire and that Dr Shipman had worked there. The way in which he killed innocent, trusting patients and got away with it for so long shows the power that doctors have. If we legislate, will we not be opening the door to all sorts of dangerous people instead of protecting the vulnerable?

Baroness Tonge: My Lords, I became a supporter of assisted dying for the terminally ill after 30 years of medical practice and eight years as international development spokesman for my party. I may not have as much experience of the dying as the noble Baroness, Lady Finlay, who spoke very eloquently earlier, but I have to say to her that I know the various clauses in the Hippocratic Oath and I notice that many of them have now been dropped. Medicine changes; for instance, Hippocrates urged us not to cut for stone. If we were not doing that nowadays, many people would suffer agonies from renal stones and gallstones. Medicine changes and we must change with it and look at things differently as different treatments become available.

Lord McColl of Dulwich: My Lords, perhaps I may point out that we do not cut for stone. It is done with a machine that smashes up the stone inside you and the dust is then passed. We do not cut for stone—unless we really have to.

Baroness Tonge: My Lords, I am well aware of that, but we went through the stage of cutting for stones. Indeed, many members of my family were relieved of their gallstones and were very grateful for it. I do not think that lithotripsy is used for gallstones, but I may be mistaken.

Lord McColl of Dulwich: It is, my Lords.

Baroness Tonge: My Lords, I want to address common concerns expressed in letters that I have received from all over the country by referring to replies from—yes—the Oregon Medical Association and the Dutch Medical Association in response to questions that I put to them. Neither of these organisations gave evidence to the Select Committee, but they are representative of doctors who are putting the law in their country into practice.

Many articles have been written and talks given. I have received many letters expressing worry that the disabled, the elderly and the terminally ill will be under pressure to die to save relatives or society the pain of looking after them. In my experience, the reverse is often true. It is the relatives themselves who cannot bear the thought of the death of a loved one and so will encourage those people caring for the dying to keep their loved one alive at all costs. In our modern society, it is death that must die in many people's eyes. Many hospital doctors are afraid that relatives will sue if they think that enough was not done to save their loved one, so the suffering is prolonged.

I have seen people kept alive at all costs. People are tortured to death—I mean that—instead of being allowed to die with dignity and in peace. My noble friend Lord Carlile said that he preferred death by nature. I wish him luck. If he prefers death by nature, he should not go near any doctors when he is dying, because I suspect that that would not happen.

Lord Carlile of Berriew: My Lords, I cannot allow my noble friend to get away with that. She has grossly misrepresented what I said. I did not say that I preferred death by nature. I said that death as a natural process and through disease seemed to me to be at least as dignified as having someone else end your life for you. That is a completely different point. I ask my noble friend not to misrepresent what I say.

Baroness Tonge: My Lords, I thank my noble friend for clarifying his position, but I urge him to think very carefully about it, because we would all like death by nature, but as I said earlier, a lot of people do not achieve that because other people will not let them have it. They prolong their lives unnecessarily.

When asked whether they had had any evidence of vulnerable people being forced into receiving assistance to die, both the Oregon Medical Association and the Royal Dutch Medical Association said that they could not give any examples. The patients to whom we are referring in this regard want to maintain control over their life and death, and they can do so in Oregon and the Netherlands.

Asked about the "slippery slope" argument, both Oregon and the Netherlands responded with demographic evidence that the law is being used as intended and that the number of people opting for doctor-assisted dying is stable and not rising. Evidence from the United Kingdom published in the *Lancet* a year or so ago, to which I believe my noble friend Lord Russell-

Johnston, referred, suggests that there are already about 18,000 medically assisted deaths in the UK per annum. I do not know where that figure comes from, but presumably those assisted deaths are performed by doctors without any regulation or oversight. I wonder how many of those deaths were done with informed patient consent. Surely that could be the slippery slope that we so dread. It must be regulated, and the doctor-patient relationship must change, with patients being in control of their lives and their deaths, not the doctors. The Oregon Medical Association found it difficult to assess whether the new law had affected that relationship, while in the Netherlands the problem had been the number of doctors who refused the patients' request; they said that 66 per cent of requests were not met because the doctor felt that the criteria for assisted suicide had not been met.

The problem of palliative care was another question posed. As we have heard, some practitioners of palliative medicine claim that if we had better facilities in the United Kingdom, no patient would want to be helped to die. I would argue with that. Pain and its relief is not the only issue; total paralysis is the fear of many with incurable neurological disease. The most famous cases, such as that of brave Diane Pretty, fall into that category. No palliative care can alleviate the suffering of total paralysis, being unable to speak, swallow, blink or scratch—a complete nightmare. Many patients in intractable pain would prefer not to end their days in a diamorphine-induced trance, unable to communicate with their loved ones properly and eventually succumbing to the "double effect" when their breathing fails. Palliative care is much needed for those people who want it, and the responses from the Oregon Medical Association and the Royal Dutch Medical Association—from authoritative associations—suggest that the reverse is true of the fears expressed in this House. In Oregon, task forces delightfully called "comfort teams" have been set up to help clinicians, and they say that no one in Oregon now goes without palliative care if that is what they want.

In conclusion, many of the objections to doctor-assisted dying come from people with a political-religious viewpoint—which is fine for them, but they should not impose their view on others. Many other objections are based on anecdotal so-called evidence, which is inadmissible. We have assurances from both the medical associations that have seen the proposals in practice. We hear much about choice nowadays; terminally ill patients have a right to choose, too. Whether they choose palliative care or assisted suicide or opt to continue suffering is their decision—and they must be allowed to decide for themselves.

The Lord Bishop of Winchester: My Lords, before the noble Baroness sits down, is it her view—as it appears to be the view of others—that those who speak on these issues in the public domain from a position of religious faith are uniquely disqualified from doing so because that is among the positions from which they speak? Has it also occurred to her that bishops and others who speak on these matters do so in part out of a centuries-old tradition and from experience of being alongside people who are dying? Not only medical and nursing practitioners but clergy and ministers, too, speak out of that continuing experience—bishops continue to be priests and pastors. I wonder if those questions have informed the things that the noble Baroness has been saying.

Baroness Tonge: My Lords, it is very important that bishops and priests continue to express their views on these issues from their religious background, because those who hold those religious beliefs want to hear what they have to say about them. Indeed, they have much experience and I would listen to every word that they say; I frequently hang on the words of the right reverend Prelate the Bishop of Oxford, who is frequently on the "Today" programme, because he is so wise. I am only saying that one cannot legislate for other people from a religious point of view; it must be their decision.

Lord Tombs: My Lords, I first join others in congratulating the noble and learned Lord, Lord Mackay of Clashfern, and his committee on dealing with such a complex and emotional subject in so careful and sensitive a way. I will not repeat the arguments so clearly set out in the report and expanded upon by previous speakers. The issues are by now clearly understood, and personal autonomy plays a major part in the arguments.

For my own part, I believe that regard for personal autonomy has played too large a part in recent developments of society and a growing recognition of this appears in the constant pleas for a recognition of individual responsibilities to accompany discussion of individual rights. But what I believe has gone unrecognised in the general discussion is the role of the law in maintaining the delicate balance on which the stability of society depends. A right, once recognised by law, is unlikely to be withdrawn, and a more likely development is a steady extension by seemingly marginal amendments. Hence the "slippery slope" becomes in practice a "legal ratchet"—a fact well recognised by human rights campaigners and exploited by them with considerable success. The extension is presented as small and so is perceived as unimportant compared with the large, earlier step.

Even more dangerous than this mechanism of gradual extension is what might be described as the background effect of the law in shaping society's values. The fact that something previously illegal becomes legal, albeit under clearly stated conditions, is in a real sense permissive and even encouraging. The general public perception is one of relaxation of previously condemned behaviour and a resulting relaxation of controls without a perceived need for any further legislation. Such a development has occurred in abortion practice, where the legislative safeguards have become steadily eroded in practice, with no resulting enforcement action. This increased disregard of carefully constructed law is unhappily present in Holland, where evidence to the committee showed a substantial number of cases of what is euphemistically termed "involuntary euthanasia", when a doctor has killed a patient without that patient's consent. That is not even assisted suicide, it is quite simply murder, although it has resulted in no prosecutions. This startling development was accompanied by an admission that 46 per cent of cases of euthanasia are not even reported, despite a legal requirement to do so—again with no enforcement action. It is hardly surprising, then, that some elderly patients in Holland choose to go to Germany for medical treatment.

It is clear that the bulk of the medical profession in this country is strongly opposed to this Bill, in spite of the disreputable manipulations of some supporters of euthanasia in the councils of some medical organisations. Happily, the general opposition remains unaffected and I would like to pay tribute to the vocation of healing that underpins that opposition. The UK scene differs from that of most countries in that we are comparatively well provided with hospices for the terminally ill, a provision which is gaining ground worldwide. The founder of the movement, the late Dame Cicely Saunders, pioneered pain management and produced that memorable aim, "dying with dignity". Today, the philosophy of the hospice movement is,

"to enable people to live until they die".

What a wonderful contrast to the bleak notion of assisted dying! Palliative care, too, is an area of medicine in which Britain is a world leader. Many patients have died naturally and with dignity as a result of adequate and supportive palliative care. Unhappily, neither of those initiatives has received adequate government support. The hospice movement remains heavily dependent on voluntary support and palliative care is not readily available in many areas of the country. As the voice of society, the Government bear a heavy responsibility in these areas and I hope that the Minister will address the problems in his closing speech.

Respect for the life of the individual lies at the heart of society, and a departure from that long-held position, at a time when pain control and palliative care are at an all-time high, seems to me perverse in the extreme. The difficulties of reliable prognosis of terminal illness and the pressures which can so insidiously creep into the minds of sufferers should themselves make us reject the proposals of the Bill of the noble Lord, Lord Joffe. I shall do so in the event of its return to this House.

Lord Desai: My Lords, I support the efforts of the noble Lord, Lord Joffe, to make death human. I supported him before the Select Committee produced its report and, if he fails this time, I shall continue to support him when he next tries the same thing again.

I have no doubt whatever that what he is doing is correct. Perhaps I should now sit down. However, I have two comments to make. It is not so much a matter of personal autonomy, although I like personal autonomy; it is a matter of only you being able to feel the pain that you are suffering. I can share pleasures; I can share laughter; I can share love, but if I am in deep and excruciating pain, I do not want a palliative or a painkiller, I want to get out of it. I do not believe in God. I do not believe that God brought me here—human beings brought me here with some assistance from a doctor. When I want to go I want to go with some assistance from a doctor. If that is not going to happen in this country, if I have the strength and co-operation, I shall go wherever I can die through my own choice. That is what I want. If fate is against it, that is tough luck. I ask your Lordships please to pass a Bill for atheists so that I can die in peace. That is what I want.

All kinds of comments have been made to the effect that we are not alone and are dependent on other fantastically interesting relationships. However, the people who say that we are in these lovely interdependent relationships are also the people who worry that if this Bill is passed people would kill their elderly relatives. We suspect that our relatives are as likely to kill us as to keep us alive. The right reverend Prelate the Bishop of St Albans is not present, but he said that he had never heard a poem about personal autonomy. As he is not here, I shall not tell him how many poems I know about personal autonomy. However, he is wrong in thinking that people do not celebrate their own freedom to be what they are. We all should have a long life and a quick death. If society will not let me have that, I shall get it somehow or other.

Lord Alton of Liverpool: My Lords, when we last debated the issue of euthanasia and assisted suicide I set out my own reasons for opposing such a change in the law, but I supported the reference of these complex questions to a Select Committee. Along with others in your Lordships' House today I should like to pay tribute to the Select Committee for the honourable and diligent way in which it has discharged its duties. I pay tribute particularly to the noble and learned Lord, Lord Mackay of Clashfern, for chairing that committee so well.

Before considering whether we should legislate in such a controversial area surely four things would be necessary. Let me take those in turn. The first is: is change really necessary? The existing law and the General Medical Council's guidelines have hitherto provided a good framework. As my noble friend Lady Finlay of Llandaff said in her powerful speech earlier today, through the palliative care movement we can provide the answer for those who are in suffering and pain. There is no division in your Lordships' House today that where bad medical practice exists, it needs to be put right, but is this the way to do it?

The arrangements that we have in this country are admired and commended by many. The Select Committee at paragraph 59, page 25 of the first volume noted in connection with the 2002 European Court of Human Rights judgment the court's view that our laws are,

"designed to safeguard life by protecting the weak and vulnerable",

and that,

"the blanket nature of the ban on assisted suicide was not disproportionate"

and that there is "flexibility" in our law. Nor could any justification for assisted suicide be found within the convention on human rights. So we should not be propelled pell-mell into change simply for the sake of it.

My second criterion that I think should be met is the argument about whether there is widespread agreement on the need for change. Quite the reverse is true. There is a clear lack of public and political consensus reflected in the thorough way in which the Select Committee has highlighted the deep differences of opinion and practical difficulties—divisions that have been mirrored again during this extraordinarily moving and at times very well-informed debate that we have had in your Lordships' House today. This should make us all extremely wary of legislating in haste. Many have expressed the fear that this is a first incremental stage—a phrase used in the Select Committee report—towards widespread euthanasia; a view underlined by the opposition of, among others, the Disability Rights Commission. Many of your Lordships will have received their representations over the weekend. I am personally involved as a patron of three hospices. I know that many other noble Lords are also involved in the hospice movement. We are all very well aware of the representations that that movement has made. It is fearful that changes in the law will undermine good palliative care and the work of the hospice movement.

Thirdly, is the medical profession demanding change? We have heard today about the BMA's neutrality. However, not everyone is neutral. The Royal College of General Practitioners, which represents some 23,000 members, says that,

"with current improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation is not needed".

The Royal College of Nursing holds a similar view. That position was tellingly reinforced in a letter I received last week from Dr. Kathryn Myers. She describes what she calls the "extremely small" number of patients who might seek euthanasia. She states:

"My clinical experience has persuaded me that there is a far larger number of chronically ill patients who have no prospect of cure who might choose, or be persuaded to choose, Physician Assisted Suicide out of a sense of duty to their families and to society as a means of lessening the financial and emotional burden that they perceive their illness places on others".

In other words, as my noble friend Lady Masham said earlier, doctors fear that the right to die will become a duty to die.

Fourthly, is there political will for change? That point was made earlier by the noble Lord, Lord Carter, in his telling speech at the beginning of our debate. Successive governments and

the Leader of the Official Opposition in your Lordships' House, have said that they will not provide time for this sort of legislation. The elected House would have to be convinced. The last time a comparable measure was introduced there during the time I was a Member of another place it was overwhelmingly defeated. Before going any further the opinion of the elected House ought to be sought again.

But if these four criteria for proceeding have not been met, what of the principles underpinning the Bill? In 1994 the Select Committee on Medical Ethics, so ably chaired by my noble friend Lord Walton of Detchant, unanimously concluded that legalising voluntary euthanasia or assisted suicide would be wrong in principle and dangerous in practice, representing a grave danger for many vulnerable people. Those principles and those dangers have not been eclipsed by the mere passage of time. And what of the Oregon model of which so much has been said during our debate? Those states in America that have examined Oregon as a model have all rejected it. Professor John Keown of Georgetown University in a letter to me quotes the latest position as,

"at least 54 assisted suicide and/or euthanasia measures have been introduced in 21 states. Not one has passed. On the other hand . . . seven states passed laws prohibiting assisted suicide".

The professor of radiation oncology at Oregon's only medical school, Professor Kenneth Stevens, is a doctor who has specialised in cancer treatment for 38 years, yet whose views were dismissed as irrelevant earlier in the debate. He says:

"The more I have learned, the more I realise the significant harm and danger of assisted suicide to the vulnerably ill and to society".

He points to a profound negative shift in attitude towards the terminally ill. He says that the commitment to care has become a commitment to the option of killing, with some non-terminal patients now considering assisted suicide. He says that there has not been a single instance in Oregon of assisted suicide being used for untreatable pain, and there have been problems with safeguards and with monitoring. It was said earlier that numbers have been about static in Oregon since the introduction of the law. I have here the seventh annual report on the Oregon Death with Dignity Act, which shows that the number of assisted suicides in Oregon—though small—has increased by more than 225 per cent over the past seven years.

With great honesty, the noble Lord, Lord Joffe, made clear to the Select Committee that his Bill is, in his words, but a "first stage" and that he would prefer to see a law of much wider application. The House should ponder deeply before endorsing such a first stage, knowing in advance the destination to which we are being invited to travel.

Baroness O'Cathain: My Lords, even at the position of speaker number 39, I feel compelled to join everyone else in congratulating the Select Committee under the wise chairmanship of the noble and learned Lord, Lord Mackay of Clashfern. It has done a brilliant job.

Today, we are debating one of the most important issues that could ever come before this House. It is an issue of gravity that affects every single inhabitant of this country; namely, whether we should agree to determining the length of our lives. Its importance is obviously recognised by this House by the very large number of speakers. In my experience, it is a far greater number than for any other non-government issue.

The proposed Bill would be profoundly contrary to the Christian faith and to the basic values shared by British people of all faiths and none. As an aside, I have been advised not to mention the Christian faith in this House. I regard that as almost unbelievable. Over 70 per cent of the population has stated in the last census that they are Christian. As has already been stated, that colours our view. The issue we are addressing is whether there are any circumstances in which we should authorise doctors to help people to end their lives.

I unequivocally oppose the demand for a euthanasia Bill. That is really what we are talking about. Patient-assisted suicide is just the beginning, as has been stated many times. If we start down that road and agree that doctors can help patients to kill themselves, the Voluntary Euthanasia Society would no doubt maintain that we have accepted the principle and that voluntary euthanasia is just an extension of that principle. I pray and hope that this House will reject the call, and most rigorously.

The psychologist Neuhaus, quoted in W J Smith's book *Forced Exit* published by Random House, New York, in 1997 put the point succinctly and suggested that those who support euthanasia,

"will attempt to guide the unthinkable on its passage through the debatable on its way to becoming the justifiable until it is finally established as the unexceptional".

Our postbags make so many points, but some are made by almost everyone. They include, first, that this is a huge step in the direction of total breakdown of trust between doctor and patient, a point made by doctors and patients; secondly, that elderly people are frightened; thirdly, that the frail fear intimidation; fourthly, that some feel that they would have a duty to remove the burden on their families; fifthly, that those nearing the end of their life feel guilt that they are spending on long-term care the inheritance earmarked for others; and, sixthly, anxiety that the parlous state of the National Health Service's finances could result in pressure being put to end the expense of care. I have just listed those points; the noble Baroness, Lady Wilkins, elaborated on them in a most moving speech.

Interestingly enough, I have had no letters supporting the proposed Bill. The BMA alone wrote to me stating that it was neutral, but how democratic was the vote? Yes, we all had a letter last Saturday trying to justify the stance, but for me it rang pretty hollow. Briefly, I shall focus on personal autonomy, which is regarded as the kernel of the issue by those who want to see the law changed. Personal autonomy is a highly dangerous concept unless it is properly understood and applied to the right issues. I have always been a believer in people taking charge of their own affairs. Individual choice and personal responsibility are important, and as economic concepts they have served this country well. But one cannot apply economic and political concepts uncritically to the moral and religious sphere. When we try to apply personal autonomy to the transition from life to death we really are trying to play God.

The right reverend Prelate the Bishop of Oxford quoted the statement of Professor Harris, one of the witnesses. I too picked up on it when I read the report. The ending of our lives determines life's final shape and meaning, both for ourselves and in the eyes of others. When we are denied control at the end of our lives we are denied autonomy. The professor implies that if we cannot control our death we are not dying well. I refute that totally. To state the obvious, we are all going to die one day. A good death does not consist of tailoring your departure from this world to your own personal wishes. What determines one's life's final shape and meaning—to use Professor Harris's words—is how one handles the dying process, which involves how one lives spiritually, physically and emotionally during the process rather

than how one evades it. To argue for assisted suicide or euthanasia on the grounds of personal autonomy is to oversimplify the problem.

Another witness, Dr Rob George, a consultant in palliative care with a great deal of first-hand experience of people dying, defined autonomy as:

"Self-government rather than self-determination".

He described people who wanted to end their lives as,

"people who are not willing or prepared to engage the issue".

The view of Dr George is on a par with many of the witnesses who had similar experiences of the dying process; namely, that those who want to decide when they die are generally people whose suffering stems more from the fact that they know they are terminally ill than from actual symptoms. We need to recognise that a request for assisted dying, like an attempted suicide, is normally a cry for help, and that is how we should treat it.

Severe depression is often a concomitant of terminal illness. It can be treated effectively, as I know from personal experience. I spoke about that on 25 June 2003 at col. 370 to support my noble friend Lady Knight in the Mental Capacity Bill. Since then, I have had additional sad experiences of the early deaths of my two younger and only siblings. The inevitable deep sadness for me was hugely compensated for by the fact that they both had "good" deaths. Frequently, the dying process is a true period of closeness and an opportunity to show love and respect; a period of reconciliation both with fellow human beings and with God. All of that is of great benefit to both the dying and to those who are ultimately bereaved. Yes, I have witnessed only happy, calm and peaceful deaths, but one cannot overemphasise what solace and good memories result.

The Select Committee's report states that Britain is the world leader in palliative care; however, we know that not enough money is spent on it. It is a disgrace that in a nation blessed with wealth like ours anyone should die in pain. Surely a wish for euthanasia is not a longing for death but a fear of pain and suffering. Barrelling headlong into a euthanasia society is completely the wrong approach. The real, humane solution lies in improving palliative care.

We have day-long debates and three-inch thick reports on a euthanasia Bill. I hope that we shall resoundingly throw out the proposal for such a Bill and hasten the preparation of and investment in just as much time and effort in a palliative care Bill.

Lord Carey of Clifton: My Lords, debates in your Lordships' House are usually important, but that on the report of the Select Committee and its implications must surely rank as among the most crucial, as far as the most vulnerable and helpless people are concerned. In contributing to the debate, I wish to dissociate myself from the view that those of us who disagree with the thrust of the intentions of the noble Lord, Lord Joffe, have a higher view of human dignity than those who present the case for assisted suicides and voluntary euthanasia. I salute the noble Lord's tenacity and recognise his concern for individuals who wish to terminate their life at a time of their own choosing. Neither side can claim to have a complete monopoly of the moral high ground. We may disagree strongly about the issues before us, but we are united in wanting the very best for such individuals and for all those who approach the end of their life in pain, distress and fear. I felt the tug of the noble Lord's argument over

several months and found the debate helpful in enlarging my understanding through some excellent speeches. The noble Lord, Lord Puttnam, was very moving, and the noble Lord, Lord Carlile, presented a very persuasive argument.

I want to take up one short although complicated issue opened up by the right reverend Prelate the Bishop of Oxford and the noble Lord, Lord Carlile. It is sometimes alleged that people who are opposed to euthanasia as in this kind of debate are religious zealots, with the implication that people without religious convictions—the so-called majority—are not opposed to it. That is a false division. Allow me to focus on just one issue—autonomy—which has been taken up again and again. We all see it as important. You do not need religious convictions to acknowledge that legalising such acts would be a mistake.

It is clear from the Select Committee's excellent report that those who argue for euthanasia use as their main argument the concept of personal autonomy, but, as we have seen, autonomy is a weasel word. Autonomy means making up your own rules, and in a civilised society that is not possible. Who is completely free of duties to others, and where do we draw the line where life's decisions are only ours to take? Behaviour in a civilised society is necessarily modified to take account of the interests of others, so principled autonomy should replace the individualistic version of personal autonomy. In the application of the principle of autonomy at the end of life, the choice of the right to die inevitably affects others—especially medical staff who act on your choice and those who are left behind.

It may surprise some to know that Christians support principled autonomy. The Christian emphasis is on duties rather than rights—on personal responsibility rather than personal autonomy. One witness to the Select Committee aptly spoke of,

"respecting the autonomy of the individual as self-government rather than self-determination".

But it is not only Christians who believe that they cannot expect to have total control over their life. What they can and must have control over is themselves. If we succeed in doing that—how many of us attempt it, and how many of us do it—life will be better for us and those around us. The inevitability of death has to be accepted, but the manner in which I accept it—not whether I can control its time, place and method—determines whether I die well.

I want to intervene in my own argument to speak gently to the noble Viscount, Lord Craigavon, who in his otherwise excellent speech charged the right reverend Prelates the Bishops of St Albans and of Oxford with perhaps imposing their view on the rest. If he reads their speeches, he will see that they argue that they want judgment to be made on the rational argument, not on a particular religious point of view. Maybe he is in danger of imposing his view. All of us together have to find a way through the issue.

Christians and those of many other faiths believe that this life is not the sum total of reality and that they are answerable to God for the way in which they live, die and help others who are dying—not by killing them, but by easing their pain and other suffering. They believe that human life is a gift from God and that we have no right to take it. You may say that most people in Britain today are not practising Christians, so why should Christian values be imposed on others? I suggest that there are many—like my parents when I was growing up—who may not go to church or have a clearly defined Christian faith and structure, but the culture from which they draw their values is essentially a Judaeo-Christian one with an

emphasis on compassion, forgiveness and the sanctity of human life. Such values transcend narrow denominational boundaries. They know too that the choice to die cannot be regarded as purely personal and private. It affects other people. To ask a doctor to help to draw your life to an end is to draw that person into your choice in a way that cannot be regarded as morally neutral. It will affect the doctor-patient relationship in a fundamental way.

Furthermore, even if people do not share the Christian view that euthanasia is morally wrong, many believe that it is misguided; I judge that from the letters that I have received. In that respect, Christian values are at one with good sense and our sense of abiding human values. There are sound secular as well as religious reasons not to go down this road, and I say that with respect to the noble Lord, Lord Joffe. People who argue against changing the law do not do so because they are religious fanatics. Some of them—a substantial number—have religious convictions that tell them that medicalised killing is wrong, but many more can see important civil reasons why society as a whole, especially its more vulnerable members, would be threatened if the law were changed.

Lord Layard: My Lords, we have all had many letters on the subject, and the most interesting one that I had directly addressed whether a doctor would be playing God if he implemented the Bill. The writer argued that, quite to the contrary, a doctor is playing God by denying a dying person their desire. That is the basic issue that we have to address. It is why the public opinion surveys of what people want are so relevant. They are not opinion surveys like those on capital punishment that ask what you would like done to other people; they are about what you would like for yourself, and 80 per cent of people want the Bill. The figure is more than 80 per cent of disabled people, and a majority of elderly people, and of Catholics and protestants, which is very relevant. The central issue is whether we should try to give people what they want in this matter.

I would never say that one should automatically allow people what they want, especially if it affects other people, as has been said many times. I would not say that, even for some purely private matters. But this matter is very private, where the dying person knows so much more than anyone else.

Regarding autonomy, I cannot imagine that any defender of this Bill thinks, as some right reverend Prelates have seemed to imply, that autonomy is the only good. No one I know thinks that. I certainly do not think that. But autonomy is pretty important when you have little else left of your life. I would have thought that the autonomy argument ought to appeal particularly to liberal-minded noble Lords on the opposite side of the House. After all, what is this Bill? It is a Bill of deregulation. At the moment there is a ban—but which is extremely irregularly applied. Today, I learnt a very relevant fact about what would happen if, for example, my mother was dying in pain at home, she asked me to buy 60 paracetamol tablets, I bought them, took them home, she took them home and she died. If I was prosecuted I would get a reprimand. It is only in hospital that I could not perform that act of love. Surely, that is an anomaly that requires some type of remedy such as that proposed in the Bill. It would be absurd to label that remedy a "therapeutic option". That is not what we are talking about. We are talking about doing in a regular way what can happen only irregularly at present. I end with the "slippery slope" argument. I have been told that in the first six months of this year, the "slippery slope" was referred to 120 times in this House in topics ranging from the Charities Bill to the Speakership of the House. Even so, we must take the argument seriously. Put most generally, if the Bill was enacted, would the system become inured to assisted dying in a manner that led to it becoming more common, perhaps through further legislation or other channels? We do have to look at other places where such legislation has been introduced to

look for evidence. Has there, in the case of either Oregon or Holland, been any increased trend in assisted dying? And what has been the impact on involuntary euthanasia which happens when doctors hasten the process of death? We have statistics from some countries, but in Holland there is no evidence that that has become more common over time. Incidentally, in Holland involuntary euthanasia of that kind is low compared with other countries for which there is evidence—probably due to the scope for voluntary assisted dying. That makes sense, does it not?

Trust of patients in doctors is higher in Holland than in any of the 11 countries surveyed, including our own. Doctors in seven countries were surveyed and were asked whether they thought that voluntary assisted dying would increase involuntary euthanasia as a result of the "slippery slope" argument. The majority said, "No". So we can let the slippery slope argument slip to where it belongs and return to the basic issue—respect for the wishes of the patient and for the relief of their suffering. If patients wish to receive life-preserving treatment we grant their desire. That is contrary, I assume, to the teachings of many religions, but we grant it. By the same logic, we should, surely, grant those patients' desire for assisted dying. In fact, would we not be playing God if we refused to do that?

Lord Maginnis of Drumglass: My Lords, I join those who have acknowledged the work done by the noble and learned Lord, Lord Mackay of Clashfern, and his Select Committee and thank them. Understandably the committee has considered the issue without coming to a conclusion but assists us by carefully defining the terms in which we might address the matter.

Unlike some, I have no great regard for euphemisms and believe that it is important to acknowledge that both "assisted suicide" and "euthanasia" are "killing". It cannot be otherwise in so far as both bring lives to a premature end. The Voluntary Euthanasia Society has claimed that a vast majority favour a change in the law. I firmly doubt that. It may be the fashionable thing to say when the question is put in terms of "unbearable pain" or "loss of dignity" associated with incontinence, but those can be superficial and misleading criteria. I have never found euthanasia to be a subject that arises in casual conversation. It is not a matter to which the "vast majority" has ever turned its collective mind. So, in terms of the vast majority, we should be exceedingly cautious. Perhaps I may deal briefly with the so-called loss of dignity. As one who has been in the presence of death—lingering death, sudden death and, I regret, violent death—I can say that there is inevitably and invariably incontinence. I do not know why the Voluntary Euthanasia Society attempts to persuade us that the indignity of incontinence is a likely motivation for a patient to want to be killed off. Incontinence is a condition often associated with comparatively healthy old age. What would the Voluntary Euthanasia Society propose in that circumstance? None of us came into this world or spent our initial years in a particularly dignified fashion, if that is the criterion by which we make a judgment. So why should we now exaggerate the relevance of that matter in the context of how we leave this world?

I have the greatest admiration for nurses and doctors who work at the coalface and particularly for those who provide palliative care—I shall return to that issue later. Where I have grave reservations is in the area where government would, as we have seen recently, deny women suffering from breast cancer access to a drug that might extend their lives and improve their quality of life because of the cost.

And what does one say about a society that over the past few years has allowed our pension system to become massively underfunded to the tune of billions of pounds? Will that not

precipitate even greater loss of dignity in old age than anything that may derive from terminal illness?

I raise those examples because I firmly believe that, should we ever legalise so-called "mercy" killing—I do not see it as such—the pressures on the sick, the elderly and the infirm would obviously be to do with pounds, shillings and pence. I shall not rehearse what I have previously said in your Lordships' House about "socially convenient" abortion, but therein lies an obvious parallel. There, we really should think about what we once legislated for and what we have now.

To those who will cite the legal safeguards that will exist, I must say that most people would be happier if life and death issues were left to those who are bound by the Hippocratic principles that have underpinned people's faith in the medical profession for hundreds of years. The law is too much of a movable feast. We saw that when, for example, Commander Paddick decided that in his area of responsibility some drugs offences would no longer be brought before the courts. Could we have similar varied interpretations in cases of so-called mercy killing? Would the huge cost factor of court appeals militate against litigants and limit recourse to the law? In case anyone suggests that I have a religious prejudice that motivates me to speak today, let me reassure him—I have. It is the same motivation that made me vote against capital punishment in another place—because I was not in a position where I could ever "cast the first stone".

Human rights, democracy, equality and equal opportunity can all be enshrined in legislation, but I was brought up to believe that, however sophisticated, intellectually able or educationally competent one may be, it is arrogant to seek to disturb the established keystones of civilisation. Parliament, particularly over the past 30 years, has substituted legislation for accepted common decency, compassion, respect for what is right and rejection of what is wrong, and I think we are worse off as a result. I therefore advocate—and I respectfully ask noble Lords to travel with me—that until we fully examine and put in place every palliative care resource that is available, we do not further consider this odious alternative.

Hospice provision is of course partly funded by government but it is the so-called vast majority that provides the voluntary funding that really sustains the system. That indicates to me that the vast majority wants to care for and comfort those who are dying—not to have this nation legalise so-called mercy killings.

Resources that would be required to sustain assisted dying—no one has sought to quantify that figure—should be directed exclusively towards palliative care provision. That is the pragmatic way and it is the morally right way.

8.30 Baroness Noakes: My Lords, we are not much beyond halfway down our speakers list. Noble Lords might therefore be glad to know that I have left my prepared speech on the Bench behind me. I will briefly make one or two points.

My purpose in putting my name down to speak was to bring motor neurone disease to the attention of the House, a subject on which I have spoken before in your Lordships' House. Motor neurone disease is a horrible disease with final stages that many sufferers fear, and rightly so. It ultimately involves complete paralysis, loss of physical control and pain. The real cruelty, however, is that it involves an unimpaired intellect.

Palliative care for motor neurone disease sufferers, of the quality and in the quantity of which we should be tolerant, is simply not available. I fully support those who say that we should continue to improve the availability of palliative care for all sufferers from terminal illness. Even if we had the most excellent palliative care, however, that would not be sufficient to avoid the need for the Bill. The sufferers of motor neurone disease will lose quality of life and dignity. Not everyone can cope with that. People have different thresholds. Only the individual can make a decision about how great a loss of quality of life they can tolerate.

I support the Bill, with all the safeguards in it. In doing so, I affirm, as a Christian, the sanctity of life. There is another principle, however, which is the right to a good death. The only person who can decide how to balance life and death is that individual, and it is that individual who should answer to God for that decision.

The Lord Bishop of London: My Lords, listening to that speech and so many of the speeches in your Lordships' House this evening, I do not think that anyone could claim a monopoly on compassion on either side of the question. I hope that your Lordships are aware that the opposition to these proposals is based on compassion as well. As a priest and former hospital chaplain, like many in this House I have attended a large number of people in their final days and hours. I have often found myself praying with them that their suffering should come to an end.

We have had the case about palliative care rehearsed many times this evening. I do not intend to go into that again. The words of the Chief Rabbi ring in my ears. I remember that he emerged from a debate and said to me, "Very soon, all the main points had been made. But, alas, not everybody had made them". At this stage of the night, a little more brevity is probably required, following the good example of the noble Baroness, Lady Noakes.

It is simply the case that we ought to ask with great urgency—people on both sides of the argument have agreed with this—why the state of the art palliative care available at some of the leading centres like Sheffield, Newcastle and Cardiff is not available to patients dying in other parts of the country. That is surely something on which we can all unite.

It is a pity that members of the committee—I understand the pressures of time—were not able to go together formally to visit a hospice, in addition to the visits to Oregon, Holland and Switzerland that have been generally described. Hospices, in my experience, are places where a lot of living is done in a very short time, in a way that often has a profound and creative effect on those facing death. That is true even for visitors and—especially so, in my experience—for those who are left behind after a death.

As has been pointed out in this debate again and again, however, there are other forms of distress. I found Professor Blackburn's evidence, which has not yet been mentioned, in response to a question from the noble Lord, Lord Turnberg, particularly telling. It is true, as we all know, that one of the most common things that you hear people say as they face death is that they fear that they are being a burden. Professor Blackburn echoed that in his evidence. He said:

"I am duly afraid of being a burden to other people in various ways. My pride would rebel against it and I would regard the narrative of my life as having gone much worse if it ended in these terrible ways".

People who are dying commonly feel that they are in the way, and it is for precisely that reason that I believe it is helpful that assisted suicide is, at present, not an option. As a life draws to its close, it is hard to be confident about one's motivation and feelings. It may be that a breakthrough to a new reality of human solidarity, to a new depth of experience, of giving and receiving and loving, is part of the education of dying. It is often hard for individuals to foresee that this may be the case. In fact, though, it is the daily experience of those in hospice care.

There are suggestions in the evidence presented to the Select Committee—we have heard much of it this evening—that the debate is really between people in thrall to religious dogma and those who are free to take an objective, human-centred view of the situation. It is, of course, true that the appeal that your Lordships received shows a remarkable identity of views between the followers of the various faith communities and traditions of wisdom represented in these islands. My right reverend brother the Bishop of Southwark signed that appeal; so did the Chief Rabbi, the Roman Catholic Archbishop of Cardiff, the director of the Evangelical Alliance, the head of the Orthodox Church and the high representatives of the Muslim, Sikh, Hindu and Buddhist faiths. In the light of that, we can probably say that the noble Lord, Lord Joffe, could have a great career in interfaith relations ahead of him. I can imagine nothing else that would have brought people together in such a way.

My friend the most reverend Primate the Archbishop of Canterbury, as we have heard, has also written about the question in a similar vein. He has asked me to say that he would have been here, but a long-standing official visit overseas has prevented him from participating in person in this debate.

The concurrence of those different voices is astonishing, but I emphasise that the appeal made to the House is not on the basis of any truth that is inaccessible to all those of good will, whether they are religious believers or not. I find there is great strength at times of distress and confusion in the simple teaching that the Almighty has,

"fixed his canon 'gainst self-slaughter",

but the appeal that you have received to reject the continuing and renewed efforts to legalise assisted dying and euthanasia does not rely on revelation.

The truth of the matter is that the debate on the proposals is difficult and complex, because there are radically different understandings of the realities of human life. Everyone would agree that it is right to struggle for independence as a person, although some people, like those with mental handicaps, are dependent to a high degree without making their life worthless to themselves or to the social networks of which they are a part. What a human life means is not exclusively the affair of any one individual. Independence or autonomy is an important stage on the way to recognising the interdependence in which we come to see profoundly that "I need you in order to be fully myself". As the noble Lord, Lord Maginnis, said, we were not born autonomous:

"We brought nothing into this world, and it is certain we can carry nothing out".

Being realistic about human life means living in the light of that fact in the period between birth and death.

We have a right to expect that society will offer care to the dying, but it would be a tragedy if granting new possibilities to a few people contributed to eroding society's recognition of the worth of human life, even when it is subjected to profound disability or impairment. It would be a tragedy indeed if changing the law increased the pressure on many people who recognise their vulnerability to consider suicide.

Lord Plant of Highfield: My Lords, I support the noble Lord, Lord Joffe, in his endeavours on the Bill and I shall certainly support it in its amended form. I speak as a Christian, indeed, as an Anglican, but what I am going to say will put me very much at odds with my friends on the ecclesiastical Benches, whose views I respect but, unfortunately, disagree with.

I shall start with the view of the value of life. I am not at all sure that Christians have a coherent account of this value. We are told that life is God-given and therefore sacred and of absolute or infinite value. Part of what this presumably means is to imply that the value of life cannot be subordinated to any other value, such as autonomy. However, if the value of life means that it is not subordinate to any other value, one has to ask whether there is a consistent Christian position here. Since the Christian tradition operates with a just war doctrine, it must be the case that human life can be subordinated to other values; namely, those accepted as making a war just. Yesterday, I heard a canon of Westminster on the radio talking at the tomb of the unknown warrior. He said that there are causes worth dying for and, let us not be squeamish, in war worth killing for. I agree with that. But then the supposedly absolute value of life is being subordinated to other values; namely, those pursued in a just war. Some Christians support capital punishment where, again, the value of life is subordinated to some other value.

It might then be argued that what is wrong with assisted dying is that it subordinates the value of life to an inadequate or even false value; namely, that of individual autonomy. We heard this argument put quite a bit today. It was put on the radio this morning by the Chief Rabbi. Sir Jonathan Sacks argued that there are choices that we should not be allowed to make and that we cannot be allowed autonomously to choose our death under the circumstances set out in the Bill. The problem with this point of view is that it is perfectly legal to refuse life-saving or life-prolonging treatment. A close friend of mine did so just a few weeks ago. He wanted to die after 10 years of living with cancer and refused treatment, which could have saved his life, for a minor infection and he died.

So if there are choices, such as the time and circumstances of our own death, that we should not be allowed to make, are those who are critical of autonomy then arguing in favour of compulsory treatment to keep people alive, even when after due deliberation they believe that they would be better off dead? I am sure that members of the Churches do not believe this. If they do not, then it seems acceptable autonomously to choose to die when this requires acts of omission from those tending you, but not when it involves help. This means that the argument about assisted dying does not turn on autonomy at all because this means that what is wrong with autonomously seeking death is not the argument about autonomy but an argument about the categorical moral difference alleged to hold between acts and omissions so that death as a result of non-treatment is autonomous and acceptable, but death as a result of positive help is not. However, this completely changes the ground to that of acts and omissions and we are no longer really talking about autonomy at all.

So is there a categorical distinction between acts and omissions? I do not think so. If the aim of an act is to render someone dead, and the aim of an omission or series of omissions deliberately undertaken, such as has certainly happened in policies to do with the selective

non-treatment of neonates with significant genetic disabilities, is also to render somebody dead, then the alleged moral difference is a consoling illusion and not a categorical moral difference. I realise how consoling the illusion is, but it is not clear that we are not as responsible for the consequences of our omissions as we are for our actions.

The same applies to the doctrine of double effect, which I also regard as a form of consolation. This doctrine, in the context of dying, states that I may inject a narcotic with the primary intention of relieving pain, even if a foreseeable, although not the intended, effect is the death of the patient before it would otherwise occur. In general, the doctrine of double effect has very perverse moral consequences because in any circumstances in which it is invoked it enables us to evade the moral responsibility for the consequences of our actions by narrowing down the sphere of intention and disavowing our responsibility for foreseeable effects.

I can perfectly see why people are attracted to it, whether it is the statesman in war arguing that the foreseeable effect of the deaths of innocents is not part of his responsibility, or in the very different circumstances of doctors treating patients in traumatic circumstances. This does not alter my view, however, that the doctrine of double effect is not capable of coherent formulation.

Of course, it can be argued that the doctrine of double effect in any case does not apply to the doctor injecting the narcotic since the effects are in fact far from foreseeable and highly individualised, so responsibility does not apply to foreseeable consequences because they do not exist. That argument is very difficult to accept simply because of the popularity of the double effect argument, particularly among doctors who write about assisted dying and reject it. If the effects of narcotics are indeed radically unforeseeable then why invoke the doctrine of double effect, because that only works on the assumption that they are foreseeable?

So I do not think that the Churches, to which I belong, have actually mounted a particularly coherent case against the Bill of the noble Lord, Lord Joffe, but I am willing to give it my support.

Baroness Chapman: My Lords, I have read the report we are now discussing. There are several issues that I could talk about, but I shall start by telling your Lordships about my experience of terminal illness.

My mum died of cancer 16 years ago. She was diagnosed with it 11 months earlier. It was not a pleasant experience. To watch someone you love die is indescribable. When it became obvious that the cancer was winning, mum chose to go into Wheatfields Hospice in Leeds. She was expected to live only a few days when she was admitted on 9 August 1989. She died in the early hours of 9 September 1989.

We had a whole month of borrowed time. Mum had her 53rd birthday. I think back to that month. How can one month be the best and yet the worst month of your life?

Our whole family have so many memories of that month. Yes, they are tinged with sadness but they are good, positive memories. Mum's pain was controlled and we had the illusion of improvement because of the skills within the palliative care team. She concentrated on her family, ensuring that we all had strict instructions to look out for each other. My life is better for having those memories.

If a Bill such as the present one had been in place we may have been deprived of those memories. Mum was, unlike me, a quiet, reserved person who hated to inconvenience anyone and worried about the stress her illness put on her family. I dread to think what choices she may have made to protect her family.

It was my first experience of palliative care. Do we want to jeopardise that kind of support, not only for the patient but also for the family?

When I began writing this speech, I wondered how to explain my concerns. Then I remembered a debate I took part in which I feel explains how I believe this Bill would affect society's attitude to people with chronic, long-term and terminal conditions.

I received a phone call from Radio Scotland asking whether I would take part in a live debate on the support for parents of disabled children with terminal conditions. The trigger for the debate was a man who was appearing in court for killing his 10 year-old son. The son had a condition where his life expectancy was 14 to 20 years. His father admitted smothering him, but was claiming that it was a "mercy killing".

I took part in the discussion. Also speaking was an MP from the Netherlands. As noble Lords can probably guess, I was defending the child's right to live his life to the full. The MP said that euthanasia was a great idea and that "they"—whoever "they" are—believe a child as young as seven knows whether he wants to live or die. I was appalled. I told him that I would not let a seven year-old child choose his menu for a day. His response was that a "good parent" would do this for his child. At that point I told him that that was an insidious use of language. His statement implied that only a "bad parent" would want to keep his child alive. He did not respond.

Bringing up a child is not easy. Doing what you think is right for a disabled child increases the pressures a thousand-fold. This Bill does not cover children, but if it becomes law we will be on an inevitable path that will be a very lonely and frightening one for many people. For all the report's claims that society will not change its attitude to life and terminal conditions, I feel that that story shows fully the reality of that kind of law on societal beliefs.

I firmly believe that palliative care should, and indeed must, be available to all, as very few people are aware of the range of support that it gives. However, there are no guarantees of palliative care within the Bill and, without considering the multitudes of other issues involved, people who are in pain and do not receive emotional and/or physical support may choose that option. They do not want to die, but living without the pain control and support is untenable.

I am concerned about other things: the terminal diagnosis and the fact that many people live way beyond their expected lifespan; the two-week delay for people to change their mind is a very short time and gives people no time to adapt to their new situation. Lots of people adapt to chronic, long-term, life-threatening conditions. They get on with their life and enjoy their right to life. In giving people the right to die, we must not jeopardise people's right to life.

Lord Cavendish of Furness: My Lords, I have listened to many outstanding contributions this afternoon and the last one, by the noble Baroness, Lady Chapman, is among them.

My interest in this debate, which I now declare, stems from my having been in the late 1980s among the founders of St Mary's Hospice, Ulverston in Cumbria. I have had continuous involvement with it and am its current chairman. Not unnaturally, I believe with great passion

in the work done by hospices in Britain and I also believe that there remains almost unlimited potential for development and innovation in this sphere of palliative care. I and many others touched on that in the debate initiated by the noble Baroness, Lady Finlay, just before the Summer Recess.

That belief does not blind me to the possibility of the law being improved as it applies to those few people whose suffering is most terrible and intractable and who, in full possession of their reason, wish to terminate their lives. I have no quarrel with the humanitarian motives that lie behind the proposals. However, I would be most uncomfortable if the Bill were to come into law as it stands and even more uncomfortable if it ran its course without serious consideration being given to the concept that palliative care, allowed and encouraged to continue its development, could in fact make the Bill redundant.

The very distinguished work of the Select Committee under the chairmanship of my noble and learned friend has rightly been widely praised. However, I feel that it was flawed in one respect. The committee travelled and consulted widely but, for reasons I still do not understand, its members did not visit a single hospice. The same point was made by the right reverend Prelate the Bishop of London and my noble friend Lady Cumberlege. Of course, comparisons with other countries and cultures have enormous value, but they also have serious limitations. I would make the point that, whereas consistent threads run through palliative care as practised in British hospices, the GP-driven model as practised in the Netherlands is striking for its difference rather than its similarity. I have no doubt that it works for the Dutch, but we are not legislating for the Dutch or the people of Oregon; we are contemplating a major Bill that affects British people. The committee was of course right to go to Holland and elsewhere; but it would have been better still if it had seen at first hand palliative care as practised here.

The Select Committee makes the point that however good palliative care is in Britain, its provision is uneven and therefore inequitable. A major contributory reason for that state of affairs which I offer to your Lordships, in case the Minister forgets to, dates back to the wretched and nakedly political action on the part of the Government when they first came to power in 1997 of removing the financial weighting that enabled rural areas to match in quality the services offered by their urban counterparts. That has caused untold harm and difficulty to providers of public service and it is high time it was revoked. I am struck by how little the Minister, who is not in his place at the moment, has to answer today, but perhaps, with his customary helpfulness, he can give me some reassurance when he comes to reply.

The people covered by this Bill endure the most extreme forms of suffering. It was suggested to the Select Committee that between 3 and 7 per cent of deaths fell into such a category. The experience at St Mary's, the hospice with which I am involved, shows that such extreme distress, which can manifest itself in suffering other than physical pain, is present in about 1 per cent of deaths that occur with us. That is lower than it used to be. The trend is for it to fall still further.

A combination of increased skills and experience, newer and improved drugs, and an increased confidence on the part of patients and their families that they will not be abandoned—which is a very important phrase—gives me grounds to believe that the suffering that this Bill addresses can in time be removed through the agency of palliative care as practised here in Britain.

It is claimed by some that doctors and health professionals regularly break the law or at least interpret it liberally in order to relieve suffering. I am sceptical. One reason for my scepticism of such claims is that there has never been to my knowledge even the smallest suggestion by any of our staff that a change in the law would improve our care. On the contrary, it is the unambiguous opinion of our medical director that the accepted definition of patient autonomy has stood the test of time and is not in need of improvement. I sometimes wonder whether the noble Baroness, Lady Tonge, has been in a hospice, because autonomy is central to our philosophy. We consult first and foremost the patient.

Many noble Lords asked why not have both palliative care and assisted suicide. This debate, which has attracted wide media coverage, is already causing unintended consequences. There is a substantial and increasing incidence of patients arriving at our hospice in varying degrees of agitation. Nothing saddens us more than when they ask anxiously if we are planning to terminate or shorten their lives. It usually takes between 24 and 48 hours before an acceptable level of trust can be restored. After that, usually, no more is heard in that vein. But, in some contexts, 24 hours of fear-induced distress is like a lifetime. Most of our inpatients admitted for terminal care have, on arrival, a life expectancy of up to 14 days. During that time, in an overwhelming majority of cases, the patient and his or her family and loved ones will find safety and comfort. The patient's pain will be controlled and pleasures will be experienced. There will be laughter and a newly won peace of mind is often powerfully evident.

However well meaning the Bill—and I have no doubt of that—it casts yet another shadow among vulnerable people whose lives have already been shattered by debilitating illness, pain and fear. It has undermined the trust that we so critically need at the moment when desperately ill people turn to us for safe haven. And that is not all. If and when this Bill passes into law, I have forebodings about what might become the culture of the future. Already we talk of an "ageing population". It is possible to picture a new generation, oppressed by a mix of global instability and economic failure, turning on the ageing population whose patrimony we have squandered and whose liability they inherit. In this nightmarish future age, it will become the duty of the old, the ill and the frail to die once they have outlived their economic usefulness. I regret to say that this Bill paves the way for such a future, bereft of all humanity. If that is thought to be fanciful, I suggest noble Lords talk in depth with those who live at the rock-face of palliative care. The truth is that they will find that what I am suggesting is already beginning to happen.

Echoing the speech of the noble Lord, Lord Carlile, the stark statistics coming from the Netherlands in respect of large numbers of euthanasia deaths occurring without consent, and the alarmingly small proportion of such deaths being reported as Dutch law requires, hardly inspires confidence. Even if these departures from good practice can be explained away, it illustrates vividly how difficult it is to legislate on such sensitive matters and perhaps explains why wiser generations in the past have shown caution. Many noble Lords have spoken about the importance of safeguards. The trouble is that safeguards are at the heart of this matter and, as the noble Lord, Lord Phillips of Sudbury, said, they are elusive.

I hope that we, too, will tread with caution and divert the entirely benign commitment to relieve human suffering into the field of palliative care, which I believe stands on the threshold of its greatest achievements.

The Earl of Glasgow: My Lords, as a latecomer to this continuing debate on the question of whether in certain circumstances we should legalise "assisted suicide" and/or "voluntary euthanasia", I am most impressed by the amount of time, care and detailed research that has

already been done on this very sensitive subject, particularly in the well-considered report from the Select Committee which, in theory at least, we are now considering. I am only sorry that any law that might resolve this issue still seems such a long way away.

As the noble Earl, Lord Ferrers, reminded us, most of us, to a greater or lesser extent, fear death. As we know, it comes to us all sooner or later—perhaps sooner rather than later for the majority of us in this House. But sometimes I wonder whether it is really death itself that we fear or rather the manner of our death. We fear terminal illness, pain, indignity and, for instance, the inability to perform natural functions without the help of others. We fear becoming a permanent burden. We fear losing our minds and no longer being able to express our feelings and anxieties. The reason is that we have all seen these conditions in others, and it is particularly distressing when we see them in the ones we love. But perhaps our greatest fear is our helplessness, the fact that we will have no control over our own death. It is because I believe that we should have the maximum possible say in the manner of our death that I support voluntary euthanasia, whether administered by oneself or by others.

The most usual argument against voluntary euthanasia for the terminally ill is that once it becomes legal, it could be abused for selfish or even criminal ends. Old, infirmed grandmothers are often cited as the likely victims: still with a desire to go on living but encouraged, pressurised or bullied into believing that they have become an intolerable burden on the rest of the family, and eventually agreeing to have themselves put down. But as has already been pointed out by other speakers, and has been demonstrated in countries where conditional euthanasia has been legalised, adequate safeguards have been introduced to protect vulnerable people against such situations. The same will surely happen here.

A much greater threat to the infirmed and terminally ill, and a point mentioned by my noble friend Lady Tonge, is exactly the opposite. It is our desire to keep the ones we love unhappily alive for as long as possible, long after they themselves might have hoped to go. It is for emotional, sentimental, ethical, often self-interested and sometimes religious reasons—not from any fear of the law—that most of us are reluctant to hasten the inevitable death of the terminally ill. Surely, whenever practicable or possible, it should be the wish of the dying person, not that of doctors or even the next-of-kin, that should prevail.

If your Lordships have not already done so, I recommend—no, as did the noble Lord, Lord Puttnam, who is not in his place at the moment, I insist—that they see a film called "The Sea Within". It is a Spanish film made by Alejandro Amenábar which came out earlier this year and can now be bought on DVD. It is a dramatised version of the true story of Ramon Sampedro, a quadriplegic paralysed from the neck down who became a Spanish *cause célèbre* when he embarked on a 30-year battle with the Spanish authorities, requesting that they allow him to die, as he put it, "with dignity". In the event, partly no doubt because Spain is a Catholic country, he failed to move them and had to devise a method of having himself put to death in such a way that none of his accomplices could be prosecuted for having assisted him.

It is a beautifully made film, and not morbid or sentimental. In fact it is quite funny in parts and, through the characters, presents all the arguments for and against euthanasia in a very comprehensive way. There is a particularly poignant moment when one of the characters, a girl who is always by Ramon's bedside and professes love for him, is asked by him to assist in the engineering of his own death. Horrified, she says, "Of course not. I love you". He replies, "No. If you really loved me, you would help me do what I really want".

We all know what a complex and delicate issue this question of euthanasia is. Every case is slightly different and our own views are largely coloured by our own personal experiences, particularly by the nature of the deaths and suffering of some of the people that we love. But one set of circumstances still seems to me relatively straightforward: a person with a terminal illness, who is still in full possession of his mental faculties but has lost control of all or some of his physical ones, and is clearly not suffering from any form of clinical depression, who wishes, begs, demands assistance to end his life, and persists in this demand for, say, six months, should be given every assistance to have his wish granted, regardless of the views of the doctors or of his family. This surely should be an automatic human right. It is a mystery to me why so many honourable and caring people believe that it is their duty to keep someone alive as long as possible when that terminally ill person has unambiguously stated that that is not his wish.

I hear that the noble Lord, Lord Joffe, may agree to amend his proposed future Bill to limit assisted dying to those who are not only terminally ill but also suffering unbearable pain. If true, this is an unnecessary limitation and complication. But I will still support all his proposals as a first step in getting the law to accept the important principle of assisted suicide and voluntary euthanasia.

Baroness Murphy: My Lords, we must all be brief today. I want to do no more than indicate my support for the introduction of a very limited Bill to enable those with terminal illness to request help to die.

I have changed my mind over the past 20 years from being actively against such a measure to being a strong supporter. Indeed, my first letter to the *British Medical Journal* in 1984, on taking up my chair at Guys, was on this very topic. It would have done credit to the noble Baroness, Lady Finlay; she would have been proud of me. But over the past 20 years, I am afraid, my patients and their families have changed my mind and it has now become a moral issue for me that we should respect the diversity of patients' wishes in the last days of life, just as, as doctors, we are beholden professionally to respect their wishes at other times. We have said with some force that we do not always respect an individual's autonomy of action where a decision may impact adversely on others. Certainly we all know that a patient's suicide during a depressive illness can have a profound and widespread distressing impact on other family members, even to the next generation. In practice, however, patients with terminal illness are in a very different position and relatives are almost always sympathetic to the wishes of their suffering loved one, even when they do not agree with the course of action they wish.

How do I know this? I worked as a gerontologist and psychiatrist in hospital and community services for most of my working life. In hospital practice we have a category called "no psychiatric disorder". This includes those referred by another hospital consultant with a request to "query depressed suicidal thoughts"; patients near the end of long and wearying illnesses who think the time has come to go and feel trapped inside the business of being and yet no longer have the physical means to end it. Of course, if they do, they make their own decision.

As has already been said, these people are quite distinctive personalities and often not very easy patients. They hate above all the prospect of total dependence on others, detest losing control and are unwilling to sacrifice their individuality to institutional norms. They want to be in charge of their fate and it is the uncertainty about the end that is distressing to an unbearable degree. It is scarcely ever a matter of pain control, although, as we know, there is

insufficient expertise in the palliation of pain and the expansion of palliative care services to the very old and those with longer term terminal conditions is long overdue. No, it is not that. What causes their unbearable suffering is not remediable by medicine nor psychological supports but by respecting their wishes and supporting them to choose their own time of death. I can think of no greater privilege, as a doctor, than being trusted to help make happen a person's final wish.

I remind noble Lords that this limited Bill proposes that a prescription be given and that the person concerned makes the final decision. Most people will be sufficiently helped to feel in control if they just have it available and can think about it. From what we have heard, only a third or so of such people would ever take it. Of course, there are many others. As a psycho-geriatrician, the majority of people I see have treatable, reversible depressions during terminal illness. Others go through periods of hopelessness after diagnosis or after a particularly gruelling course of treatment and come out of it again. You have to sort out one from the other. That requires strict safeguards, but I believe it is possible to make these distinctions, which I hope to address at greater length in some future debate.

For the moment, I should like to praise the quality of the committee's work, which I found enormously helpful in setting the international scene. Of course those who take the religious view that only God can decide when life begins and ends must always reject the notion of assisted dying. I understand that. But for me and for many others, particularly in those parts of the medical profession that are changing their mind, human suffering demands a human response.

Lord Brennan: My Lords, this debate should not be afflicted either by religious extremism towards the secular thinker or secular bigotry towards the religious believer. It is important—is it not?—that we attach to this problem disciplined thinking and clear analysis. After the rather ironic comments suggesting that a secular contribution is the expression of an opinion but that that coming from a religious believer seeks to impose an opinion, I am gratified that my noble friend Lord Plant, a good Christian man, in his reasoned analysis supports the Bill. I will seek to emulate him as a Christian by opposing it by a reasoned analysis.

The present law forbids euthanasia because it is thought that that state of the law protects the common good. The Bill will damage the common good in the following ways. First, patient autonomy cannot prevail against the common good. There is no right to assisted dying. To assert that assisted dying is a private matter is an abuse of language. It occurs because you need a doctor or a nurse to effect the conclusion. To say that a doctor who refuses to do that is playing God I find incomprehensible. If his duty is to preserve life and he wishes to have no part in causing death, the concept of playing God becomes bizarre.

The state exists to protect people against intentional private killing. It is completely illogical to suggest that laws directed at preventing it or allowing it are not public but private. If it is allowed, it will damage the common good. First, it will produce a divided profession. The noble Lord, Lord Patel, tells us that medicine is divided on the issue—we do not know in what proportions. If it is divided, what happens to the medical ethos? There are those who wish to preserve life—within reason—and those who will be ready to end it on request. That is a fundamental difference of ethos, so described by the BMA in spring last year.

What of the example of the hospice patient, as the noble Lord, Lord Cavendish, described? Is the fear and apprehension that is created in the common good? How many patients are we talking about? Are we talking about the 350 or 360 that the noble Earl, Lord Arran,

mentioned, or the 650 which the noble Lord, Lord Joffe, mentioned on the radio this morning? Are we talking about the intelligent, clear-thinking, controlling minds or are we talking about everyone? I have found the presentation of the debate thus far by its proponents to be extremely confused.

If assisted dying is only for the intelligent clear thinker, why so? Why discriminate against those with a marginally less intelligent analysis but who have the same emotional desire? These are all serious questions. Who is to perform the act? Is it to be by prescription through the doctor and not by dispatch from the doctor? If it is not dispatched by the doctor, who is going to do it? The patient will receive it from someone. How do we control it? To put it bluntly, do we have some kind of "Ofdead" regulatory system in this field of life and death? It seems astonishing.

I shall make two further, short points. When the disabled people we care for seek our help for their needs, are we to patronise them when they express to us their fears? What will happen in the future if quality of life is a factor in the giving or withholding of treatment? Is it sensibly to be argued that some doctors will not take into account the economic factor in determining whether to end a patient's life at their request, or even advise them in a way that is directed at the economic well-being of other patients who need treatment? It is too idealistic to think that that will not be the fact.

As regards the slippery slope, looking at this issue with intellectual discipline, I find it surprising that, from Oregon, the Netherlands and Switzerland, a system of self-reporting by doctors should be regarded as a proper analytical basis for considered action of this gravity. Would we do it in any other walk of life? Of course, we would not.

My final point is on the position of the medical profession. If the common good wants trust in doctors, doctors should tell society what they want to give society through medical care. The BMA maintained its position for 30 years. It has changed it in a rather tawdry exercise in procedural stratagems. It did so with an 11-vote majority on a vote of 175 from a membership of more than 100,000. Let us compare that with the Royal College of General Practitioners. When its executive sought to be neutral, it insisted on its members' opinion being taken and the majority clearly went against euthanasia. That has not happened yet with the BMA.

This report is surely the occasion for informed debate by the public. Paragraph 232 and Appendix 7 categorically warn against the present state of public opinion being thought to be reliable. It clearly states that we need further work. I conclude with one short remark. No one who values liberty should want to reduce the ending of life itself to just another lifestyle choice. Is that the society in which we live.

Lord Neill of Bladen: My Lords, I begin with an apology. Regrettably, I had duties to perform in a court of law and could not be here at the start. To some extent, I had the compensation of having heard the noble Lord, Lord Joffe, on the "Today" programme, so I got some of the highlights from him then—and, of course, we have debated this matter before. The other thing to say at the outset is to declare my total absence of any qualification for speaking on this subject; only the fact that I have lived entitles me to speak.

I hope that the noble and learned Lord, Lord Mackay of Clashfern, will not be embarrassed if I add my voice to what is now a chorus of eulogy for the excellent quality of the report, the manifest skill with which he must have conducted the committee—as one can read between the lines—and also for assembling such a massive body of excellent and very interesting

evidence. The only way in which to set the House ablaze at this hour would be if I were to say that I did not think that it was a good report; I would be the first person to say that and it would be an absurd opinion to enunciate.

The noble Lord, Lord Walton of Detchant, is with us; I have found his earlier report greatly fascinating to go back to. He, too, assembled some great evidence. The House of Lords can be really rather proud of the written record of the testimony that has been established in this field. I have not done the research, but I would guess that it is without parallel anywhere else, as it is really magnificent material.

I spoke to an earlier version of the Bill, which is recorded in *Hansard*. My concern was in particular with the vulnerable, and I have not been persuaded that that issue has disappeared or has been taken care of. I want to make a few observations on one or two points.

It is funny how words can appear on the scene and then assume an extraordinary dominance, as has happened with the word "autonomy". We have been talking about patient autonomy—but I wonder whether I have autonomy as a non-patient. I find that I have not, as I am controlled in everything I do by law and morality, in my profession by an ethical code, and in private life by all the bonds that we all have of love and affection. As for oaths, we have the astonishing Clause 10(3), to which noble Baroness, Lady Cumberlege, drew attention, which means that what is now a breach of an oath will be deemed not to be so. One might ask oneself what Parliament is doing in encouraging people to be false to oaths that they gave on entering a profession. That is very strange—but no doubt a point of detail.

As I do not believe in non-patient autonomy, naturally I do not find patient autonomy a very convincing idea. It seems to elevate a personal choice in some agonising and heartbreaking cases, such as the noble Lord, Lord Puttnam, described. One could not hear about those cases without thinking that they were absolutely terrible and that it would be marvellous if somebody removed that person from the earth. But one is balancing that against the widespread effects of introducing a Bill, which may subsequently be an Act, along the lines proposed.

Four areas concern me. First, we know that a lot of the medical profession are strongly opposed to the proposals. What would be the practical effect? Imagine an appointments committee looking for a registrar, perhaps, in a hospital. Would it be legitimate for that committee to ask, "Would you mind telling us how you stand on the assisted dying question? We have had a number of those cases lately. Of course, it is a difficult choice, but this is a very strong field of competition". One can imagine such a situation.

Secondly, the proponents of palliative care and the hospice movement have given their evidence. There is the evidence from the National Council for Palliative Care in volume two of the report, on page 151—but I need not go into that; if one goes to the *fons et origo*, Dame Cicely Saunders, one finds:

"We believe that euthanasia or assisted suicide is socially dangerous and a negative answer to a problem that should be tackled by other means".

That is a quotation from volume two, on page 101. There is unanimous opposition from the hospices, and this evening we have had the advantage of hearing the direct and compelling evidence from the noble Lord, Lord Cavendish of Furness, who spoke about a particular hospice.

With regard to the nursing profession, I believe that it is unfortunate that there has been some challenge to the evidence given by the Royal College of Nursing—but nevertheless it seems to be the case that a significant body of nurses want to have nothing to do with the Bill or the ideas underlying it. An interesting sub-issue was raised as part of the nursing evidence, as a very substantial percentage of the nursing profession comes from overseas, and a large number of those come from Catholic countries. So very severe problems might be encountered with the nursing profession in that respect.

I turn to my fourth category of people whom I am worried about—people whom I then called "the vulnerable". I was rather surprised to see that the people subject to hidden pressures are classified as a sub-head of the slippery slope. As far as I am concerned, they are not on any slippery slope; they are bang on the level with the whole of the proposals. They are an integral part of what is proposed. We have a lot of evidence that people will feel—I am not talking of a Balzac scene of a family persuading an old person that it would be better to sign his or her death warrant—that they should not be here and that they are taking resources from the family. Paragraph 97 of the report states that Dr Jim Gilbert raised the concern,

"that some patients, while not opting for ending their lives, would feel themselves to be presented, if the law were to be changed, with an ongoing choice to be made".

"Ongoing choice" are brilliant words—the matter would not go away. A person would be thinking about it six months or nine months later, depending on his or her condition.

Finally, I am troubled about the safeguards. The very first safeguard at Clause 2(2)(a) states:

"The attending physician shall have been informed by the patient that the patient wishes to be assisted to die".

However, the noble Lord, Lord Joffe, said that his intention was that the patient must initiate the request. However, the report points out in paragraph 24 that,

"nothing in the Bill . . . prohibits a doctor or nurse suggesting assisted suicide or voluntary euthanasia to a patient".

So the first condition is really a non-condition—simply that the patient says, "Doctor, I have a bit of paper for you. I would like to die", but you do not investigate the prior conversations.

Like the noble Baroness, Lady Finlay of Llandaff, I was greatly struck by the evidence of the woman reported in volume three who for 10 years, according to her testimony, said that she wanted to die and tried to commit suicide but finally, over the past nine years, has turned into a campaigner for the disabled both in this country and in India. That was a remarkable testimony. If the Bill had been in place, she would have been dead many years ago.

Lord Lucas: My Lords, I was very happy to discover that the noble Baroness, Lady Murphy, has covered a lot of what I wanted to say, so I hope that I can be reasonably short. I felt totally in tune with her speech. I have seen this process at first hand a couple of times. Fortunately, they fell into that Hippocratic divide—the double effect—where it was possible for a doctor to treat the people concerned in a way which enabled them to die when they wanted to because of the particular conditions in which they found themselves.

I do not see that as any different from assisted suicide. It looks exactly the same from outside. A patient is offered an alternative, chooses death and dies. I really do not see as relevant the fact that the doctor under those circumstances by some trick salves his or her conscience, or is perhaps happy with the process anyway. In both cases everyone involved—the patients, their families and the more remote people involved—was profoundly grateful that that option was available. Those events happened some while ago now but, looking back on them, I found them a joyful experience. What was achieved was something that everyone felt was right. The goodbyes were said, the suffering was avoided, the end was what the patient wanted and the rest of us understood, consented, went along with it and were part of it.

So the process is there. It is already with us but it is not available to the relations of the noble Lord, Lord Puttnam, because they happen to fall on the wrong side of some line. It would not perhaps be available to the noble Lord, Lord Desai, when he wanted it. Why should he not be able to sit down with his wife at his side and have her assistance to bring about his end, if that is what he wanted and she consented to? In what way does that trouble other people's existence if that becomes possible? We have accepted that people can kill themselves. I suspect that many of us have difficulties with that. Some people do not really like the idea of us having the right or ability to end our lives when we wish. Most of us are conscious of the harm it does to do it out of time. But to do it properly, in a way where everyone is drawn in and there is consent and understanding, is a joyful experience; it is not terrible.

A number of the problems that have been raised relate to the medicalisation of the process. I do not see why doctors should be involved; the Swiss do not involve doctors. I want someone whom I love next to me should I choose that way out; I do not want it done impersonally by a doctor. I would not impose it on a doctor that I know, and I certainly do not want some impersonal doctor. What I require of the medical profession in these controlled days is the means. It is not fair to chuck yourself in front of a bus or train, or even off Beachy Head, or to cut your wrists in the middle of a field. It imposes so much difficulty and inconvenience on other people. To do it in a way where you do not impact on society requires someone's help to make it possible. I can no longer have a revolver in my drawer; a knife is an extremely messy and uncertain business. Medication is the most sensible way of doing it. If there was a court procedure or if there was some other means of proving that what was being done was right and was not murder, and I just took the relevant prescription along to a chemist and got the dose, why the need to involve a doctor at all?

I very much hope that this debate, if not this Bill, will lead to the facilities that happened to be there for two people I loved being there for me when my time comes.

Baroness Emerton: My Lords, I, too, pay tribute to the committee so ably chaired by the noble and learned Lord, Lord Mackay, which produced such a balanced report with clarity on such complex and sensitive issues.

I speak as a retired nurse with 53 years of experience in the profession. I have two brief points to make from a nursing perspective. First, there is the nurse-patient relationship. Consistently, research shows that 80 per cent of care delivered to patients is provided by nurses. Given that wealth of experience, it is regrettable that their unique position and expert contribution has been omitted from the draft legislation. That is particularly so in the light of evidence that nurses play a crucially important role in supporting patients and relatives at the end of life, particularly Macmillan, Marie Curie, hospice, hospital and community nurses.

Virginia Henderson, an eminent professor of nursing from the United States, defines nursing thus:

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery or to a peaceful death that he would perform unaided if he had the necessary strength".

I strongly believe that the introduction of a law relating to assisted dying would seriously damage and compromise the nurse-patient relationship, leading to fear of that option at the most vulnerable time in patients' lives. Respect for the intrinsic value of life is central to the nursing profession. Midwives and nurses caring for women undergoing termination of pregnancy have the right to refuse to participate in the procedure on the grounds of conscientious objection. Other nurses do not have, and would not want, that option in these circumstances.

Secondly, if patients believe that they have no other choice or option but to ask the clinical professions for help in committing suicide, those professions and society have failed them. Palliative care in this country, as we have heard this afternoon, is the envy of the world. We have become skilled in the management of pain and in symptom control, particularly for those with cancer, but we cannot be complacent. We need to continue our research to find new ways to relieve distressing symptoms, particularly for those with neurological conditions. It is also important to recognise that palliative care is not just pain control by drugs. "Palliative" derives from the Greek word *pallios*, meaning "shield". As well as physical care by drug therapy, the psychological, emotional, spiritual or even financial impact of a diagnosis or suspected diagnosis of a disease that might be life-threatening is very much an area where highly trained and skilled palliative nurses can assist a patient through the darkest times with care and compassion towards a peaceful and dignified death, as opposed to the indignity of an unnatural death. Certainly, I can testify to nursing, as a member of a healthcare professional team, many patients under the shield of palliative care, delivering clinical, psychological, emotional and spiritual support within the banner of holistic care. There are of course regrettable circumstances, as described by the noble Lord, Lord Puttnam, but that demonstrates the urgent need for resources for providing high-quality care for the dying.

The Royal College of Nursing, which represents 370,000 nurses as a professional organisation, opposes the legalising of assisted dying. The noble Viscount, Lord Craigavon, questioned how accurately it represents the total number of nurses. It would be impossible to consult 370,000 nurses and come out with a unanimous answer. It is a majority answer. Certainly, some nurses choose to support voluntary euthanasia.

The pathway to death is one that we each have to travel. The key to achieving improvements in the care and treatment of dying people is, as a priority, further investment of resources in training for existing and new doctors, nurses and other healthcare professionals, as well as the development of hospice and palliative care, not the introduction of the Assisted Dying for the Terminally Ill Bill.

Lord Sheldon: My Lords, I also express my great appreciation for the report and the detailed and voluminous evidence that it contains. It was rather surprising when one received the amount of information available; it was well beyond what one might have expected for such a committee. The noble Lord, Lord Joffe, has undertaken a valuable campaign to give those who have been subjected to great suffering and indignity the right to bring to an end a life that has become unbearable.

Time is on the noble Lord's side. He came into the area rather unexpectedly but, as time has gone on, more and more people have been impressed with the arguments that he puts, and he has created a number of people who have a contrary view. He has brought the matter right into the forefront of political life in a way in which I had never suspected that it might be in my time.

I fully support the proposed Bill, but am concerned about one consequence, which I would like to receive further consideration. The problem is that, in some cases, death can be a release for not only the patient but for some of the family. There could be pressure from the family, expressed or not, in connection with the financial consequences of a lingering death. There is also the burden of attending to the needs and wishes of the patient.

The patient's life may be very limited in time, but in some cases it may linger for a greater period. During that time, the financial position of the patient may decline rapidly, and the family's expectation of financial inheritance may affect their attitude. Besides that, there are problems of visiting and attention to the affairs of the patient. All of that may consciously or not be transmitted to the patient and encourage and prompt a decision to seek an early end to an unwelcome and lingering life.

The role of the hospice movement has been a great help against that. The Tameside hospice in my previous constituency has had an impressive effect on bringing in palliative care and great consideration for the limited life of the patient. I appreciate the value of the work that has been undertaken there. But, as the noble Baroness, Lady Hayman, said earlier, not all suffering can be relieved. Palliative medicine is undoubtedly limited. It may improve with time; it would be surprising if it dealt with more extreme cases. Some people find similar kinds of pain greater than others. There is a great distinction in the way that people perceive such matters.

Fundamentally, however, although we do not choose to come into this world, most people have found their lifetime's experience satisfactory and, to many, happy. But we must have the right to bring it to an end in those cases where the disadvantages of life have become so much greater than the benefits that they have previously enjoyed.

Lord Guthrie of Craigiebank: My Lords, I belonged for 44 years to one of the professions that see death at first hand more often than others. Like doctors, soldiers cannot afford to marginalise death as something that does not impinge on their life. I make that point because I know that that attitude exists in a large part of our society and because I am afraid that, if we are not careful, we might be tempted to focus on the more comfortable philosophical side of the subject and to neglect the hard realities.

Let us start with one of those hard realities: many people in this country die in pain or with other distressing symptoms of terminal illness. That is one argument advanced to legalise voluntary euthanasia, but we need, first, to ask why it is that, in this day and age when medicine has made such great strides, people are still dying in pain. The Select Committee answered the question. Its report records that Britain is a world leader in the science of effective palliative care. So why are people dying in pain? The answer has nothing to do with medical science. It is because too few doctors and nurses in the National Health Service have been given core training in the techniques of alleviating pain and other symptoms of terminal illness; because there is a large shortfall in the number of palliative care consultants; because hospitals other than those that are specialist do not have the resources to treat the dying effectively and sympathetically away from the bustle of mainstream general wards; and—last

but by no means least—because we do not make supporting hospices and providing proper care for people to die at home enough of a national priority.

I do not envy the task of the resource allocators in the Department of Health. The essential problem that they face is that patients have ever-increasing expectations of curative treatments while the cost of such treatments rises rapidly. National health—like national defence, with which I have been closely associated—is an area where we could spend almost limitless sums of money to good effect. But the budgetary line must be drawn somewhere, and available resources must be allocated according to a system of priorities. Surely, therefore, with demographic changes taking place, that is an area of medicine that deserves a much higher priority. It is the failure of successive governments of all parties to do that that has fuelled the demands of the pro-euthanasia lobby and which, if we are not careful, will lead us into the error of killing the patient instead of the pain. Moreover, unlike expensive new treatments, such as cardiac surgery, palliative care is relatively low-cost. A substantial injection of funds into that branch of medicine would therefore benefit far more people than some of the projects that hit the headlines but actually benefit relatively small numbers of patients—what we used to call, when I was concerned with resource allocation in the Ministry of Defence, getting more bang for your buck. We should remember that we may all need palliative care at some point.

I now turn to another hard reality. We are told that the demand is for assisted suicide or voluntary euthanasia, so why should not those who want to do that be able to do it while those who do not want it can stay as they are? That notion—that all that you have to do is to draft a law and that is what will happen on the ground—is naive in the extreme. All laws are evaded or broken, and it is simply irresponsible to ignore the potential for abuse or elastic interpretation of what the law says. The Select Committee on Medical Ethics concluded unanimously 10 years ago that it was not possible to set secure limits on voluntary euthanasia and that,

"It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused".

The latest Select Committee's report is full of warnings about that: about the silent, and often internal, pressures on dying people to avoid being a burden on their children; about incremental creep in the law; about the margins of error in terminal prognosis; about the near impossibility of defining unbearable suffering or mental competence; and about what has happened in other countries that have legalised such acts.

In Holland, the Select Committee tells us, one in every 38 deaths is the result of either legal or illegal euthanasia. The Dutch sister of our Voluntary Euthanasia Society, known as the NVVE, has secured the legalisation of euthanasia. The chairman of the NVVE's medical committee told the committee that his organisation's next goal was legalising euthanasia for people with dementia. After achieving that, he said, the ultimate goal was legalisation of what is known in Holland as the "end-of-life pill". Today, we have heard people say that there is no such slippery slope, but how else could it be described? I understand that now the Dutch Parliament is about to have euthanasia of children—the so-called Gröningen protocol—laid before it.

Another Dutch pro-euthanasia witness put it another way:

"Euthanasia is not a medical problem at all"—

he said—

"I personally feel that it is a normal medical procedure".

He continued:

"However, the patients need the doctors because we have to access the medication . . . Eventually maybe they can decide for themselves and have the possibility to do so without consulting a doctor".

Those are chilling words.

Although we are talking here of euthanasia to relieve the suffering of terminal illness, the Dutch experience seems to be moving towards death on demand. If we once embark on that road, the pressures to go further will grow. Although I respect the compassionate motives of those who advocate a change in the law, I look at the way that the campaigning organisations behave once they have a foot in the door. Did not the noble Lord, Lord Joffe, himself tell the committee that his recent Bill might be just "the first stage"?

My advice to your Lordships, therefore, is to think carefully before taking the leap in the dark that some Members of the House suggest. Remember that we know how to deal with the pain and distress of terminal illness. It is tragic that it is not available to all, through the misallocation of National Health Service resources. Be warned of what has happened elsewhere.

Lord Turnberg: My Lords, there were of course, as we have heard, very strongly held views on both sides of the argument in our committee, on which I was privileged to sit. Yet the report which was produced sets out the issues far more clearly than I ever expected, or even hoped for. That, of course, is largely due to the masterly work of our chairman, the noble and learned Lord, Lord Mackay of Clashfern—a remarkable achievement.

I start by expressing enormous sympathy for the view that patients suffering unbearably from a terminal illness who ask to be relieved of their misery should be helped in whatever way is possible. I imagine that very few doctors are unmoved by the patient who says "Help me out of my misery". My anxieties reside elsewhere, however: in how it might be possible to avoid the unintended consequences of a Bill which allowed us to help patients to commit suicide. Even in a largely secular society, where the views of the main orthodox faiths on the essential sanctity of life above all else may not hold sway, there remain major practical problems.

Much was made in the evidence before us of the need to preserve the patient's autonomy; that is, every patient's wishes should be acceded to wherever that is possible. Where a patient insists on being helped to die, they should be so assisted. However, a patient's autonomy cannot be absolute. We have to consider the downside of our acceding to that patient's autonomy where others may suffer. It cannot be absolute autonomy where others are involved. The benefits to the individual are rather clearer than the risks to others.

It is here that I worry about patients who may feel a sense of obligation or coercion to go along the route to assisted suicide. They may feel that they are an increasing burden upon their families and carers, or a drain on their resources, or a continuing cost to the National Health Service. As they sense they are going to die anyway, why not have themselves removed from this life? It is a sense of burden to others, rather than unbearable suffering,

which encourages them along this route. That this is a realistic burden was emphasised to our committee by a group of disabled people who felt very vulnerable indeed. So a Bill designed to help one group of patients might open a door to harm others.

Then there is the whole set of problems about definition of words, such as "unbearable" suffering—incidentally, I am much more attracted to the alternatives of "intractable" or "unbelievable" suffering, which suggest that at least an effort has been made to relieve it—or the word "terminal". Can we say with any degree of certainty that someone will be dead within six months, as has been suggested in the Bill? Predictions of that type are very insecure. Why, indeed, do we not refer to three or 12 months? Why do we need to have any time limit at all if someone is suffering unbearably? The illogicality of restricting assisted suicide to the terminally ill will, I fear, soon send us down that route.

I ought to say a brief word about the position of doctors in all of this. It seems clear from surveys that many—probably most—doctors would be unwilling to take part in assisted suicide. This means that only a subset would be involved in prescribing the fatal doses. Patients would have to be referred to such doctors, who may find themselves specialising in this type of practice. It is quite unclear what elderly or vulnerable patients might feel about doctors who have in their therapeutic repertoire the possibility of helping them to die. Who knows what might happen to the doctor-patient relationship?

Finally, I want to say a word or two about experience that was gained abroad, in Holland, Oregon and Switzerland. Some members of the committee gained confidence from what we heard there. I, on the other hand, was not reassured at all. In Holland, as we have heard, about one in 40 of all deaths is apparently due to euthanasia or assisted suicide, while in Oregon it is only one in 700. I think Holland goes too far, as many have suggested. In Oregon there are a number of complicating factors, not least the medical insurance payment business; that is, payment for palliative or hospice care that is limited to six months, when a renewal of cover has to be negotiated. What sort of pressure might that exert on vulnerable patients and their families?

I have every sympathy with the need to alleviate suffering, and we should do everything we can. I fully understand the reasons for assisted suicide in principle, but my fear is that in framing a law that allows it to happen, we will be placing some patients in a difficult dilemma, and they could be harmed in a singularly irrevocable way.

Lord Elton: My Lords, in a debate in which allegations of religious prejudice have been flying around, I should begin with a declaration of an interest as a licensed lay minister in the diocese of Oxford—or, rather, I am allowed to so describe myself by application every two years, following my 70th birthday, to the right reverend Prelate the Bishop of Oxford.

So much has been said, it is difficult not to repeat, but it seems to me that at the centre of this debate is the value of human life. Dying is an essential part of living. Getting it right, therefore, is a precious necessity. The value of life lies in the power to love and be loved; to love our neighbours as ourselves; to act as social animals; and to put others before ourselves.

The whole of society is a criss-cross of loving relationships, marred by relationships of hate and by circumstances that prevent the exercise of love. What is the function of the state in preserving the best for its citizens? Surely is it to preserve the most effective and freest expression of love between its members? One way to do that is to ease the path of someone

out of suffering, and, if we put that question, of course the answer is yes. If we consider the circumstances surrounding the issue, however, the question is not so simple.

The noble Lord, Lord Puttnam, made a speech quite different from any other. It seemed to me that most of us were talking from divisional or brigade headquarters, while he was talking from a foxhole on the front line. He had actually been in the room where these events were happening. That has the advantage that he can speak with passion and absolute knowledge, but it is not the place from which you can see how these events can be altered. For that, you have to be further away.

I join my noble friend Lord Cavendish in asking the Government to come clean on their attitude to this Bill. Eventually, if time is given to it in the other place by the Government—and that is the only way it will get on the statute book—it will be a government Bill in all but name, and the state will have said, "This is how we value human life".

If the state says that the ultimate decision must be to let people out of suffering at their own request, under certain limited provisions, it has said something about human life that has not been said before by any government in this country. That will change the attitude of our society to life, and it will do so at a time when the ratio of our population between those under 65 and those over is rapidly changing. There is a danger, therefore, as my noble friend has said, that the younger generation will see the older generations—of which most of us, I remind your Lordships, are members, although we should not argue from self-interest—as surplus to requirements and non-productive, and will say "Do help the old dears off this planet".

That will completely change the view that the younger generation has about life and what it is for. I am convinced that we are here to learn what love is and how to express it. If I may venture into realms that will offend those who do not like religious prejudice, we are being prepared to express love in a more perfect way after the event of death has taken place. If we curtail that, as is suggested, moving scenes of enormous value, such as that described by the noble Baroness, Lady Chapman, an hour or two ago, simply would not take place. I have seen enough of elderly people who are already concerned that they are a burden to society, to their friends or to their families when they are still able to get around on two sticks. That feeling of guilt ought not to be encouraged. They should be defended from it.

I ask the Government whether they are going to do that by allowing a Bill that will allow people to commit suicide by one name or another, or are they going to do it by addressing the scandalous imbalance in the provision of the palliative care that we are capable of providing but are not providing in equal amounts throughout the country? That is a crisis and should be treated as such—I am reassured to see the jocularly waving head of the noble Lord who is to answer. This must be a matter of concern to the Government because it will touch us all in this generation and it will touch many more in the next.

Lord Warner: My Lords, before the noble Lord sits down, I make clear that I think this is a serious subject and I was nodding in jocular form at his remark about "scandalous".

Lord Lewis of Newnham: My Lords, much of what I wanted to say tonight has already been said far more eloquently than I could hope to do. First, I also commend the noble and learned Lord, Lord Mackay, and the committee on the report, which I found places this very difficult problem in perspective. It is an excellent report and I spent a large amount of my summer reading it and the written submissions. I shall briefly discuss two aspects of the report; one is

medical and the other concerns palliative care. I was initially favourably inclined towards the Bill. However, having read the report and the evidence that has been given, I now have serious doubts, many of which have been discussed this evening. One of my main worries and concerns is the imposition on the medical community that the Bill will make. Although I have talked to only a limited number of doctors, by far the majority appear to be opposed to any form of assisted dying and worry about the effect it may have on doctor/patient relationships.

In considering the view of the medical profession, I was particularly impressed by the evidence given to the committee by my noble friend Lord Walton, who has vast experience in medical matters. However, I was somewhat disturbed by what appeared to be a change of attitude on the part of the medical professional bodies in taking a neutral position on this problem—I am not clear what a neutral position to a problem like this can be, but let us carry on. The position was somewhat clarified by the reply that the noble Lord, Lord Walton, made to a question put to him by the committee. He said that in discussions with the president of the Royal College of Physicians it appeared that the procedure necessary to produce a reply would have involved an extensive inquiry. The college felt that it did not have the time to consult its members and so declared a neutral position. I find this perturbing.

Subsequently, there appeared to be some doubt about the assessment of the opinions of at least one of the other societies concerned; namely, the BMA. I am sure all noble Lords have had a letter about this. Last month, as has already been said by a number of noble Lords, the Royal College of General Practitioners issued a statement indicating that it does not agree with a change in the legislation. I genuinely believe that before any decision is taken on this topic we must have the considered opinion of the medical profession. If time is necessary, time must be given for that opinion to be obtained. It was interesting to compare this evidence with that of the Royal College of Nursing. It appeared, in contrast, to be against the proposal, although I am slightly concerned now with the remarks of the noble Baroness, Lady Thomas of Walliswood, who appears to contest that remark.

Perhaps I may turn to palliative care. One of the most important points that appears to me to arise is the role of palliative care. The general point made by many of the groups is that with adequate opportunity for palliative treatment, the possibility of near or even complete relief from pain can be achieved. If that is correct, the main point of the Bill appears to be answered.

A point made by the National Council for Hospices and Specialist Palliative Care Services is that in many cases the delivery of palliative care to patients is performed by general clinicians where the quality of care can be variable. That, it states, leads to bad deaths and unnecessary suffering, a situation that has been noted by those in favour of euthanasia. I think that that illustrates a very important point.

Although it appears that the UK is in the forefront of countries providing and working in this area, some of the statistics provided in the Department of Health's submission are alarming. These are points which have already been referred to. There are 172 palliative care hospices, of which 75 per cent are in the voluntary sector. They have approximately 2,600 beds. Considering the size of the problem of the number of potential patients in need of such care, this does not seem an adequate set of figures.

In addition, Professor Higginson from the Department of Medical Law and Ethics at King's College said that,

"research in the UK into ways to understand patients' wishes about, or to find ways to improve, care at the end of life has been relatively neglected".

In fact he made the point that less than 0.2 per cent of cancer research money is devoted to that particular area. Clearly funding is essential if we want to carry out this sort of work. Any Bill of the kind we are discussing today is bound to put available resources in other directions; and it has even been suggested that the finances that would be required to implement this Bill could better be utilised in improving the position of palliative care within the community.

I turn finally to the position that seems to apply to the case for Holland. We have had a lot of discussion about Holland this evening. It is true that with the introduction of assisted dying funding for palliative care initially rose, but my understanding is that it has now dropped and is in a very poor situation. That reflects a very serious matter for concern. The funding of palliative care in this country requires more attention. There is little doubt that there is a need to deal with the problem of pain and death. However, I feel that the proposed Bill reflects the poor position that there is for the correct solution to this problem—a realistic provision of palliative care facilities for those who need the treatment.

Lord Clement-Jones: My Lords, like many noble Lords I took part in the last debate we had on this subject in June 2003. I strongly supported the establishment of the Select Committee although I did not support the Bill. Despite personal experience as a carer, I have tried as dispassionately as I can to test the arguments that I used in that debate against the Bill against the evidence which has been given to the committee.

In our last debate one of my key arguments was that assisted suicide or voluntary euthanasia would crucially alter the duties of and trust in the medical profession. The overseas evidence from Oregon and the Netherlands taken by the committee is therefore I believe absolutely crucial in this debate.

As regards the Netherlands, Dr Johan Legemaate, legal counsel of the Royal Dutch Medical Association, KNMG stated that,

"without a sufficient level of trust, we would never have had the development we have had over the past 30 years."

Yet other Dutch health professionals claimed quite the opposite. Dr van den Muijsenbergh, a Dutch GP, told the committee:

"At the level of the patient doctor relationship I see a growing anxiety among terminally ill patients, as well as, other patients, that they think it is not decent not to ask for euthanasia sometimes, because they feel that they are such a burden to their families or to their carers".

She also talked of the pressures faced by her GP colleagues. Evidence from Oregon from Doctors Hamilton and Toffler was similar in content.

I therefore still have strong concerns that the traditional role of and necessary trust in doctors would be eroded by the Bill. Then, as many of your Lordships said, we come to the relationship with the availability of palliative care. The crucial argument made by overseas witnesses is that there is a case for assisting dying even where excellent and widespread

palliative care is available. But it is far from clear that in the Netherlands or Oregon there is actually good palliative care.

In the Netherlands, Dr van Coevorden, a GP and part-time consultant in palliative care, does, I grant, described an enormous boom in palliative care training and in hospice care. He considers that that has been stimulated by the law on euthanasia and that such provision is now at a high level. But the fact is that other witnesses had a completely contrary view. It appears that the boom in training courses in palliative care was the result not of the legislation but of the prior debate about voluntary euthanasia. The funding for research and training is now in fact diminishing. As we heard from the noble Baroness, Lady Finlay, there are no full-time palliative care posts in the Netherlands at all. Dr van Coevorden himself admitted that if you give proper care, you will see requests for euthanasia fall. Some of those giving evidence alleged that Oregon also has extensive palliative and hospice care and that it has grown substantially, but other evidence, such as that from Professor Katherine Foley of the Sloane-Kettering in New York, completely contradicts that.

So the suspicion remains that palliative care has not been fully developed in either Oregon or the Netherlands. However, as we have heard in the debate today, massive strides in palliative care have been made in this country during the past five years. Even the past year has seen major advances. Surveys show that palliative care doctors themselves are overwhelmingly opposed to the proposals. Should we not, as many noble Lords have said tonight, be concentrating on ensuring that patients have the best palliative care and developing adequate resources in the NHS and in our hospices? As palliative care doctors can testify, all patients have moments of despair, even the most positive, as I can testify from experience.

However, in the words of one US doctor who gave evidence to the committee:

"Patients can be given a sense of control without being handed a deadly weapon".

The burden of proof is on the supporters of the Bill and, after consideration of the evidence taken by the Select Committee, I do not believe that the right to get professional assistance in handling one's own death has been made out. I do not support going forward with the Bill.

Baroness Young of Old Scone: My Lords, it is quite late and I thought that I might just stand up to say that I support the Bill tabled by the noble Lord, Lord Joffe, and sit down again. That would certainly make half of your Lordships very happy for the support and the other half of you very happy for the brevity, but I want to say a little more on this important topic. I am very grateful to the Select Committee for giving us this opportunity to debate it. Like my noble friend Lord Puttnam, I should like to focus on individuals rather than on doctors, nurses or churches: to focus on people.

We all die. Some of us will die better than others and, for painful and difficult deaths, palliative care can help and certainly needs improvement in its quality and distribution in this country. In my previous existence I was involved in the enlargement of palliative care, but I do not believe that it is enough. It is not enough for control freaks—the noble Baroness, Lady David, was very unhappy about being designated in that way—who, after a lifetime of trying to control their lives may find themselves at the end of it unable to control it. I include myself in that category.

The other group of people on whom we have not focused enough is those with long-standing terminal diseases for whom the dread of a terrible death threatens to blight even the

comparatively disease-free part of their lives. A few years ago, a group from your Lordships' House were privileged to hear from a young woman with early motor neurone disease. She had experienced her mother's lingering death from the same condition. Despite support and palliative care, it was a horrible death for her mother and for the family. The young girl now faced a long decline in her own health in the same way, with clear knowledge of what lay in store for her in the future. She desperately needed the comfort of knowing that when her time came she could make a choice in order to avoid going through that terrible sort of death. The Bill introduced by the noble Lord, Lord Joffe, would give her that lifelong comfort.

In the debate, we have heard a lot about the sanctity of life and the preciousness of the gift of life. But I believe that life is no longer sanctified or precious if the holder has come to the point where life is no longer seen as a precious commodity. We have heard a great deal about respect. The noble Baroness, Lady Greengross, summed it up when she said that a dying person should not have to beg for his or her wishes to be respected. A dying person should not have to save up his or her drugs surreptitiously and risk an amateur and botched suicide. A dying person should not have to travel abroad to die among strangers. That is not respect. The Bill is a very carefully crafted set of proposals. I very much admire the thoughtful way in which the noble Lord, Lord Joffe, has conducted the drafting and his commitment to amend it to best meet the widest possible range of views. It contains multiple safeguards against misuse. It deserves our and, indeed, the Government's support.

Lord May of Oxford: My Lords, I wish to express my appreciation for the Select Committee's report and also to explain why I support the principles set out in the original Bill introduced by my noble friend Lord Joffe. There seem to be, broadly, at least two distinct categories of objection to assisted dying, both of which deserve respect. Quite apart from that, I see the discussion of further investment in improving palliative care as a distraction. Of course we should be doing that as well.

The first category deals with practical issues. There is the worry that the Bill could lead to terminally ill people being coerced into death earlier than desired, which is one aspect of the slippery slope. Another legitimate worry is that medical practitioners could be asked to act in ways contrary to their personal beliefs—my noble friend Lord Lewis referred to the imposition on the medical profession—and there are others. I believe that careful crafting of a Bill on assisted dying—indeed, the original Bill offered by my noble friend Lord Joffe—can deal effectively with such worries, although, of course, consideration should be given to the further recommendations made in the Select Committee's report.

The second category of objections derives in essence from personal beliefs—often, but not always, religious beliefs—which in their strongest form can equate assisted dying with murder. The most reverend Primate the Archbishop of Canterbury put it with admirable clarity in the *Mail* at the weekend, when he said that life is a gift from God, with the corollary that it is up to God, not the individual, to decide when to end it.

Essentially, this is an argument about how the rights of the individual are weighed against the rights of the community. Many of the anguished debates in this House are about such weighing of the rights of the individual against the rights of the community, whether the issue is as trivial as fireworks or as large as terrorism. But it is my belief that this is a subject in which primacy should be given to the right of the individual to choose, if she or he so desires, to avoid extreme suffering and to die with dignity.

But my values, shared with many noble Lords, derive from the Enlightenment: plurality, individual liberty of conscience and empirical evidence as the best way to formulate policy. In this latter context I applaud the excellent report from the Select Committee. Some of its facts bear repetition. Studies in the Netherlands and in Oregon show no signs of increasing rates of assisted dying, no slippery slope and, indeed, in the Netherlands doctors are if anything interpreting the rules more strictly over time, as reported on page 395 of the *Lancet*, Volume 362.

Indications in Oregon suggest that hospice referrals and the attendance of doctors at palliative care conferences have increased since 1997. Indeed, there has been a longer time-span in which to observe that than there has been in Holland. Studies in Oregon and the Netherlands suggest that many, perhaps even most, of those obtaining prescriptions for the lethal cocktail do not use it. Quoted in the *New Scientist* earlier this year, the director of the Netherlands Right to Die Society said, succinctly and tellingly, that,

"no longer obsessed by their fear of death, they can spend their energy on living the life that is left to them".

Finally, even acknowledging the faults of all public opinion polls, it is clear that the principles set out in my noble friend Lord Joffe's original Bill command wide—roughly 80 per cent—public support. I hope that I misunderstood the noble Lord, Lord Carter, when he seemed to suggest that the other place is nevertheless unlikely to make time to consider a new Bill from my noble friend in this Parliament. That would be outrageous, given the time the other place has devoted, for example, to concerns for self-determination for foxes.

So I welcome the report of the Select Committee in all its fair-minded complexity. I hope that my noble friend will bring forward a new Bill and that the Government will make time for it in both Houses.

Lord Alton of Liverpool: My Lords, before my noble friend sits down, would he address the point he made about the number of assisted suicides in Oregon? He said that the figure has remained steady over the period of seven years, when in fact the latest report issued on 10 March this year by the Department of Human Services in Oregon includes a graph indicating that there has been an increase of over 200 per cent over the period.

Lord May of Oxford: My Lords, I have not seen the report, but I should like to look at it after the debate.

Lord Griffiths of Burry Port: My Lords, the hour is late, and I am number 64 in the batting order. We have heard legal, moral, medical, philosophical and theological views put forward. At this stage perhaps it may be of some consolation that another angle may be opened up, for the line of argument that I want to put to noble Lords is pastoral. I am a Methodist minister; that is my day job. I come to this place to hear the distilled wisdom of your Lordships speaking in such debates. My angle of view allows me to be with people in suffering, from their first reported symptoms right through to after the death and bereavement. That is a long period of contact with those going through the critical stages that we have been discussing today.

It is of course a privilege to be present in homes in very private conditions where people other than immediate family are not normally welcome. In homes and in hospitals I have been able to join the loved ones of the dying of all ages, including children. For a number of years I was

chaplain at the Middlesex University Hospital after the opening of the new ward to treat adolescents with cancer. So I have seen my fair share of deathbeds, and I have wrestled very hard with some of the questions that have arisen from them.

We were told earlier in the debate that human conditions required human solutions. Nothing about the fact that I believe in God protects me from feeling very human and vulnerable at some of the moments I can think of. I have looked at the sufferer, with pain and agony sometimes, and my only wish for that person has been that they would go now. I think of the carers and the anguish written into their faces. I have wanted for them only that they be released from what, in my view as an observer, is clearly a huge burden. Then there is my plea to God himself that if he had the power he would do something to switch the machine off now and relieve us all from the squalid drama going on in front of our eyes. Oh yes, I have had plenty of moments like that, but they do not prevail, and that is not what it is all about. When it is all over, I have engaged with families in an analysis of what has happened. There is the grief first of all; there is the anger; and, supremely, there is the guilt. How often have I heard the question, "Did we do all we could? Were our thoughts unworthy when we wanted him to die?". You cannot put the clock back then, of course.

I do not want to raise the weasel words of the debate, as I might define them, of "autonomy", "sanctity of life" and "slippery slopes", which have meant different things to different people as the debate has unfolded, but there have been things in the course of the debate that have struck me with great force. The phrase of the noble Lord, Lord Brennan, that the legislation would represent a change of ethos was a strong phrase. The reference to the need for an improvement in and an extension of the provision of palliative care has been a resounding theme repeated again and again. I shall not forget the story told by the noble Baroness, Lady Finlay, at the beginning of the debate about the young man who met all the criteria that would have made an assisted suicide very appropriate in the circumstances but who went on to other outcomes of a radically different nature and who now remains the lone parent, years later, looking after the family.

From the welter of documentation that I and all other noble Lords have received I pick out a paragraph from the midst of the neutrality of the Royal College of Physicians, which has come out with some fairly startling facts for us to consider. It states:

"It will be evident from the foregoing that the management of the dying patient, and, more specifically a clear understanding of the issues surrounding the request for assisted dying, both require a high level of competence in making the complex diagnoses. Anyone involved in the assisted dying process should have received rigorous training in how to discuss these issues with patients and with their supporters; in the legal framework of assisted dying; in the appropriate methods of assisting patients to die; and in the context and settings in which this should take place".

That will not be cheap or easy to achieve. The unquantified cost implications of putting what seems such a simple proposal into law needs to be put before us too.

It is the enshrining of difficult cases in the framework of law that worries me greatly. Assisted dying is what it is all about. I want to assist people in dying by adding value to their last moments; by showing solidarity with them in their last days; and by surrounding them with care and love so that in a context of reciprocity and support they can die with the dignity that they deserve. It is not only by framing a law and helping to foreshorten people's lives that you achieve that outcome.

Lord Northbourne: My Lords, I had not intended to speak in the debate, but when I read the excellent report produced by the noble and learned Lord, Lord Mackay, and his team I realised that there seemed to be something lacking.

The report places very strong emphasis, on the one hand, on the sanctity of human life and, on the other hand, on the right to personal autonomy. The lack of emphasis that surprised me in the committee's report arises from the fact that, although there is a lot about the suffering of terminally ill people and about the dilemmas that would face doctors if law along the lines of the Bill were ever enacted, there is next to nothing about the families of those who might end their life through assisted suicide or euthanasia, especially very close relations—the spouses, the children and, in some cases, alas, the parents. Those issues have been mentioned in the debate in one way or another by the noble Baroness, Lady Flather, the noble Lords, Lord Lucas, Lord Turnberg and Lord Elton, and the noble and right reverend Lord, Lord Carey of Clifton.

The Bill seems to regard people who want medical assistance to end their life as being a world in their own right. There is no requirement in the Bill to consult or even to notify the family of someone planning to take their life in that way. Clause 9 contains a requirement that the attending physician should recommend to the applicant that he or she or his or her next of kin should be notified, but he or she is not obliged to do so. I understand the need for patient confidentiality, and I understand the need for a sense of autonomy, but human beings are, with minor exceptions, social animals. We each rely and depend on our friends, nursing staff or, if we are reasonably lucky, the love and care of our family or those members of our family who are still alive to care for us.

There is an issue of trust in that family and that group. I suggest that, if the Bill is to return to the House, rather more care and thought should be given to the effect on families of taking the decision. That can operate in either way—I am not arguing in favour of the Bill or against it. More consideration should be given to the role that the family plays—the trust, the love and the support that it offers people, especially those suffering from a terminal illness and all the stresses and problems that that involves. The death of a family member often has a huge impact on other members. It is a mistake, in my view, to see this only as a personal act. It was John Donne who said:

"No man is an island".

We seem, in a sense, to have forgotten that. It is late, and I do not think that I need say any more. I have made the point that I wanted to make.

Lord Hylton: My Lords, the debate has ebbed and flowed. I rise as a layman, who will die one day, to help voice the opposition, in the House and in the country, to the former Bill of the noble Lord, Lord Joffe. I have had letters from all over the country, all of them against the Bill.

Soft words such as "euthanasia" or "assisted dying" tend to destroy the trust between patients and their doctors and nurses. Suicide is not a crime, but why should the medical profession be expected to provide it on request? What is to happen to the old who can no longer make a request and to sick children who cannot yet speak? Physicians no longer, it seems, take the Hippocratic oath, but after the Shipman case and other examples of negligence or malpractice, trust is quite fragile. I do not want to face the spectre of Dr Death.

Doctors themselves are far from happy. My noble friend Lord Alton has already detailed the current state of opinion in the medical profession, so I need not cover that again. This Bill or its successor could have pernicious, unforeseen consequences. Some patients would seek compliant doctors who may know nothing about them beyond the mere facts stated on their case notes; and others would try to find doctors who would let them live out their natural span. We would also hear more about cost-effectiveness and bed-blocking.

The evidence from countries where therapeutic killing is legal is far from reassuring. We have heard something about that tonight. In the Netherlands, Belgium and Oregon, it is clear that safeguards prove ineffective; guidelines are not always observed; and there is under-reporting of actual cases. The *Lancet*, a reputable journal, has examined illegal infant euthanasia in Flanders. Given that background, let us uphold the sacredness of life for people of all ages. Let us not be beguiled by false notions of utility or, on the other hand, by excessive compassion, but support the best palliative care as given in hospices. Such care should be made available throughout the National Health Service.

Lord Lipsey: My Lords, my first-ever public speech, in the Oxford Union nearly 40 years ago, was in support of euthanasia, an issue about which I have thought again only this summer. Since I made that speech, the argument has moved forward in two significant regards. The first, much remarked on tonight, is the improvement in our care of the dying—stronger drugs for pain control, a greater willingness on the part of doctors to prescribe them to those who need them, and the wonderful growth of the hospice movement although it is common ground on all sides of the House that we need to do more to improve palliative care and hospice care.

The other factor, which has not been remarked on, is that the diseases that used to carry people off to a merciful death are now terribly treatable—pneumonia, for example, the old man's friend. People with the most appalling neurological afflictions in particular can linger on and be kept alive by modern medicine for years and years.

Those two arguments point in contrary directions and they are as difficult to weigh today as they were then, although the Select Committee has done a wonderful job in putting the considerations on every side. While I am balanced in favour of change, I am much concerned about the notion that old people will somehow feel obligated to end their lives out of a false sense of the burden which they are imposing on others.

I want to draw one contrast between those who favour a change in the law and those who do not. The noble Lord, Lord Joffe, whose efforts are commended even by those who strongly disagree with him, is a very rare creature. He is a man who changes his mind in response to evidence. I know this because I sat with him on the Royal Commission on Long-Term Care of the Elderly, and he was persuaded there to drop his original predisposition in favour of spending money on better care rather than providing it free to the better-off. He has changed his mind quite a bit on this Bill—I am not sure he is right to have done so—to put in additional safeguards.

I am afraid that the same does not apply to most of the opponents of the Bill. The right reverend Prelates the Bishop of Oxford and the Bishop of London both told us to listen to their arguments. The trouble is that I suspect that, whatever was done to refute or demolish those arguments, they would still hold the same position, which is deeply rooted in their faith. They are entitled to have that opinion, but we should recognise that difference between the proponents and opponents.

I do not therefore have any hope of convincing those fundamental opponents, but I would just make to them two incredibly simple points at the end of a complex and subtle debate.

First, I respect and enormously admire people's willingness to declare for themselves that however ghastly their sufferings at their end—and for all that palliative care can provide, it cannot alleviate every suffering; we have heard from noble Baroness, Lady Noakes, about motor neurone disease—they commit themselves in advance to accepting those sufferings, because that is in accord with their belief. What I cannot respect and admire is their willingness to impose their commitment on others, using to do so the law of the land, a land that is increasingly a secular land that does not share those particular values. Secondly, although I am no theologian, it seems to me as a simple soul that to condemn many of your fellow human beings to an agonised, undignified and unchosen end in the name of your abstract principles is a bit unchristian.

Baroness McFarlane of Llandaff: My Lords, I wish to speak very briefly about the contribution made by nursing and midwifery, because those have been the professions in which I have worked. I came to nursing in 1947, which is a few years ago, and the ways of treating the dying were very different then; but I must have sat for many nights beside the beds of dying patients at Barts, where I trained. Many noble Lords will know that Barts is a monastic foundation, or has one; I feel that I entered into a seamless robe of caring that stretches from 1123 right down to me. I inherited some of those values and seek to emulate them in my life still.

I believe that as nurses and midwives, we have the great privilege of sharing the joys and sorrows of the beginnings and ends of life. I remember the relief that I felt when Dame Cicely Saunders came into view, with her developments in palliative care, which added so much to our ability to care for people. I am indebted to her throughout my professional life.

I want to say how much I feel that voluntary organisations add to care in this whole area. I have had the privilege of serving on the committees and councils of a number of voluntary organisations, such as the Malcolm Sargent Cancer Fund for Children, not to speak of my own hospice, St Anne's Hospice in Cheadle. It has been a great privilege to see how much people who work in organisations of that kind contribute to the values of our society in all that they do. I admire tremendously the role of voluntary organisations in our society. What amused me recently was to find how much job satisfaction there is among the workers at St Anne's Hospice in Cheadle. This year it won the award for the second best place to work in the UK and the first best place to work in England, as listed by the *Sunday Times*. That is an achievement. When one is doing work of that kind, there is tremendous job satisfaction, which many other organisations might like to emulate.

I wanted also to dwell on the importance of family and all that family contributes to the care of the terminally ill and dying. I listened to the experiences recounted by the noble Lord, Lord Putnam, and the noble Baroness, Lady Chapman, and felt how fortunate I have been by contrast. October 10 is a very significant day in the history of my family as it was my mother's birthday. She was born in 1882 and lived to be 108. I learnt a great deal from her about geriatric nursing and making a good death. She was a focus of the family over many years. We gathered on this day round her bed year after year to celebrate her life. It was a life worth celebrating. She kept me in place as regards my nursing skills. I remember one evening struggling to get her rather copious arm into a garment that was clearly not made for her. She turned to me and said with some venom, "If that is how you nurse your patients, I am sorry for them". There was I, a professor of nursing. I should have known better, shouldn't I?

As I say, that occasion kept the family together for years. We used to gather on 10 October. Every year we would say, "We had better go this year; it is bound to be the last", and on she would go to 102, 103, 104. I think that Her Majesty was fast running out of congratulatory telegrams. That was a blessed experience which has held us all together ever since. I feel so fortunate that I can rejoice in that. I make those inadequate observations about what it means to be a nurse and to have the tools of palliative care at one's disposal, and about what it means to be a midwife and meet life at its start and revere it. It would be difficult for me to change from that mode of care to handing a deadly mixture to a patient. It is something that is alien to all my professional values.

Lord Habgood: My Lords, in view of some of the fears that have been expressed I promise not to offer your Lordships the slightest whisper of theology. I speak as a member of the 1994 Select Committee, and as one of those who did not change his mind subsequently. However, I have asked myself how two Select Committees could come to such different conclusions in a matter of a mere 10 or 11 years. I think the answer is that the two committees began from different places. Where you begin frequently determines where you end up. It seems to me that the present report, admirable though it is—I share all that has been said in praise of it and of its chairman—starts from the wrong assumptions and inevitably goes on from there to draw what I believe to be the wrong conclusions.

The 1994 report began with the prohibition of intentional killing, which we saw as the cornerstone of all civil law as well as the basis of trust in the medical profession. Our committee gave much weight to the likely consequences of undermining that prohibition. The new report begins with the concept of personal autonomy, but I believe understands it in a way that fails to give due weight to its potential for being manipulated.

I accept that, on the whole, autonomy is highly desirable and should be respected. But it is important not to forget that the exercise of autonomy is, to a greater or lesser degree, socially conditioned. It takes a very strong-minded person not to be influenced in their perceptions of themselves and of their desires by the way in which other people think about them and by the general social expectations of their culture. In particular, it takes the kind of self-esteem that enables people to struggle against adversity and to want to go on living despite many disadvantages. That self-esteem depends to a considerable extent on the public estimate of their condition. If the general estimate is that they would be better off dead, that is how they themselves are likely to feel.

Let me give an example from a French writer, Emmanuel Hirsch, in a book about accompanying the dying. He wrote:

"In the field of choice between life and death, resort to the notion of individual autonomy is in part an illusion. A patient whose physical and mental faculties are deteriorating may truly want to die, but this desire is not the fruit of his freedom alone. It may be, and more often is, the translation of the attitude of those around him, if not of society as a whole, which no longer believes in the value of his life and signals this to him in all sorts of ways. Here we have a supreme paradox: someone is cast out of the land of the living, and then thinks that he, personally, wants to die".

The truth is that we are not solitary, autonomous units. What we are and what we do are irreducibly social. Let me relate that to what the report in paragraph 102 calls "the paradigm shift", and what I prefer to call "cultural change". Changes in social practice change our perceptions of ourselves and of other people. That is the most dangerous and most widespread

aspect of the slippery slope. It is not just that laws are found to have loopholes, or that their application becomes more casual as vigilance decreases, or that individuals find ways of justifying exceptions in their own case. We are familiar with that kind of slippery slope and can in theory devise all sorts of safeguards against it. The central point is that as new practices become familiar, the culture changes, and that has consequences for the way in which people think about themselves. We may imagine that we are making an autonomous choice, when in fact we are merely responding to changed social expectations; as is all too obvious nowadays in the choices made about abortion.

A few years ago, I watched a very moving documentary film about a Dutch doctor preparing one of his patients for euthanasia and then actually performing it on film. It was all very sensitively and tastefully done, and I marvelled at the amount of time, care and emotional energy expended on this one patient. There was a degree of care that it would be hard to match in this country given our present resources. At the end of the film, the doctor was asked whether he found the whole process too emotionally demanding. "Yes", he said, "but it gets easier as you go on". That is precisely the point, because that is the way the world works. That is why I believe that it would be a profound mistake to follow those who have chosen to go down this road.

Lord Haskel: My Lords, the topic of assisted dying provokes the whole range of human responses—ethical, personal, physical, political, legal, emotional and spiritual—and the advantage of speaking late, as I do, is that I have had the enormous benefit of all those responses this evening.

Like most people, in my life as these important matters arise, I deal with them through ideology and principle. I have spent most of my life in the world of business and industry, and you certainly need ideology and principle to survive successfully in that world. But as time moves on and circumstances change, even ideology and principle have to be reassessed—the noble Baroness, Lady Murphy, spoke of that—otherwise we would never have change and progress.

I recognise and respect that, through faith or professional ethics, people can be against assisted dying. Several noble Lords have spoken about that. Like other noble Lords, I respect their ideology and principle, but change and progress is made through a careful re-examination of those ideologies and principles. From this debate, it seems that assisted dying, when subject to proper safeguards, need not violate those established principles. As we have heard, it can be a blessing.

Of course I recognise that, in order to safeguard our principles, there needs to be an exhaustive examination of those safeguards, and your Lordships' committee has been most diligent in that. The noble and learned Lord, Lord Mackay, and others told us about the visits to Oregon, the Netherlands and Switzerland. They have read the submissions of several hundred witnesses and listened to the oral evidence of 150 witnesses. To give you a measure of the amount of work put into this by the noble Lord, Lord Joffe, I quote him directly:

"Such was the complexity and passionate interest in the Bill and the Select Committee, that it has probably required more sustained work by me than the nine month trial in which I defended Nelson Mandela and the leadership of the African National Congress in 1963".

It seems that the committee, in examining the safeguards, has been both exhaustive and exhausting.

I shall be brief. After reading the report and listening to this debate, I am satisfied and convinced that adequate safeguards can be put in place to protect my principles. This is not the start of the slippery slope. It is a matter not of hard cases making bad law but of relieving the suffering of the hard cases. In view of that, I would strongly support any future Bill, and I congratulate the committee and the noble Lord, Lord Joffe, on their diligence.

Lord Moser: My Lords, we have had a remarkable debate, and for that all of us are grateful to the noble Lord, Lord Joffe, and the excellent report before us. In view of the late hour, I shall confine myself to just one point in the report.

The report dealt with evidence from many experts and professional groups, but also public opinion. Public opinion has been mentioned by a number of noble Lords. It is obviously important for the subject. There is enormous interest out there. Ultimate decisions on the matter will rest with Parliament and so, if for no other reason, with public opinion. What do we know about what people think?

The committee did not have time to commission its own opinion research, so it asked an organisation called Market Research Services to assess survey evidence over the past two decades. To my mind—this is very much my own field—the assessment by that organisation was far too dismissive of the weight of opinion and the enormous excellence of some of the surveys. They were criticised as being too quantitative, which is not a criticism in my view, and too simple for such a complex topic. In fact surveys, when technically sound, can be helpful indicators of public opinion, even on complex issues. But the assessors were right in giving more positive weight to the work of the National Centre for Social Research, which is generally regarded as the best of this country's—and perhaps Europe's—survey organisations. I declare my interest as a trustee from that organisation's early days. The centre carries out so-called basic social attitude surveys, which have been extremely valuable and for a decade have covered the subject of our debate. Incidentally they were the only surveys that were conducted neutrally without any connection with vested interests—pro or con.

The results have been clear. Support for voluntary euthanasia and assisted dying rose from some 75 per cent in the mid 1970s to some 82 per cent in the mid 1990s—much the same picture as emerged from all the other random surveys of the general population that have been referred to. I would not wish to suggest, nor does the Select Committee report, that this strong public opinion in favour of a change in the law makes the issue decisive for our conclusions. But, equally, it would be wrong to regard it as marginal. The state of public opinion, which is shifting all the time in favour of a change in the law—and some new surveys are being carried out—must play a part in our considerations and leads me to conclude that the steps before us today, a formal Second Reading followed by the Committee stage, would be overwhelmingly in accord with public opinion. My simple point is that public opinion on this matter is not marginal.

Baroness Howells of St Davids: My Lords, I, too, add my congratulations to the noble and learned Lord, Lord Mackay, for his balanced report. I intend to place on record why I am deeply unhappy with the Bill that the noble Lord, Lord Joffe, intends to present. Those reasons are such that I am unlikely to support any future Bill on this subject, because I envisage the negative fallout on the poor and on the black community in particular. Will this Bill be used later as a form of ethnic cleansing?

There is one certainty in life and that is death. It is final. There is no turning back. I urge the House to support the old-fashioned notion to let nature take its course. One of the most striking features of any assisted dying Bill is its lack of contact with the real world. It depicts people who are wholly rational, who have thought long and hard about ending their lives and who have access to good palliative care. But that is not the real world. Most people who receive a terminal prognosis are at a very irrational stage of their lives. Most have not thought about ending them at all. Why should they have done so? Many of them do not have access to the best palliative care and, above all, they are frightened and confused. It is all very well for any Bill to talk about referring people for psychiatric assessment if there appears to be a psychiatric disorder or offering them a palliative care assessment. But anyone who knows anything about the matter will tell you that in a multiracial society doctors often cannot spot depression and internalised pressures and that hearing about good palliative care is a world away from experiencing it.

There is another way in which the Bill falls short of reality. My attention was caught by a statement made to the committee by one of its witnesses—Professor Irene Higginson of King's College, London. Professor Higginson, who specialises in palliative care, told the committee:

"There are certain under-privileged communities which have lower access to palliative care services".

She continued:

"Work that we have done in the south London area has shown a mixed experience in advanced cancer, for example, among the local black Caribbean community".

And reports showed, said Professor Higginson,

"a trend towards a greater number of unmet needs and also reports of less satisfactory care . . . compared to a local white UK-born population".

Is assisted dying the answer?

Noble Lords may ask what this has to do with euthanasia. The answer is simply this: the more disadvantaged that people are in accessing palliative care services, the greater the push for them to access assistance with suicide or euthanasia. Let us look at what the Select Committee was told when it visited Oregon to inquire into the working of the so-called Death with Dignity Act. The Oregon health department, which collected data on the numbers and characteristics of people who opt for medical assistance with suicide, told the committee:

"Asians are about three times more likely than whites",

to take lethal drugs supplied by a doctor to help them out of their confusion.

I want to look at another aspect of this matter, and I am glad to see that the committee flagged this up clearly in its report. Society does everything possible—and rightly so—to prevent or frustrate suicides, yet here we are considering whether one group of people—the terminally ill—should be aided and abetted in killing themselves.

I have long been concerned about suicides among prisoners—especially among black prisoners—and about the watch that is kept on them to prevent tragic and ill-considered actions. What kind of signal will it send to prisoners who are suffering—and many of them are, in the words of the Bill of the noble Lord, Lord Joffe, "suffering unbearably"—if we decide that such suffering is a key criterion for being helped to end one's life rather than being discouraged from doing so? Not only is there a complete inconsistency here, with society facing in opposite directions, but in my view there is a risk that over time this will translate, however subtly, into less rigorous oversight of suffering prisoners. It is no good to say that we are talking here only about the terminally ill; a Rubicon will have been crossed, and it would be less than realistic to expect there to be no impact on other situations of unbearable suffering.

Finally, what about nurses, of whom mention has already been made? The report says much about the problems of doctors but precious little about the effect on nurses. Community nurses see dying people all the time. They could not withdraw from participating in this law without withdrawing from the nursing profession. It is all very well to say that there will be a conscience clause but, in reality, many nurses will fear for their jobs if they are seen to be unco-operative, and the likelihood is that they will either find jobs other than nursing or take their skills abroad. The Royal College of Nursing pointed to the high proportion of trained nurses in the UK who come from cultures which are hostile to euthanasia, and predicted a haemorrhage of trained staff if a Bill like this were to become law. I ask the House: is this really what we want in the UK.

Baroness Neuberger: My Lords, it is impossible to make a proper winding-up speech after such a long debate with such excellent speeches. They have been absolutely in the tradition of this House, where passions have been running high but courtesy has nevertheless largely been shown, and even some humour. I, too, congratulate the noble and learned Lord, Lord Mackay of Clashfern, and his committee on their excellent report, and the noble Lord, Lord Joffe, on his Bill and the huge sincerity and unfailing courtesy with which he has brought it forward.

The Select Committee has produced an excellent report, and it has given us a way of taking forward some real concerns. We have heard compelling testimony about the unbearable nature of the suffering of some of those who are terminally ill, and who do not wish to choke to death or die in some other horrible circumstance. We know, from the committee's report and the evidence it heard, that there is a considerable body of opinion, in this House as elsewhere, that believes that people with such conditions should be able to ask for their doctors to help them to die, with all the safeguards discussed.

The committee looked closely at issues of patient autonomy, as has this debate, and examined the growing view that patients have the right to call the tune. This debate has also examined existential questions about the meaning of life, and about suffering as part of life. It has touched on questions of the doctor-patient relationship, and whether a change in legislation will damage that relationship—particularly that between older people and their general practitioners. We have also heard quite a lot about those "weasel words" the slippery slope, as the noble Lord, Lord Griffiths of Burry Port, put it, and the slippery slope argument, with evidence, particularly from the Netherlands, that euthanasia has not been wholly voluntary in all cases, as the noble Lord, Lord Tombs, reminded us.

We have heard that only some 54 per cent of euthanasias are reported to the authorities. In some of these cases, the evidence suggests that euthanasia includes neonates, people in comas and people with a mental illness. Most worryingly of all, according to Irene Keizer from the

Dutch Ministry of Health, Welfare and Sport, 25 per cent are people who could have made a request but did not. Then we have had all this firmly rebutted, particularly by my noble friend Lord Taverne.

So where are we? In my view, the Select Committee was right to conclude that assisted suicide should be viewed separately from voluntary euthanasia. I was delighted to hear that the noble Lord, Lord Joffe, is minded to restrict a successor Bill, should there be one, to assisted suicide alone. There are clearly many among us, and I am one, who regard the killing of patients by their doctors, with intent to kill, despite its being at the patient's request, as wholly wrong. I agree completely with the noble Lord, Lord Walton of Detchant, on that.

Furthermore, many regard such killing as utterly incompatible, as do I, with the ethical principles and position of trust which doctors hold. Those who hold such a view would argue that, for societal and moral reasons—*pace* what the noble Baroness, Lady Hayman, has said, it is not only a religious view—even if a patient is utterly incapacitated by their disease and incapable of killing themselves, they should not be able to get someone else to kill them intentionally. That might be hard, but it may also be right for societal reasons. Unlike the noble Lord, Lord Plant of Highfield, I think there is a difference between commission and omission in these cases.

In the case of assisted suicide, however, the principles are different—even though, in the voluminous correspondence that we have all received, many seem not to think so. If individuals, understanding the consequences, take their own lives—particularly with the safeguards suggested in the original Bill of the noble Lord, Lord Joffe—then that is not unlawful killing committed by doctors or, indeed, nurses. It is arguable that doctors need not be a part of this other than for prescription purposes, as in Switzerland. The Select Committee wisely suggests that,

"if society wishes to legalise acts which run counter to accepted medical ethics, it would be wise to consider whether such acts might not be carried out by other means".

In other words, outside the medical world, as the noble Lord, Lord Lucas, suggested. Two final points at this late hour. If a new Bill is to come before us that can ultimately be debated, as I hope, by a Committee of the whole House, it is important that such a Bill distinguishes not only between assisted suicide and voluntary euthanasia, but between physician-assisted suicide and other means. If doctors are to be involved, the Bill should make provision for them to opt in rather than out, as with other conscience issues. It also needs to make some provision for informing or discussing such issues with family members, as several people have suggested.

Secondly, with all the discussion we have had in this debate about palliative care, real measures need to be taken now for patients to experience good palliative care nationwide, whatever condition they are dying from. It is a disgrace that that is not yet the case, because otherwise people cannot make a real and informed decision. The Liberal Democrats' spring conference in March last year passed a motion in favour of assisted dying, but, your Lordships will be glad to hear, it left its parliamentarians free on conscience grounds. It is clear that we on these Benches are of mixed views, as is the whole House. Given the extraordinary attacks we have heard on my noble and real friends the right reverend Prelates opposite, I want to say my last bit as a rabbi. I come from what some say is the most life-affirming of all faiths, and we are a pretty life-affirming lot. Our toast when we drink is "*lochaim*"—not to health, but to life.

I am profoundly opposed to euthanasia. I am in no way convinced that medical involvement in suicide can be right. In a pluralist society, though, I do not necessarily believe that my view should stop all others—provided that doctors and nurses are not involved—and especially that it should stop those very few who genuinely find their pain unbearable, or, as the noble Lord, Lord Turnberg, puts it, "intractable". However, that should only be the case if there is a full and proper informed debate about the social change that might ensue, as the noble and right reverend Lord, Lord Habgood, has put it, and if the fears of those in hospices and the old and vulnerable are thoroughly dealt with, and those experiencing those fears reassured. It should be the case only if equal time is given to the issue of palliative care, and real investment is put into it, so that those hard and moving stories that we have heard today become a rarity, if not completely absent.

Lord McColl of Dulwich: My Lords, I too pay tribute to the skill of the noble and learned Lord, Lord Mackay of Clashfern, whose wisdom and good humour have proved to be essential. In summing up from these Benches, I should say that the leader of our party, Michael Howard, is strongly opposed to the Bill, but of course there will be a free vote.

I have enjoyed the debate. As usual, I have learnt a great deal from your Lordships, and, as always, I appreciated the noble Lord, Lord Maginnis, putting things in perspective, especially at the very beginning and at the end of life. We doctors can be carried away with enthusiasm, like the paediatrician who said in a lecture, "The first few minutes of life are the most dangerous". An old man from the back shouted out, "The last few minutes are pretty dangerous, too".

My noble friend Lady Flather has invited me to mention my experiences in Holland to reinforce what the noble and right reverend Lord, Lord Habgood, said. I asked a Dutch doctor what it was like doing his first case of euthanasia. "Oh," he said, "we agonised all day. It was terrible". However, he said the second case was much easier, and the third—I quote—"was a piece of cake". That left us feeling cold.

When the noble Lord, Lord Joffe, introduced his Bill, he said that he recognised that it should not place vulnerable members of society at risk, nor compel doctors or other members of medical teams to participate in processes to which they have a conscientious objection. My fear is that the Bill will fail in both those respects. A Bill legalising euthanasia or assisted suicide would be a radical change in our law. The so-called safeguards are anything but safe. They are rather like banisters along the side of a high staircase that look fairly sturdy from a distance but give way when they are leant upon for support. As my noble friend Lady O'Cathain said, the risk of undiagnosed depression is very real and depression is common among the terminally ill. The risk of misdiagnosing terminal illness is also real. The Royal College of Pathologists told the committee that that sort of misdiagnosis occurred in about five per cent of cases. Yet, if a depressive illness goes untreated or a non-terminal illness is wrongly diagnosed, no one will ever know or be able to do anything about it, for the simple reason that the patient will be dead.

The Bill does not even require the physician who certifies that the patient complies with the safeguards to have any previous knowledge of the patient, nor does the Bill allow or require the physician to consult others who know the patient, such as his or her family. Then there is the danger that what appears to be a voluntary request to die is no such thing. If the Bill is passed, it will start a process over which we have no control and from which there will be no turning back. It is likely to cause a subtle change whereby it is expected of the elderly and vulnerable that they should opt for assisted death. The elderly and vulnerable should never

have to justify their continued existence to others, nor should they have to justify their continued existence to themselves. How voluntary is a request that is made against a background of expectation created by the Bill, an expectation that the vulnerable will chose death over life?

The present law is not perfect, but it makes a clear distinction between the removal of treatment allowing nature to take its course on the one hand and the active commission of death on the other. The Bill removes the clear line and in its place introduces fuzzy lines that are arbitrary. As the noble Lord, Lord Phillips of Sudbury, asked, how does one objectively assess unbearable suffering? If it is a reason to end the life of people who are expected to die shortly, how long will it be before it is argued that it should be applied to others whose suffering can be expected to last longer? The new lines drawn by the Bill are liable to shift, as the noble Lord, Lord Turnberg, said.

The law as it stands does not allow the patient to demand medical treatment that his doctor does not regard as medically indicated, but the Bill creates two exceptions to that rule. Assistance with suicide and the lethal injection will become treatment options that the patient can demand and the doctor cannot refuse, provided that the checklist of so-called safeguards can be ticked.

It is no comfort to point to the conscience clause. At best, it will be divisive and, at worst, it will be ineffective in protecting would-be physicians who will probably opt out of geriatric care, just as those who rely on a similar clause in the Abortion Act have opted out of gynaecology. The noble Lord, Lord Neill of Bladen, speculated about the questions that would be asked of somebody applying for a job. How right he is; that is exactly what happened over the Abortion Act. The question that was asked of would-be obstetricians and gynaecologists by interviewing committees was whether the candidates would be prepared to take their share of abortions. If they said "Yes", they were considered for the appointment; but if they said, "Yes, I will act within the law", they would be excluded. Hundreds of midwives and obstetricians had to emigrate because they were discriminated against in that way.

Engineers are trained to design potentially lethal machines to fail to safety. For example, a thermostat that monitors the temperature on a heated oil tanker will be designed so that should it fail the heating element turns off, thus avoiding the possibility of overheating and explosion. The law as it stands now fails to safety. It errs on the side of prolonging life and protecting the vulnerable. For all its intended safeguards, the Bill will not fail to safety. The present law errs on the side of life; this Bill will err on the side of death.

Today the noble Lord, Lord Joffe, indicated that he proposed a new Bill that will relate to assisted suicide but not euthanasia. I fear that that revision is mere expediency. Imagine the reality. If I, as a doctor, place a lethal pill in a patient's hand and he swallows it, that would be legal; but if I place the pill on the patient's tongue a few inches away, that would be murder. One cannot make laws on that basis. The two acts are morally equivalent.

There have been several mentions of the double effect. It is important to stress that that is generally misunderstood. The medical profession has been accused of hypocrisy, and it is alleged that we give patients, say, heroin to relieve their symptoms but really what we are doing is killing them. People who make such criticisms are ignorant of the elements of pharmacology. The dose required to relieve a symptom is a fraction of the dose required to kill, which, after all, is the definition of a good drug. It is called the therapeutic index. What Cecily Saunders did so brilliantly was that she realized that the answer to relieving symptoms

was to keep a constant level of drugs in the blood so that the patient was kept free of pain but was able to enjoy life; whereas in the old days we waited until patients got pain and then gave them a slug of heroin, which put them out for a while. When they surfaced and got the pain again, they would have another injection. That intermittent regime had its problems. So there is no hypocrisy at all.

When a patient comes into a hospice, it takes about 24 hours to settle the various doses of drugs to deal with the anxiety, to deal with the pain, and to deal with the breathless. Once the dose, say, of heroin has been fixed, it stays at that dose largely until the patient dies. So the idea that doctors are killing patients in this way is certainly not true.

Finally, I am glad that the noble and right reverend Lord, Lord Carey, stressed that religious views should not be excluded from the euthanasia debate. I have never tried to impose my Christian views, but what I have done on debates on euthanasia and in articles that I have written is to quote a TV programme shown on the much maligned BBC. It was called "Five Steps to Tyranny", and it brought together all the scientific and historical evidence that led to the conclusion that,

"we are all capable of doing the most appalling things to other people".

That was not a religious programme; it was a secular programme. The law is a great dam holding back the wildest excesses of the wild men, but it also holds back the potential for evil inherent in mankind. However careful and thoughtful the noble Lord, Lord Joffe, has been, many regard his Bill as a crack in the dam that could put in danger the elderly, the vulnerable and the dying: the very people most in need of protection.

Lord Warner: My Lords, I am grateful to the noble and learned Lord, Lord Mackay of Clashfern, for introducing this debate. It has provided a chance for this House to continue the important debate on how people should be treated as they reach the end of their lives. I join other noble Lords in saying that the noble and learned Lord and the members of the Select Committee have done an excellent job in assimilating an impressive range of evidence in such a challenging area, and I will comment further on their report a little later.

In the available time, I cannot respond to all the individual points made by speakers. First of all, I want to acknowledge the strong and sometimes opposing views that we have heard today. These reflect the strength of feeling held on this issue within society and the Government are well aware of the differences of opinion and belief and the reasons behind them. I also want to acknowledge Parliament's role in considering issues of this nature. In our response to the Select Committee, the Government stated:

"It is appropriate that Parliament should lead on debates of this nature and provide the forum where all shades of opinion can be heard".

The wisdom of your Lordships has been, and will continue to be, particularly valuable in this respect.

As many noble Lords have said, we are not alone in having this debate. Other countries are considering similar issues. For example there were debates in California about a Death with Dignity Act earlier this year; a private Member's Bill to legalise assisted suicide in Canada has been introduced recently; and, as has been mentioned, the Council of Europe has considered issues about assistance at the end of life in detail, although I understand that it

rejected the idea of active euthanasia. I am aware that in Scotland there has been a consultation on a draft proposal for a private Member's Bill to allow capable adults with a terminal illness to access the means to die with dignity.

As several noble Lords said, it is more than 10 years since the House of Lords Select Committee on Medical Ethics reported on euthanasia. It is pertinent to have the debate again and on a more specific aspect and in the light of experience elsewhere—for example in Oregon and the Netherlands, from which noble Lords draw differing conclusions. In 2003, this House debated the Patients' Protection Bill introduced by the noble Baroness, Lady Knight, and the earlier Bill of the noble Lord, Lord Joffe.

Last year, the House decided that a Select Committee should be established to consider the revised draft of the noble Lord's Bill and I feel that those who served on the Select Committee have demonstrated the wisdom of that decision. I want to commend the Select Committee on such comprehensive evidence gathering; on handling such a difficult issue with sensitivity and balance and on producing such a comprehensive report. Like other noble Lords, I congratulate the noble and learned Lord, Lord Mackay, on steering that process with such fairness and skill.

I well understand the persistence of the noble Lord, Lord Joffe, on this issue. There is no doubting his compassion and integrity, but it is clear that others are equally committed to opposing views. This private Member's Bill raises profound and complex ethical questions and it is right that the Government take a neutral stance while we listen to the debate on the Select Committee's report. Neutrality continues to be our position.

I was especially interested to hear of the reality in places where this sort of legislation has been introduced—for example, on the differences between Oregon and the Netherlands. The report makes clear that there seems to be general agreement that there are a number of people,

"who might be regarded as serious about ending their lives, who are not psychiatrically ill and who are unlikely to be deflected from their purpose",

and that that number is very small. Equally importantly, the report details the concerns of groups who fear that any legislation in this area could result in pressure on people who do not fall into this group to seek to end their lives. It also highlights the need for stringent safeguards in any future Bill. Many noble Lords have emphasised that point today.

I was also interested in the picture presented of public opinion—a very interesting contribution was made by the noble Lord, Lord Moser—and that of healthcare professionals. The report quotes a number of polls that show public support for the principle of assistance to die—for example, the various British Social Attitudes surveys showing rates of between 75 per cent and 82 per cent in favour. But it also gives a valuable health warning that such figures cannot be taken conclusively as the considered view of the UK public. Healthcare professionals' views are, of course, important, as many noble Lords have indicated, because they will have much more direct knowledge of the realities involved. It is interesting to note the report's point that,

"It seems likely that medical professionals view the issue of the legalisation of euthanasia as less straightforward than the lay public".

All of those aspects must be weighed carefully as we consider the way forward.

A feature of the debate has been the number of times that noble Lords have raised issues around palliative care and have paid tribute to the advances made in this country. Patients need good symptom control. The Government recognise the importance of providing effective and efficient palliative and specialist palliative care services. Thanks to people such as the noble Baroness, Lady Finlay, and I should add, the Government's support, we have made much progress in this field over recent years. I certainly pay tribute on this occasion to those working in this area and I accept that we need to do more. That is why we are investing an extra £50 million per annum in specialist palliative care services. This substantial increase in NHS funding for specialist palliative care—about 40 per cent more than 2000 levels—provides direct benefit to patients.

In 2003-04, more than half this extra money went to the voluntary sector, mainly to hospices to support their valuable existing work and to expand that work. Nationally, the additional £50 million has so far funded 38 new palliative medicine consultants, 143 new clinical nurse specialists and 38 new specialist palliative care beds, which is a pretty good start. Between 2001 and 2004, we invested in training about 10,000 nurses and other health professionals who were not specialist in the principles and practice of palliative care.

The relief of pain has been mentioned in this debate on many occasions. A recent National Audit Office survey showed that in 2004 five out of six cancer patients thought that hospital staff had done all they could at all times to relieve pain, while more than nine out of 10 felt they were given enough medication or other help to deal with pain after leaving hospital. In both cases, patients' experiences were a real improvement on the position reported in 2000. Clearly we would like those figures to be better, but I would suggest that great improvements are being made in that area as a result of hard work by NHS and voluntary sector staff.

Choice in palliative care and end-of-life care are key areas that we are working on. In our general election manifesto we said that we would increase the choice for patients with cancer and double the investment going into palliative care services, giving more people the choice to be treated at home. I have to say that I do not recall any other parties giving such a commitment. The details of delivering our commitment are being worked through in consultation with a wide range of opinion. I am sure that in this process we will look at the points concerning rural services made by the noble Lord, Lord Cavendish, and the kind of health inequality issues that my noble friend Lady Howells made. Our commitment will help us to improve end-of-life care for children as well as adults.

The views of the public, service users and staff on end-of-life care issues will be an essential element of the important consultation exercise we are currently engaged in: *Your health, your care, your say*. We want to hear what people have to say and we will take account of what they tell us in the way that we discharge our manifesto commitment on palliative care.

It is always worth bearing in mind that there is little point in consulting the public on end-of-life issues and then being unwilling to listen to what is said. We know that the public want more personalised healthcare and that this is likely to extend to end-of-life issues: how people can die with dignity and in their own way. The importance of patient choice and personal autonomy is a central theme throughout the work of the Department of Health and will continue to be such a theme, despite some of the considerations raised today. It is right that we, both individually and as a society, should ask ourselves how we feel about and respond to the issue of helping someone to end their life. The sad cases raised by a number of noble Lords where people request help with dying challenge deeply held moral beliefs about the value of life and the qualities themselves which make it valuable. As some have argued today,

it challenges the very idea of the sanctity of human life. But in a diverse, multicultural and often secular society, which is the one we live in today and which rightly recognises the dignity of all citizens and their right to make autonomous choices, we have to consider those aspects as well.

However, patients increasingly have access to information about their healthcare and exercise their right to make decisions about the treatment choices available to them, including declining interventions where to them this seems appropriate. We know that the rights to individual liberty must be balanced in part against the freedoms and interests of other members of society, an aspect raised by a number of noble Lords. Thus perhaps the ultimate decision that a person can make, to control the time and manner of death, is not a purely personal one. This debate forces upon us the contested question about whether patients, by exercising that very autonomy, should have a right to ask for and receive help to die from doctors whose prime task, as has rightly been said, is to heal. Thus, it could be said that such requests could damage the fundamental trust between doctor and patient, although I would suggest that acting to relieve unbearable suffering for terminally ill patients could also represent a final act of care and respect. On the other hand, experience in other countries shows that some members of the medical profession are willing, on a voluntary basis, to assist people who have made a well informed and personally determined choice about dying with dignity at a time of their own choosing instead of continuing with a painful existence that they consider unbearable or intractable.

These are complex arguments that the Government feel they need to listen and consider carefully from a position of neutrality. Our role as parliamentarians, among other things, is to gauge and reflect society's views in all their diversity. We are here to develop sound policies and laws that may need to move with the times if that is required for a particular issue, but we must not be afraid to maintain the status quo if, despite different viewpoints, that is what we judge to be fundamentally in the best interests of society as a whole. Above all, we have a duty to protect the vulnerable and to ensure that any measures for change we do promulgate bring benefit and not harm.

It was helpful that in introducing his revised Bill the noble Lord, Lord Joffe, set some clear parameters for the debate. For example, his Bill concerned itself with competent people only and those who are terminally ill. This helps to focus the debate more clearly. As the Select Committee report highlights, a number of issues arise around the use of terms and how they are defined. It is clear that robust safeguards will be vital in any Bill that is reintroduced. The committee has also made a useful distinction between assisted suicide, when a doctor provides the means to allow a patient to end his own life, and voluntary euthanasia, when the patient needs the physical help of a doctor to do so. For the purposes of legislative clarity, the two should be addressed separately. It also highlights the difficulty of dealing with the qualifying terms in legislation.

I imagine that those drafting any future Bill would want to reflect on the detailed consideration that the Select Committee has given these points and the points that have been raised in the debate.

I conclude by repeating my thanks to the Select Committee for the valuable piece of work it has carried out in producing this balanced and comprehensive report and to all noble Lords for the important and considered points made today. This is a profound issue that deserves careful scrutiny. The quality of argument and the intensity of the views expressed have done full justice today to the subject. I have little doubt that we will return to this subject as many in an

aging society think more about end-of-life issues and how they can leave this world in a manner that is dignified and reflects their personal values. The noble Lord, Lord Joffe, seems likely to ensure that we will do just that.

However, in response to the question about government time for a Bill, posed to me by my noble friend Lord Carter and others, I remind him and them that we have a busy Session in both Houses. Let me reassure the noble Lord, Lord Patten, that the Government have not signalled that time will be given for a future Bill and I am not doing so today. In this House allocation of time is a matter for the usual channels, thankfully, and not for me. I hope that I have achieved a suitable degree of inscrutability in my remarks, consistent with the Government's position of neutrality on this issue. On that note I conclude my remarks, despite attempts by several noble Lords opposite to get me to go further.

Lord Mackay of Clashfern: My Lords, we have certainly had a full debate, punctured only by a Statement of no doubt considerable importance. It did not extend our time beyond midnight, which the Chief Whip, with his usual skill, had managed to forecast.

On behalf of the Select Committee and myself I thank all noble Lords who have said they are grateful to us. We did our best to provide a basis for today's debate and the quality of the contributions that have been made have justified our feeling that we have succeeded in doing so. It is not my function at this stage to deal with criticisms of the committee's report, such as we omitted this, that or the next thing. Obviously there is nothing we can do about now—we have finished—and it will be for those who wish to take up these issues to consider what, if anything, they should do about them.

In closing, I should say that all members of the committee were appreciative of what the Government have done. We had very clear evidence from officials from the Department of Health, including medical professionals, about the efforts being made to improve palliative care. We were very appreciative of that and believe that the Government have made a very useful improvement in that area. From what the noble Lord, Lord Warner, said, it looks as though we can anticipate more of the same. As a neutral I do not want to say anything about what other parties may have had—that was a slight deviation from the neutrality of the noble Lord, Lord Warner—and I do not seek in any way to deal with that. But we were appreciative. Palliative care is very important—we all realise that—and we await whatever happens in the future.

Many points have been made by your Lordships and I am sure that when the noble Lord, Lord Joffe, is considering what he will do next he will take time to consider what your Lordships have said and to see whether he can provide a perfect example for answering all the difficulties.

I very much thank all noble Lords. I do not think the Motion requires to be withdrawn because I did not ask for Papers. I asked that your Lordships should take note, and you have done that very fully indeed.

On Question, Motion agreed to.

House adjourned at eleven minutes before midnight.