# House of Commons

Friday 11 September 2015

The House met at half-past Nine o’clock

Prayers

The Second Deputy Chairman of Ways and Means took the Chair as Deputy Speaker (Standing Order No. 3).

Mr David Nuttall (Bury North) (Con):I beg to move, That the House sit in private. Question put forthwith (Standing Order No. 163).

The House divided: Ayes 1, Noes 239. Division No. 68][9.35 am AYES Bone, Mr PeterTellers for the Ayes: Mr Jacob Rees-Moggand Mr David NuttallNOES Abrahams, DebbieAlexander, HeidiAllan, LucyAllen, Mr GrahamAmess, Sir DavidAnderson, Mr DavidAndrew, StuartAnsell, CarolineArgar, EdwardBailey, Mr AdrianBaker, Mr SteveBarron, rh KevinBarwell, GavinBenn, rh HilaryBerry, JakeBingham, AndrewBlackford, IanBlackman, KirstyBlenkinsop, TomBlomfield, PaulBlunt, CrispinBottomley, Sir PeterBrady, Mr GrahamBrake, rh TomBridgen, AndrewBrokenshire, rh JamesBrown, AlanBrown, LynBrown, rh Mr NicholasBruce, FionaBryant, ChrisBurden, RichardBurgon, RichardBurrowes, Mr DavidCadbury, RuthCameron, Dr LisaCampbell, rh Mr AlanCampbell, Mr GregoryCarmichael, rh Mr AlistairCartlidge, JamesCaulfield, MariaChampion, SarahChishti, RehmanChurchill, JoClark, rh GregCoffey, Dr ThérèseCosta, AlbertoCowan, RonnieCoyle, NeilCrabb, rh StephenCrausby, Mr DavidCrouch, TraceyCunningham, Mr JimDavid, WayneDavies, GeraintDavies, GlynDavies, Dr JamesDavies, MimsDonelan, MichelleDowd, PeterDrummond, Mrs FlickDuncan, rh Sir AlanDurkan, MarkEagle, MariaEfford, CliveElliott, TomEllison, JaneElphicke, CharlieEustice, GeorgeEvans, Mr NigelFerrier, MargaretField, rh FrankField, rh MarkFitzpatrick, JimFletcher, ColleenFlint, rh CarolineFlynn, PaulFoster, KevinFox, rh Dr LiamFrazer, LucyFreeman, GeorgeFuller, RichardFysh, MarcusGardiner, BarryGhani, NusratGibb, Mr NickGillan, rh Mrs CherylGoodman, HelenGoodwill, Mr RobertGrady, PatrickGreen, ChrisGreen, KateGreening, rh JustineGreenwood, LilianGreenwood, MargaretGriffith, NiaHalfon, rh RobertHall, LukeHands, rh GregHanson, rh Mr DavidHarris, CarolynHayes, HelenHayes, rh Mr JohnHayman, SueHeappey, JamesHermon, LadyHinds, DamianHoare, SimonHollobone, Mr PhilipHopkins, KrisHowarth, rh Mr GeorgeHowlett, BenHuq, Dr RupaJenrick, RobertJohnson, GarethJones, rh Mr DavidJones, GeraldJones, HelenKawczynski, DanielKeeley, BarbaraKendall, LizKennedy, SeemaKerevan, GeorgeKerr, CalumKnight, JulianKyle, PeterLamb, rh NormanLancaster, MarkLaw, ChrisLefroy, JeremyLeigh, Sir EdwardLetwin, rh Mr OliverLewell-Buck, Mrs EmmaLewis, CliveLucas, CarolineLucas, Ian C.Lynch, HollyMadders, JustinMak, Mr AlanMalhotra, SeemaMalthouse, KitMann, JohnMann, ScottMarris, RobMarsden, Mr GordonMaskell, RachaelMatheson, ChristianMathias, Dr TaniaMcCaig, CallumMcCartney, KarlMcDonagh, SiobhainMcDonald, AndyMcDonald, Stewart

MalcolmMcFadden, rh Mr PatMcGinn, ConorMcInnes, LizMerriman, Huw-Metcalfe, StephenMills, NigelMonaghan, Dr PaulMoon, Mrs MadeleineMorris, Grahame M.Morton, WendyMullin, RogerMurray, IanMurrison, Dr AndrewNokes, CarolineOnn, MelanieOpperman, GuyOwen, AlbertPaisley, IanParish, NeilPenning, rh MikePennycook, MatthewPerkins, TobyPhillips, JessPhillips, StephenPhillipson, BridgetPhilp, ChrisPow, RebeccaPrisk, Mr Mark-Pursglove, TomQuince, WillRayner, AngelaRees, ChristinaReynolds, EmmaReynolds, JonathanRimmer, MarieRitchie, Ms MargaretRobinson, Gavin-Robinson, MaryRutley, DavidSandbach, AntoinetteShannon, JimSheppard, TommySimpson, DavidSkinner, Mr DennisSlaughter, AndySmith, ChloeSmith, JeffSmith, RoystonSmyth, KarinSolloway, AmandaSoubry, rh AnnaSpellar, rh Mr JohnSpelman, rh Mrs CarolineStarmer, KeirStevens, JoStewart, IainStreeting, WesStride, MelStringer, GrahamSwayne, rh Mr DesmondTami, MarkThomas, DerekThomas-Symonds, NickThroup, MaggieTimms, rh StephenTomlinson, MichaelTracey, CraigTrevelyan, Mrs Anne-MarieTugendhat, TomTurley, AnnaTurner, Mr AndrewTwigg, StephenUmunna, Mr ChukaVickers, MartinWalker, Mr RobinWarburton, DavidWarman, MattWhately, Helen-Whitford, Dr PhilippaWilson, CorriWilson, Mr RobWinnick, Mr DavidWollaston, Dr SarahWragg, WilliamWright, Mr IainZeichner, DanielTellers for the Noes: Sarah Newtonand Stephen BarclayQuestion accordingly negatived.

**Assisted Dying (No. 2) Bill**

Second Reading

Madam Deputy Speaker (Natascha Engel):

I wish to make a short statement. More than 85 Members have indicated that they wish to catch my eye in this debate, which is unprecedented. I would like to help as many Members as possible to put something on the record, and therefore ask Members who are speaking to be generous with interventions but for intervening Members to make only one or two interventions. Please, though, keep these to a minimum for the mover of the Bill. It is not customary to impose a speech limit on private Members' Bills, but I hope speakers will restrict themselves to five minutes, and that includes taking interventions. I should make it clear that the Chair retains the right to impose a formal speech limit. I do not wish to do so, but I will review that as the debate progresses.

9.49 am

Rob Marris (Wolverhampton South West) (Lab):

I beg to move, That the Bill be now read a Second time.

I thank all Members for giving up their constituency Friday to take part in this debate. I also thank Lord Falconer, who was the original author of the Bill, and Dignity in Dying—I have never been a member, but it has given me assistance on the Bill. I would also like Members to pass on my thanks to their staff, who have been dealing with quite a large volume of correspondence in many constit-

uencies. Now we have got that vote out of the way, I hope that today will see Parliament at its best, with an open debate and a free vote on a matter of conscience.

I will take interventions, but, as you have requested, Madam Deputy Speaker, I will take very few because so many hon. Members wish to speak. So that hon. Members have some idea of where I am going and when I may address particular issues of interest to them, let me say that my speech is in three parts. I will start with the context of the debate, move on briefly to the content of the Bill and then seek to address the concerns that many people have raised with me.

The context is that the current law does not meet the needs of the terminally ill, does not meet the needs of their loved ones and, in some ways, does not meet the needs of the medical profession. We have amateur suicides and what is technically illegal assistance going on, and those who have the means to do so are going off to Dignitas in Switzerland. In the Tony Nicklinson case, the Supreme Court recognised that there is a problem that needs to be addressed by Parliament.

Fiona Bruce (Congleton) (Con):

If I am correct, in the Nicklinson case only two of the judges recognised that there was an issue. Seven of the judges—the majority—indicated that the law on this is in accordance with the margin of appreciation under the European convention on human rights, and that has recently been confirmed by the Strasbourg Court.

Rob Marris:

My understanding is that five judges expressed grave concerns about a possible breach of article 8 of the convention.

The Supreme Court has indicated that Parliament should address this issue. We have a situation in which Directors of Public Prosecutions—principally, the previous DPP, my hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer), who hopes to speak today—have felt it necessary to issue pages and pages of guidelines on when it would be in the public interest not to prosecute in possible cases of assisted death. It is time for Parliament to grasp the issue.

Social attitudes have changed in the past 50 years. As politicians, we all know not to rely too much on opinion polls. However, opinion polling of 10,000 people by Dignity in Dying, carried out independently by Populus, has suggested that there is extremely strong support for the kind of measure I am proposing.

Susan Elan Jones (Clwyd South) (Lab):

Can my hon. Friend tell the House why he thinks that so many disability organisations and the British Medical Association are opposed to the Bill?

Rob Marris:

Many disability organisations appear to think that this Bill has particular relevance to those with disabilities, but it does not. Disability is not an illness—it is rather old-fashioned to suggest that it is—and disability is certainly not a terminal illness. Despite repeated requests from its members, the British Medical Association has refused to debate this issue since 2012, and it has refused to poll its members. That is regrettable. In that context, The British Medical Journal editorial supports the Bill.

Andrew Bridgen (North West Leicestershire) (Con):

Will the hon. Gentleman give way?

Rob Marris:

No, I will not for the moment. I must make some progress.

I respect the views held by people who are strongly opposed to my Bill. I share their motives for wanting a better society and to ensure that we have a law that protects people. On the tube this morning, I stood next to a man in a hoodie on which it said, "Understand difference", which I thought was quite appropriate. This debate is not about opinion poll numbers; it is about a matter of conscience, ethics and the kind of society in which we live. We need such a debate, and Parliament should not only debate this issue today when 85 hon. Members wish to speak but scrutinise the Bill in Committee in detail, and it should come back to the House for further scrutiny.

John Pugh (Southport) (LD):

Will the hon. Gentleman clarify something that has been bothering me? He has called this Bill the Assisted Dying Bill but there is not a person in this room who would not assist the dying. In the interest of clarity, why did he not call it the assisted suicide Bill?

Rob Marris:

It is quite simple: it was called the Assisted Dying Bill in the House of Lords. I refer hon. Members to the Bill's long title, which is often overlooked:

"A Bill to enable competent adults who are terminally ill to choose to be provided with medically supervised assistance to end their own life."

I think that is pretty clear.

Several hon. Members

rose—

Rob Marris:

I am sorry but I must make some progress. The Assisted Dying Bill has a clear process with multiple safeguards. I will briefly go through that because there has sometimes been confusion about what I am and am not proposing. The Bill co-

vers a patient who is terminally ill, which involves a prognosis of less than six months.

Helen Jones (Warrington North) (Lab):

The Bill is founded on the belief that it is possible to predict the time of death accurately up to six months. In fact, most doctors would say that that is impossible. It is certainly impossible to predict death beyond a week or two. Is that not the case?

Rob Marris:

My hon. Friend, like me, is a solicitor, and she will know that professionals commonly give advice on a balance of probabilities. That is the same for medical professionals. On the gross statistics, when errors in prognosis occur for the terminally ill, it is usually an overestimate of life expectancy.

The second point is that the patient must be aged 18 or over and ordinarily resident in England or Wales. The patient must be of sound mind, and must voluntarily sign a declaration that they wish to embark on this process. Then the attending doctor, as defined in the Bill, countersigns the declaration—

Barbara Keeley (Worsley and Eccles South) (Lab):

Will my hon. Friend give way on that point?

Rob Marris:

I will not. The patient's attending doctor countersigns the declaration—

Ms Gisela Stuart (Birmingham, Edgbaston) (Lab):

Will my hon. Friend give way?

Rob Marris:

No. I will make some progress. The doctor countersigns the declaration that the patient is terminally ill and of sound mind, is acting voluntarily, and has been informed of palliative and other care available. A second independent specialist doctor with expertise in that area countersigns that declaration. If a medical person has a conscientious objection to any of that, she or he—quite properly—does not have to participate in any way. Having had the signature of two doctors, the declaration has to go to a High Court judge. If the High Court judge agrees and makes an order, there is a 14-day cooling off period.

Mr David Jones (Clwyd West) (Con):

On the High Court judge's agreement, what independent inquiries does the Bill provide for that judge to make?

Rob Marris:

Like many Bills it does not fetter the discretion of the High Court judge. It is up to the High Court judge what inquiries they feel it appropriate to make. After the 14-day cooling off period, if the patient still wishes to proceed a medical person

takes the lethal medicine to the patient and waits. At that point the patient could decide not to proceed. The medical person stays there until that decision is made. If the patient decides to take the lethal medication, the medical person waits there. If the patient decides not to take the medication, the medical person takes the medication away. There is no question of it being left on the premises.

Ms Stuart:

I held two public meetings, including one at the Birmingham Medical Institute. This part of the Bill worried the medics most and they were deeply opposed to it. They said, "If I am the attendant medic, what do I do if the person starts choking? Do I intervene?" They felt that it put them in an absolutely impossible situation. What is the answer to that?

Rob Marris:

That has not been the experience in other jurisdictions.

The operation of the Bill will be monitored by the chief medical officers of Scotland and Wales who will lay an annual report before Parliament. For further reassurance, there is a sunset clause of 10 years. Those are the contents of the Bill.

Sir Peter Bottomley (Worthing West) (Con):

The hon. Gentleman introduced the idea of comparison with foreign jurisdictions. The Netherlands has a different law from ours, introduced originally on the same basis. When it was introduced over 10 years ago, on euthanasia, there were 1,600 deaths a year; now there are 4,100. On a UK scale, that would be 15,000 so-called voluntary medically assisted suicides a year. Are those the sorts of numbers the hon. Gentleman recognises, or is he saying we will not be like that?

Rob Marris:

The Bill is not about euthanasia; it is about the self-administration of lethal medication at the end of life. [Interruption.] I hear an hon. Gentleman chuntering about Dignity in Dying. If he recalls, I said I have never been a member of that organisation. It may have other agendas. This Bill is not about euthanasia.

Siobhain McDonagh (Mitcham and Morden) (Lab):

Does my hon. Friend accept, however, that there are people who will be voting with him today for whom this is the start of the process? I went into the Lady Members room on Monday night to see a Minister and one of my own Back Benchers, who is here today, talking about how this is a start. They are coming here to vote today because they want something much more permissive in the future.

Rob Marris:

My hon. Friend knows the constitution of our country. If someone wants to change the law in another way, they will have to have the guts to introduce another Bill to this House.

Nadine Dorries (Mid Bedfordshire) (Con):

Will the hon. Gentleman give way?

Rob Marris:

I will not; I must make some progress. I am conscious of the time.

I appreciate that in England and Wales the medical profession is divided on the Bill, and that, probably, the majority are against. However, as far as one can tell, there is a significant minority who are in favour of the Bill, some of them, one suspects—this is what polling indicates—because they would themselves like to have the proposed option were they terminally ill. There is no contradiction between what is proposed in the Bill and having widespread high-quality palliative care. It is not a contradiction; it is not a question of one or the other. A minority of patients' needs cannot be met through palliative care. Despite the best efforts of palliative care from professionals, those patients keep suffering.

Dr Tania Mathias (Twickenham) (Con):

On that note, may I say that the Assisted Dying Bill can be debated only when we have universal, high-quality palliative care? In my constituency I have Shooting Star Chase, which is internationally top level. That is essential to giving people real choice if they were ever to consider assisted dying.

Rob Marris:

I want good quality, widely available palliative care and I want people to have the choice, but I do not think the House should be holding terminally ill people hostage until we get good palliative care. The availability and funding of palliative care are not in my hands.

Stephen Timms (East Ham) (Lab):

Will my hon. Friend give way?

Rob Marris:

No, I must make some progress. I am sorry.

The European Association of Palliative Care says there is no correlation between the quantity and quality of palliative care in any jurisdiction and whether or not that jurisdiction has legislation like or similar to the Bill. The legislation I am proposing today, as many Members will know, is broadly based on the Oregon Death with Dignity Act, which came into effect in 1997. It has been in operation for 18 years. My Bill has the additional safeguard of judicial oversight.

When the Act was passed in 1994, the Oregon Hospice Association was strongly opposed to it. It has reversed its position, and it now recognises—in my view correctly, although I am not an expert—that assisted dying is one of the choices that ought to be available to dying people. In Oregon, 90% of people who have

an assisted death—0.25% of those who die each year—are enrolled in hospice care, and Oregon is ranked among the best states in the United States of America for palliative care provision.

Sir Edward Leigh (Gainsborough) (Con):

Would the hon. Gentleman care to comment on the Wagner case? Mrs Wagner was encouraged to take assisted suicide, rather than chemotherapy, on the grounds of cost. It worries many of us that market forces and family pressures will promote ever more assisted suicides.

Rob Marris:

I will take a detour for the hon. Gentleman, because there are urban myths. Barbara Wagner was a 65-year-old lifelong smoker with lung cancer, who was insured—this is America—under the state plan. Her doctor prescribed medication that cost $4,000 a month which had an 8% chance of extending her life by four to six months. Her insurance health plan did not cover treatment where there was less than a 5% chance that the patient would be alive after five years. When she told her health plan provider that she would not be paying for the treatment, it informed her that one of the other options was the Oregon Act. It should not have done that, and it has since revised its notification process.

I am told that depression is often present among those who have a terminal illness. That is not surprising; if I had a terminal illness, I think I would get depressed. It is up to the two doctors to determine whether depression has driven someone to make this choice, or whether it is a free choice, and if those doctors have doubts, they can refer the patient, as part of the process, for an independent psychiatric evaluation.

Another concern is that patients will feel that they are a burden on their loved ones or the health service and so wish to exercise this option. I hope that patients do not feel that, but I cannot guarantee it. It is patronising and wrong to say that someone should be denied the choice because one factor in their decision making is that they would feel that they are a burden. They should have the choice.

Joan Ryan (Enfield North) (Lab):

To say that we hope that they will not feel a burden is not a reassurance, because hope is not enough. There is evidence that under the Death with Dignity Act in Washington state, 59% of people who went down this route indicated that they were doing so because they felt that they were a burden on their family and friends. In Oregon, which my hon. Friend refers to as the model for the Bill, that figure is 40%. This is unacceptable.

Rob Marris:

If my right hon. Friend looks at the figures again, she will find that for those people she mentions burden was not the major factor, but it was a factor, and people should be allowed to make a decision.

Simon Hoare (North Dorset) (Con):

Will the hon. Gentleman give way?

Rob Marris:

No, I must make some progress now. I can take no further interventions, I am afraid.

The coercion of the vulnerable is the most difficult issue, for me and many people in the House and outside. That is where the context in which the Bill is being put before the House should be borne in mind. This Bill provides protection for the living. What we have at the moment is protection for the dead when it is too late. It is only after people die in questionable circumstances that the police and the prosecuting authorities investigate, and then a decision is made on whether a prosecution would be in the public interest. I make no criticism whatever of the prosecuting authorities or the police, who are doing the job and fulfilling the role that we in Parliament have asked them to do, but they are doing it after the fact—and the fact is that in many cases there are only two witnesses to what happened when the person died, and one of those witnesses is dead. There are safeguards in the Bill for the living: the two doctors and the judge.

In Oregon, there is not one documented case of abuse or misuse. There are many rumours and urban myths—the Barbara Wagner case is one of them. No one there has ever been charged with a crime. The Oregon health authority collects the data quite properly each year, as would be the case for chief medical officers under this Bill, and there are no documented reported cases of abuse in Washington state, Montana or Vermont.

The fact that other jurisdictions have this sort of legislation is not per se a reason for England and Wales to have it, but it does provide a significant body of evidence for us to look at. That evidence is felt so significant that in California it is likely that later today the upper chamber will sign off an assisted dying Bill and it will be sent to Governor Jerry Brown for signature. The indications are that he is very likely to sign it.

Mr George Howarth (Knowsley) (Lab):

Will my hon. Friend give way?

Rob Marris:

No, I said I could not take any more interventions.

Let me quote from a report by Barbara Coombs Lee, published in the Annals of the New York Academy of Sciences, entitled “Oregon’s experience with aid in dying: findings from the death with dignity laboratory”. Barbara Coombs Lee declared no conflict of interest when she submitted that paper, although I have to tell Members that she is involved with Compassion & Choices in Denver Colorado. The paper was published in July 2014. I hope, Madam Deputy Speaker, in

light of the need for evidence, that you will show me some latitude in quoting not at considerable length, but at a little more length than is usual. She says:

"The data set from a variety of sources confirms that those who complete an aid-in-dying request are equally divided between genders and mostly white, well educated, insured"—

this is the United States—

"and receiving hospice services. Several commentators who articulated concerns about the DWDA—

the Dying with Dignity Act or the Oregon Act—

"have publicly stated that their fears about abuse of the vulnerable have not materialized. One commented, 'I was worried about people being pressured to do this. But these data confirm that the policy in Oregon is working. There is no evidence of abuse or coercion or misuse of the policy."

Ten years after that Act had been in operation in Oregon, the University of Utah examined its operation and the data arising from it. I quote from it prudently again. The university

"found no evidence of heightened risk for the elderly, women, the uninsured, people with little education, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses or racial or ethnic minorities. The only group disproportionately represented among aid-in-dying patients was people with AIDS."

It continued:

"The executive director of the disability advocacy group, Disability Rights Oregon testified before the American Public Health Association in 2007 that he had no knowledge of any cases in Oregon to contradict the findings of that report."

[Interruption.] One of my hon. Friends says from a sedentary position, "So it is about disabled people." No, it is not about people with disabilities. However, I understand, and so did the author of this report, that there are concerns and that is why that evidence has been looked at, and I seek, as did the author of that report, to allay those concerns.

Lord George Carey, the former Archbishop of Canterbury, has said:

"There is nothing sacred about suffering, nothing holy about agony, and individuals should not be obliged to endure it."

I agree with him.

When we talk about choice, some hon. Members need reminding of section 1(4) of the Mental Capacity Act 2005, for which many Members present today, including me, voted. That subsection states:

"A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

We need to bear in mind that different people faced with the same set of circumstances on occasions make different choices, and at the moment the law in England and Wales has not got the balance right between protection and choice. My Bill would provide more protection, particularly for the living, and more choice. Most of those who would fulfil the criteria in the Bill will, for faith or other reasons, never choose an assisted death. I do not know whether I would, if I had a terminal illness and a prognosis of less than six months, but I and many others would find it comforting to know that the choice was available—to have the option of choosing a dignified and peaceful end at a time and place and in a manner of my own choosing at my own hand.

There has been a trend in our society, which I support, that if the exercise of a choice does not harm others, in a free society we should allow that choice.

10.17 am

Mrs Caroline Spelman (Meriden) (Con):

I respect the sincerely held views of the hon. Member for Wolverhampton South West (Rob Marris). The whole nation will be looking at our debate on this issue today and it is right that we show respect for the strongly held views on all sides, but I beg to differ with him.

Historically, our society has abhorred suicide and based that view on the principle of the sanctity of life, but that argument is becoming harder to make in an increasingly secular society. The view that life is a gift from God with all that it entails, including pain and suffering, and that it is not for us to bring it to an end, is perceived to be at odds with the prevailing view of our rights, including a perceived right to end our own life.

Naturally, none of us likes the idea that our death will be painful and difficult. We need to do more to reassure people that it does not have to be. Our hospices offer outstanding help and support to the dying and their families. The recently opened Marie Curie hospice in Solihull is a brilliant example of this. It is possible, with sheer humanity, to make dying better. Still, 50% of us will die in hospital when we do not wish to, and a recent report on end-of-life care in hospitals shows gaps in medical training to provide the care that is needed. There is a significant risk that passing this Bill would reduce the available resources. The deputy chair of Hospice UK has suggested that such a change could threaten funding for hospices.

Mrs Cheryl Gillan (Chesham and Amersham) (Con):

If the Bill goes through, it will create an enormous dilemma for our hospice movement. My own hospice, Rennie Grove Hospice Care, has written to me to say that it

“will not be involved in the provision of assisted dying to people under its care.”

That could lead to a situation in which people who needed care in such a hospice might not want to go to it, which would effectively remove a choice from dying people to have the palliative care that they require.

Mrs Spelman:

My right hon. Friend demonstrates one of the dilemmas that the Bill presents.

The National Council for Palliative Care has said:

"We believe the current Assisted Dying Bill puts vulnerable people at risk, without improving access to care".

The heart of the issue of assisted dying goes deeper still, however—to society's attitudes to ageing, to death and to dying. Why do so many people say, "I don't want to be a burden"? In societies that revere the elderly, there is less fear among old people that they impose a strain on everyone else. One of my constituents put it like this:

"We are born into dependency, we rely on the goodwill of others even when we are in our prime, and dependency is a necessary feature of our senior years."

The Archbishop of Canterbury has said that this Bill would lead Britain to cross

"a fundamental legal and ethical Rubicon".

Respect for life underpins our criminal and human rights laws, as well as the Hippocratic oath, taken by all our doctors, to promote life. The Bill challenges that respect for life. It would result in a major shift in these principles, fundamentally changing the relationship between a doctor and their patient. It would not just legitimise suicide, but promote the participation of others in it. Even if we consider assisted dying to be acceptable in some circumstances, the law should not be changed.

Mr George Howarth:

The right hon. Lady talked about people feeling that they did not want to be a burden, as though that was not a rational choice to make. In some circumstances, however, it can be perfectly rational for someone to say, "I do not want to be a burden on my family or on the health service, and this is probably the end of my life."

Mrs Spelman:

Let me put a rational question back to the right hon. Gentleman. How is it that senior members of our society have reached a point at which they feel they might be a burden? The increasing secularisation of society has contributed to this, because the Christian principle of honouring our fathers and mothers must have become weakened if our parents and grandparents are starting to feel that they are a burden to us.

Yasmin Qureshi (Bolton South East) (Lab)

rose—

Simon Hoare

rose—

Mrs Spelman:

I should like to make a bit more progress before I give way.

Assisted dying should be the absolute exception, not the rule. In practice, the law as it stands has seldom been used to convict anyone for assisting someone else to die. Strong laws protect vulnerable people. The existing law protects the elderly, the disabled and those who might otherwise feel pressured to die. It is difficult to prove definitively that someone has not been coerced. It would be almost impossible to pass a law that could definitively prove one way or another whether an elderly person had been coerced.

Yasmin Qureshi:

I thank the right hon. Lady for giving way. I agree with what she is saying, and I should like to give the House a small example of why that is the case. My mother is 83 years of age and has a number of health issues. Last year, she was in and out of hospital, and in April this year she was told by the consultant that she did not have much time to live. In May, she was given about three days. My mother has now recovered and is very healthy again. Before I left home at 5 o'clock this morning, I had tea and biscuits with her, and she was walking about. She has recovered, but when she was suffering, she was saying, "I feel I am a real burden on my family. I can't do this." She was very emotionally distressed, and she still sometimes gets distressed, but she has survived and she is now healthy.

Mrs Spelman:

I suspect that in the course of this debate we will hear a lot of personal examples such as that given by the hon. Lady, which speak volumes about the predicament the Bill presents.

Research by Age UK has shown that about 500,000 elderly people are abused each year in the UK and there is a very real danger that if this Bill were to pass, many of these people could be put at further risk. As the Care Not Killing campaign has said:

"The right to die can so easily become the duty to die."

An opinion survey commissioned by the charity Scope last year showed that the majority of disabled people also fear change to the assisted dying law. For them, the current situation provides protection for the living. There are surely reasons why most doctors are against this Bill. Only one in seven doctors would agree to assist a suicide, so the chances are that the doctor involved would not be known to the patient or the family, which is undesirable.

This is also a Bill without any detailed, up-front safeguards. It outlines a process, but does not give enough detail about how it would work. The so-called "safeguards" are left to codes of practice; set out in clause 8, which states that they "may" be issued by the Secretary of State—but "may" is not strong enough. The first so-called "safeguard" is that the Bill applies only in the case of a terminally ill adult with less than six months to live, but, as has been pointed out, it is difficult to ascertain whether someone does have just six months to live. In addition, clause 1 suggests that the process must be entirely voluntary and initiated by a patient, but if assisted dying becomes regarded as a medical treatment, it is likely that a doctor would be under some positive obligation to suggest it to patients.

The disposition of this House towards this difficult subject will reveal these strong views. I have lost both my parents, one of whom suffered in death. I have sat with good friends who were slipping away in a hospice. I have wept over friends prematurely departing this life. Grief is made worse by missing the parting. As the letter from all the faith leaders put it,

"for very many people... the natural processes of dying, allied with good palliative care, enable them and their families to experience precious moments of love, care, reconciliation and even hope; processes that ought not to be truncated."

Several hon. Members

rose—

Madam Deputy Speaker (Natascha Engel):

Order. Before I call the next speaker, may I say that that contribution was 10 minutes long, which, even by my maths, is double the voluntary limit of five minutes? Unless we stick to five minutes and be generous by making only brief interventions, we will not get as many Members as I would like on to the record. With that in mind, I call Jim Fitzpatrick.

10.27 am

Jim Fitzpatrick (Poplar and Limehouse) (Lab):

It is a pleasure to follow the right hon. Member for Meriden (Mrs Spelman). I congratulate my hon. Friend the Member for Wolverhampton South West (Rob Marris) on introducing the Bill. He does this House a great service, as did Lord Charlie Falconer in the other place, because this debate just has to happen. The courts have said that Parliament needs to review the law as it stands now after the decision of the former Director of Public Prosecutions, Keir Starmer, to amend guidance on this matter. I pay tribute to the former DPP also for the meticulous way he and the Crown Prosecution Service felt their way forward after so many high-profile cases demonstrated that something had to change. He is

now, of course, my hon. and learned Friend the Member for Holborn and St Pancras, and he brings great authority to this place.

There are three key issues here: first, for those with terminal illness who are facing pain, suffering and indignity, it is about having the right to choose; secondly, it is about the need to protect the vulnerable against undue pressure and to legislate for safeguards; and, thirdly, it is about treating every citizen with the same degree of respect and dignity, and affording them the opportunity to access the best advice and professional help available.

On the right to choose, this—I should declare an interest—is personal. As many colleagues know, before being elected to this place I served in the London fire brigade for 23 years, during which time I worked with asbestos, as did the Minister for Policing, Crime and Criminal Justice, who is sitting on the Government Front Bench. Its heat-resistant properties meant that the fire service used it for all manner of things. For example, we used to wear asbestos helmets and gloves. I do not know how many people here have seen the terminal stages of asbestosis or mesothelioma. Not only is it not pretty, but it is damned ugly, and if that is what lies in store for me, I want to control my own exit.

Secondly, we need to protect the vulnerable. As my hon. Friend the Member for Wolverhampton South West said, there are 15 safeguards in this Bill compared with two existing safeguards. I would go through them, but he has covered them and time is against us. However, in The Times this week, Lord Finkelstein, not somebody whom I would normally quote, wrote:

"At the moment, you can press your relative to commit suicide, as long as you don't get caught doing it. The investigation into the pressure that has been placed on the deceased doesn't take place until after you are gone. By which point it is a little late. Far from increasing the chance of people dying because they have been press-ganged into it, a new law would protect them from this. Doctors would be involved, a judge too. And you would still be there to give evidence for yourself. This is all much safer, not less safe, than the current position."

My final point is about fairness. I am a huge admirer and supporter of the hospice movement. Locally, Richard House hospice and St Joseph's hospice care for residents in east London provide a magnificent service. Not everyone will want to be assisted to die. For those who do not, they should have the right to choose their own fate. Many will be so sedated that they may not be aware of their passing at the end.

Until the Crown Prosecution Service amended its advice, families or friends had been open to prosecution. But there still remains the huge obstacle of the lack of professional medical assistance. In his previous position, my hon. and learned Friend the Member for Holborn and St Pancras wrote:

“I have become increasingly concerned about two inherent limitations in the guidelines. The first is that although those who have reached a voluntary, clear, settled and informed decision to end their lives can now be confident of the compassionate assistance of loved ones without automatically exposing them to the criminal law. The only assistance they can be provided with is the amateur help of those nearest and dearest. They cannot be provided with professional medical assistance unless they traipse off to Dignitas in Switzerland.”

Rehman Chishti (Gillingham and Rainham) (Con):

The hon. Gentleman referred to the guidelines of the former Director of Public Prosecutions. Some would say that, having overseen those guidelines, the view that the former DPP now takes on assisted dying may be tainted by bias and that, like the United States, we should have an independent commission on bioethics so that an independent view can be reached.

Jim Fitzpatrick:

I have great regard for the hon. Gentleman, but I think that he is impugning the integrity of the former DPP in reaching that decision and in his ability to speak for himself later on today.

Switzerland would be fine for people such as us or others in similar well-paid jobs or on decent pensions, but it is not an option that is available to many of our fellow citizens. Who wants to travel to Switzerland? Why should we have to? Why cannot we die at home, which is where most people want to die? The law needs to change; the law will change. Society is making decisions without this House’s agreement, but, ultimately, it is up to us to make much better legal provision.

This Bill should be sent to Committee and examined properly, because that will not happen today. The case is compelling. I wish to thank all those involved in the campaign organisation—the staff, supporters and patrons of Dignity in Dying—for assisting my hon. Friend and for giving us this opportunity today. Legislating opportunities on this stuff comes around once every 20 years. Today we should make progress.

10.33 pm

Crispin Blunt (Reigate) (Con):

I congratulate the hon. Member for Wolverhampton South West (Rob Marris) on promoting this Bill and my right hon. Friend the Member for Meriden (Mrs Spelman) on her speech. It is the first time that I have heard the arguments put forward around the sanctity of life. Those arguments were notably absent from the letter addressed to us all by the two archbishops. I congratulate her on making those arguments. Although some may believe that suffering is a grace-filled opportunity to participate in the passion of Jesus Christ, which is selfishly stolen away by euthanasia, I say please count me out.

Alberto Costa (South Leicestershire) (Con)

rose—

Crispin Blunt:

I ask my hon. Friend to forgive me. We are very tight for time, and he will get the chance to make his own arguments.

To die well is a simple concept and one that would not have shocked Socrates or Seneca. However, an aversion or allergy to a proper, weighty consideration of what a- good death is and should look like is a shibboleth of a society that has been shaped by Christian concepts of the sanctity of life.

I came to this House in 1997 as a convinced supporter of the principles behind the Bill and, like many of its supporters, I came to that decision through my own personal experience. I watched my two parents and, in particular, my father-in-law die of cancer. He had conversations with his children, saying that if he ever found himself in that situation he wanted them to take care to trip over the cables so that if he was on a life-support machine it would be switched off. He died without even have the possibility of controlling the time of his own death and I found it truly appalling that his personal autonomy was limited in that way.

The Bill contains all the necessary safeguards to protect people.

Alberto Costa

rose—

Crispin Blunt:

I would take interventions, but I am conscious that many people want to speak.

The arguments about a slippery slope or the vulnerability of people in the letter to us from the two archbishops and the religious leaders simply ignore the fact that this applies only to terminally ill people. Two doctors have to sign off on the fact that the person will be dead within six months and the process is overseen by a High Court judge. On the subject of freedom, I ask my right hon. and hon. Friends to consider who will be the beneficiaries of this legislation. It is not us in here, who, if we were faced with these circumstances would be capable of taking the decision for ourselves, but it is the people who cannot exercise that ability and need someone else to help them make that decision in the last six months of their life; when they want to exercise the option of ending their life with dignity, at a time of their choosing, having had the opportunity to talk to their family and have all the conversations to which my right hon. Friend the Member for Meriden referred. They will then know when the end of their life will come. The Bill gives people in those circumstances a little bit of control at the end. Perhaps most importantly, it gives everyone the potential to have that little bit of control the end. In Oregon, hardly anyone—0.3% of people dying—exercises the right. The whole Oregon experience entirely supports that this is a

practical, sensible, humane and decent measure. I went there to see it in operation, as I am so interested in this issue.

For nearly everyone, the Bill will provide the comfort of having a degree of control over the end of their life. We must and ought to have a right to choose, despite the concerns about what a valid choice looks like. Those issues are addressed in the Bill. I say in particular to my right hon. and hon. Friends that this is an issue of freedom. The logo of our party for a long time was the torch of freedom, and that is why I am surprised that there is so much opposition to the Bill on the Conservative Benches. I understand the Catholic and faith lobby will have in-principle objections, but I am slightly appalled that they should seek to sustain legislation that limits my personal autonomy when 80% of the population, presented with this proposition, would support it.

In the 21st century, mutual tolerance should have taken us beyond that. We are the party of freedom and choice and surely there could be no greater demonstration of our commitment to those principles than the principle in this Bill. Hiding behind the slippery slope argument will not do. If two doctors and a High Court judge are not enough, what is? My hon. Friends should seek to insert in Committee the safeguards they feel are required, but they should not abandon the guiding principle of our party and oppose the freedom that the Bill enshrines today.

10.39 am

Lyn Brown (West Ham) (Lab):

I am afraid that I cannot support this Bill. My concern is that we will fundamentally change the way that our society thinks about and deals with the terminally ill, severely disabled people and the vulnerable, troubled and elderly.

My mum died suddenly and unexpectedly, riddled by cancer, but I know that my mum, faced with a terminal prognosis in a world where there was the possibility of state-assisted suicide, acceptable and accepted by society, would have tormented herself during her last months with the question of when she should ask for that button to be pressed. She would have worried about the stresses that my sister and I would have endured, she would have worried about the weight of her care being shouldered by the nurses and the doctors, and she would have been anxious that folk would think that she was consuming too many resources, selfishly staying alive, costing money, when she could and should just die.

My mum was not vulnerable. She was not alone or a depressive. She was dearly loved; and yet I know that the mere existence of legal and assisted suicide would have placed an enormous burden on her. But what of those without a loving family? What of those elderly people—let's face it, they do exist—with families more interested in the cost of care, and its impact on their dwindling inheritance, than the priceless gift of life? Would not some of my more vulnerable constituents think that they ought to take a course of action because it is available and

despite the safeguards in the Bill, which I acknowledge have been carefully crafted? Can we be absolutely sure that they would not be pressured into it?

It is naive to believe that we can prevent an elderly, expensive or asset-rich relative being encouraged, coerced or emotionally blackmailed into taking their own life. And if just one person makes that decision to end their life as a result of such pressure, that would be a tragedy.

The Bill seeks to provide the right to assistance in dying only to those who are terminally ill. I believe supporters of the Bill have real integrity and do not intend its scope to be extended further. But if the Bill is passed, I believe that its scope will be extended, partly by case law, to apply to more people. Holland introduced assisted dying for the terminally ill in 2002. Initially, hardly any patients with psychiatric illnesses or dementia sought suicide. Now, just 13 years later, assisted suicide is sought and granted to elderly, lonely or bereaved people. Pressure for doctors to accede to requests comes from patients and relatives, as I believe it will here.

Mr Alistair Carmichael (Orkney and Shetland) (LD):

The hon. Lady is talking about the consequences of giving the Bill a Second Reading. Will she address for a second, though, the consequences of not giving the Bill a Second Reading? Assisted suicide will be available; it will simply be available to those who have the means and the determination to go elsewhere. What does she think should happen for these people, and for those who are currently protected from prosecution by the DPP's guidelines?

Lyn Brown:

I am against this Bill because I worry that the mere existence of the process of assisted dying will make the vulnerable more vulnerable. It will change fundamentally the relationship between a patient and a doctor, and I oppose it most strenuously, because I think it will fundamentally, slowly but inexorably, change our society's attitude to death and the dying, with a creeping invidious expectation that our elderly, infirm or disabled should take themselves out of the igloo of old, and die a dignified death, leaving the young, fit and able unencumbered by their burdensome, difficult, messy, expensive, pain-filled and challenging lives.

Life is precious. But the virtues in a society that set it apart as wholesome, decent and ethical are those which nurture and value that life. They are the qualities of tolerance, understanding, forbearance and, dare I say it, love, which are such precious commodities. They engender and sustain compassion and ensure a growing humanity, a more civilised society for the living, that shields and truly values life.

10.44 am

Fiona Bruce (Congleton) (Con):

The hon. Member for Wolverhampton South West (Rob Marris) says that there has been a lot of misunderstanding about the Bill. There is no misunderstanding at all: the Bill would authorise doctors to provide a lethal substance for people to kill themselves with. That substance is not a "medicine", as the Bill disingenuously describes it, but a poison. No wonder doctors oppose it, and we in this House should do so too.

The hon. Member for Wolverhampton South West says that the Bill sets out a clear procedure with multiple safeguards. What clear procedure? What safeguards? Let us look at the Bill. It states that doctors must be satisfied that a patient has a settled and voluntary intent to end his or her life. How should doctors be satisfied that the intent is settled? The Bill does not say. Would they need to see the patient once or twice, or over what period of time? The Bill is silent. What steps should doctors take to be satisfied that the intent is voluntary, and that there is no coercion behind the patient's request? The Bill is silent. Given that Action on Elder Abuse reports that there are over half a million reported incidents of physical and emotional elder abuse in the UK each year, the Bill should be clear on that critical issue, but it is not.

Simon Hoare:

It is actually worse than my hon. Friend suggests. Given the very low number of GPs who have indicated that they would seek a licence, it is more than likely that both doctors seeking to make the certification would not know the patient and therefore would not be able to tell whether they were more or less depressed or to assess their rate of degeneration. That is the fundamental weakness of the Bill.

Fiona Bruce:

My hon. Friend is absolutely right. Those doctors could not be sure, and they would not be able to assess the even more subtle internal pressure that an individual might feel to express a wish to end their life because they feel a burden. What special procedure is there in the Bill for the particularly vulnerable in our society, such as those with mental health or learning difficulties? There is none. No wonder Mencap and Scope oppose it.

The hon. Member for Wolverhampton South West speaks of multiple safeguards. Where are they in the Bill? I do not see them. Does he mean the provision that the decision should be referred to a High Court judge? If this was not so serious, it would be laughable. The judge would not have to meet the patient; they would only have to confirm the doctors' decision, and in a time frame of 14 days, making independent scrutiny all but impossible. Absent will be the detailed, rigorous examination that the family court gives to life and death issues, such as turning off a life-support system. Gone will be the investigative powers of the Director of Public Prosecutions under the current legislation to rigorously

investigate cases of assisted suicide referred to him. Removed will be the strong deterrent against malicious behaviour that the current law provides.

Gareth Johnson (Dartford) (Con):

The Bill would require the dying person to make a declaration, and that declaration would have to be witnessed. Quite rightly, the witness cannot be a member of the dying person's family, but they can be a beneficiary of their will. Is my hon. Friend as concerned about that as I am?

Fiona Bruce:

I am extremely concerned about that "conflict of interest", as we in this place might call it.

Vulnerable patients would be left in a weaker position than they are now. The inclusion of a judge to effectively countersign a form confirming the doctors' decision adds no protective value whatsoever. But wait; here in clause 8 is a provision that would allow the Secretary of State to issue at some future date—not before we have passed the Bill—a code of practice. A code of practice would relate to such critical matters as assessing a patient's capacity or what counselling should be given, or recognising that depression might impair a patient's judgment.

In other words, the Bill says to us, "Parliament, decide now and sign this blank cheque, and at some future date as yet unknown some safeguards may be considered." That is wholly unsatisfactory. That will be too late. The deed will have been done. We will have changed the law. We will have crossed the Rubicon, from killing people being illegal to killing people being legal. That is not doing justice. We are here to protect the most vulnerable in our society, not to legislate to kill them. This Bill is not merely flawed; legally and ethically it is totally unacceptable and we must reject it.

10.50 am

Keir Starmer (Holborn and St Pancras) (Lab):

May I lay out for the House the history of the guidelines that I issued and my experience in operating them? I am well aware of the deeply held views on all sides, and very respectful of them, as I have been throughout the past seven years. I will therefore attempt this exercise as a factual chronology objectively stated so that people can see the conclusions that I have reached.

I was six weeks into my post as Director of Public Prosecutions when I had to decide whether to prosecute the mother and father of Dan James, a young and very gifted rugby player who was paralysed after an accident on the rugby pitch in Nuneaton and wished to end his life. He did not want to die alone and persuaded his parents to go with him to Dignitas. When they came back, they were arrested and interviewed, and I had to decide whether they would be prosecuted. I decided that they should not be prosecuted.

John Pugh:

Will the hon. and learned Gentleman give way?

Keir Starmer:

I would prefer it if the House allowed me just to lay out the history so that everybody can understand it. I will of course try to take on board all the points that are being made.

I took it to be the compassionate act of a loved one, and using the exercise that the DPP had, decided not to prosecute.

A courageous woman with multiple sclerosis, Debbie Purdy, was in the process of bringing a case against the DPP in our courts. It started as a case against my predecessor, but became a case against me, and it was reaching the final stages. She noticed the reasons that I had given, and she argued before the House of Lords judicial committee that the DPP should be required to set out in guidance the approach that was being taken, and would be taken, to assisted suicide.

John Pugh:

Will the hon. and learned Gentleman give way?

Keir Starmer:

For the reasons I have given, I genuinely think it may be more helpful for the House if I just completed the exercise. I am deliberately trying not to put my views into this chronology so that people can simply see it for what it is, whatever view they take.

Debbie Purdy persuaded the committee that I should be required to produce guidelines. In the last judgment of the House of Lords judicial committee before it became the Supreme Court on the other side of Parliament Square, it ordered that I should do so. I was, of course, at that stage deeply aware of the views that were held on all sides, and I decided that a very wide public consultation was necessary so that the guidelines would be as fully informed as they possibly could be. I decided also to issue interim guidelines so that people could see the words on the page of the guidelines before the consultation exercise started, and so that it would be a meaningful consultation rather than one where views would be expressed in the abstract but without a real, detailed eye on what I was proposing.

The interim guidelines were underpinned by two principles. The first was that the criminal law should rarely, if ever, be used against those who compassionately assist loved ones to die at their request, so long as that person had reached a voluntary, clear, settled and informed decision to end their life. The second was that very strong safeguards are needed to protect those who might be pressurised in any number of subtle ways. Those who encourage the death of the vulnerable should feel the full force of the law.

The response to that consultation exercise was huge. Most criminal justice consultation exercises have responses numbered in the low hundreds; the response to my consultation exercise was nearly 5,000, and that is treating all the heads of faiths as one respondee when, in truth, they were responding on behalf of very many within their communities. It was probably the widest consultation on this particular area of our law ever conducted. It included, as one would expect, members of the public, doctors, other healthcare professionals, representatives of all faith groups, judges, public servants, Members of this House and Members of the House of Lords. In the course of that exercise, I personally met many who were most concerned about the guidelines.

There was overwhelming support for the interim guidelines that I had published and the two principles that underpinned them: compassionate assistance to those who are clear they want to end their lives, yes; pressurising the vulnerable, no. Accordingly, when I issued the final guidance that is still in force, I adopted the same two underpinning principles. They have now been used for five years. I personally oversaw about 80 cases, looking at the details in each of the files, and made decisions in 79 of those cases that no prosecution should be brought, and there was no clamour to change the guidelines.

Throughout the process, I thought long and hard about the position of doctors and health professionals, and whether their acts of assistance should come within the guidelines, in favour of prosecution or against. I took the view then, and I still hold the view now, that if the DPP indicated that doctors or medical professionals were unlikely to be prosecuted for assisting, that would undermine the intention of Parliament when it passed the Suicide Act 1961. I took the view that Parliament was not prepared to go that far when it passed that Act, and that the DPP should not, by the back door, as it were, indicate in the guidance that doctors and health professionals would be unlikely to be prosecuted if they assisted. Therefore, in the guidelines, when they were first drafted and as they are now, a factor making it more likely that someone will be prosecuted is that they are a doctor or a health professional assisting someone.

That particular issue came to a head in the Tony Nicklinson case, which went to the Supreme Court recently. Tony Nicklinson, as many people in this House will know, suffered a series of strokes and became completely paralysed save that he could move his head and eyes. Because of his paralysed state, he could not carry out his wish to end his life without assistance. He applied to the High Court for an order—a declaration—that he be permitted a doctor to assist him in his death. When he lost his case in the High Court at the first stage, Mr Nicklinson embarked on the difficult and painful course of self-starvation, refusing nutrition, fluids and medical treatment. His case proceeded to the Supreme Court, as everybody here knows, and in June 2012 the majority held that there was an incompatibility between our current position and fundamental human rights, but because of the margin of appreciation they should not themselves make a declara-

tion to that effect but leave it to Parliament to further consider the issue, and today is that opportunity.

Nadine Dorries

rose—

James Berry (Kingston and Surbiton) (Con)

rose—

Keir Starmer:

I do just want to complete this exercise—

Several hon. Members

rose—

Madam Deputy Speaker (Mrs Eleanor Laing):

Order. The hon. and learned Gentleman is not giving way.

Keir Starmer:

I hope that I have been faithful to my obligation to try to put this in a neutral, objective way, setting out the position.

As Director of Public Prosecutions I never expressed a view on the law; I faithfully applied the law. I have come to the position I now hold on the basis of my experience of the guidelines. It was not a pre-conceived view that I held back then, in answer to a comment that was made earlier; it is a view that I have arrived at on the basis of my experience.

My experience is that there are two inherent limitations in the guidelines that I issued. For the reasons I have explained, my understanding of the constitutional role of the DPP was that doctors and medical practitioners are more likely to be prosecuted. The first limitation is that, as a result, those who have reached a voluntary, clear, settled and informed decision to end their lives can now be confident of the compassionate assistance of loved ones without exposing them to the law, but they cannot have the assistance of professionals. They can have amateur assistance from nearest and dearest, but they cannot have professional help in fulfilling their desire unless they have the means and the physical ability to get to Dignitas. One of the points that Debbie Purdy made to the judicial committee was that she wanted to live her life for as long as possible, although she wanted to end it at her own choosing, and that if she was forced to go to Dignitas she would have to end her life earlier because she would lose the physical means of getting there.

I understand those who say that we should revert to a position where nobody should be given any assistance at all, but we have arrived at a position where compassionate, amateur assistance from nearest and dearest is accepted but professional medical assistance is not, unless someone has the means and physical

assistance to get to Dignitas. That to my mind is an injustice that we have trapped within our current arrangement.

On the second limitation in my guidelines, the only safeguard I could put into them was a requirement for an after-the-event investigation by the police into what had happened. Let me quote what the president of the Supreme Court said when he analysed that. This is what our most senior judge—not me—said:

"A system whereby a judge or other independent assessor is satisfied in advance that someone has a voluntary, clear, settled and informed wish to die and for his or her suicide then to be organised in an open and professional way would…provide greater and more satisfactory protection for the vulnerable, than a system which involves a lawyer from the DPP's office inquiring, after the event, whether the person who had killed himself or herself had such a wish".

I have heard the comments about the safeguards in the Bill and I know how hard it was to come up with the right safeguards in my guidelines. It took me time to arrive at safeguards that I think could be generally accepted.

Mr Nigel Evans (Ribble Valley) (Con):

On a point of order, Madam Deputy Speaker. At the beginning of this sitting, we were told that 85 Members had put in to speak and we were given guidance on how long our speeches should be. I fully appreciate that the current speaker is making a valuable contribution, but please could you remind the House yet again of the time limit you think people should adhere to without a compulsory time limit having to be set? [Interruption.]

Madam Deputy Speaker (Mrs Eleanor Laing):

Order. I am grateful for the advice of my hon. Friend. I would not have taken advice from any other Member of this House, as I am quite capable of judging how long a Member is taking. My hon. Friend is in the unique position of being able to offer me advice and I am taking it. The hon. and learned Member for Holborn and St Pancras (Keir Starmer), who currently has the floor—

John Pugh

rose—

Madam Deputy Speaker:

Order. The hon. and learned Gentleman is in a unique position of being able to give information to this House on this extremely difficult issue. I have therefore allowed considerable leeway for him and I am sure the House will agree with that. At the same time, I am also sure that he will soon conclude his remarks.

John Pugh:

Further to that point of order, Madam Deputy Speaker. The cases the hon. and learned Gentleman is talking about at length are not covered by this Bill. They are not terminally ill cases.

Madam Deputy Speaker:

Order. That is not a point of order. We are not wasting time this morning on points of order. There are many people who wish to speak.

Keir Starmer:

Thank you, Madam Deputy Speaker. I will finish as quickly as I can. I understand the frustration of Members who are waiting to speak.

It took me a great deal of time and thought to arrive at appropriate safeguards in the guidelines. In my view the same amount of time and appropriate thought is necessary for the guidelines in the Bill. They have been discussed by others, so I will not repeat them, but what I will say is that I will be open to debate with anyone whether the safeguards are strong and robust enough, and I will work at Committee stage with anyone in this House to make sure not only that they are as strong and robust as possible, but that they have the best consensus possible among the different views held in this House.

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11.4 am

Nadine Dorries (Mid Bedfordshire) (Con):

It is a privilege to follow the hon. and learned Member for Holborn and St Pancras (Keir Starmer). I would have liked to have intervened on his speech, because cases such as those of Nicklinson and Purdy, which he highlighted, are not covered by this Bill. Locked-in syndrome, in which the person is paralysed except for movement of the head and the eyes, has no six-month limit. This Bill applies to people who are terminally ill and will die anyway within a six-month period. Neither of the cases that the hon. and learned Gentleman highlighted falls into that category.

I met a neurologist earlier this week who told me of a skiing accident he had had. He said, "Of course, the one thing all we neurologists fear is locked-in syndrome," and that was what he feared from his head injury. I told him, "But this Bill wouldn't apply to you." I asked him for how long people with locked-in syndrome can live. He replied, "30 or 40 years—that's why we fear it." What doctor can tell someone with locked-in syndrome, "You have six months"? They cannot.

One of the issues with the Bill that has really bothered me is the conflation of those illnesses, conditions and diseases it can cover and those it cannot. I have heard locked-in syndrome mentioned many times. Motor neurone disease is another illness on which a six-month time limit cannot be put. We always quote Stephen Hawking, who is an ambassador and is still alive many years later. Who would have put six months on his life at any time? People keep mentioning illnesses such as motor neurone disease and locked-in syndrome, but this Bill does not apply to them. We must not conflate them and what the Bill covers.

Robert Flello (Stoke-on-Trent South) (Lab)

rose—

Simon Hoare

rose—

Nadine Dorries:

I am not going to take any interventions, because so many people are waiting to speak.

In the 1980s, as a nurse, I had the privilege or the honour—I do not know the right word to use—to hold the hand of a young gay man when he was given a diagnosis of AIDS. It was not HIV, but AIDS—he was in a very bad way. He was given not six months, but 12 weeks. He is still alive today, as are so many of the other young men and women who were diagnosed at that time with HIV and AIDS and given fewer than six months to live.

Medical research ran ahead and found treatments for them to hold on to their lives for longer while even better treatments were developed. That race is still in progress: treatments are still being developed. We have now reached the point where somebody diagnosed with AIDS is far more likely to die of something else, but we would never have thought that in the 1980s. Many people present are probably thinking, "But this isn't the 1980s," but we did not know that AIDS was going to arrive in the 1980s and we do not know what is down the road, what new viral disease will land—it will probably be a virus, given the information we have—and what the AIDS of tomorrow will be. Six-month prognoses worry me, because no doctor can predict a life expectancy of six months.

I will use a personal case. Last August one of my closest friends visited her consultant after a series of tests had been ordered by her GP. At that meeting with

the consultant, she was given 14 days to live. That was an accurate prognosis—it was accurate because it was 14 days. She went home, we got into bed and I spent 14 days on her bed. Her death was painless and peaceful; it was not for everybody around her, but it was for her, and those last 14 days were wonderful, until the very end when she was fast asleep and unaware. That is the beauty of palliative care today: no one needs to die a painful death. The combination of drugs that are administered to people in their final days ensure that they do not suffer pain.

The poison administered when someone makes the choice to take their own life, however, is not pleasant. They do not swallow a concoction of drugs and fall asleep. It is not a nice end. It is certainly not peaceful. They choke. It is not a good death. To people who argue that it is a good death, I say that it is not: it is painful and barbaric to die in that way.

I listened to the head of the hospice movement on Radio 4 this morning and I know of the fears and have read all the emails from people representing the hospice movement in my constituency. The hospice movement has very rightly highlighted that the pressure on people in hospices will shift over a period of time.

I want to make a final point. There are people all over the country who do not have a family member or relative as their next of kin. They do not have loved ones. For them, the next of kin is the state. It sends a shiver of fear down my spine to think that such a Bill might be legislated for and approved when so many people who are protected by the law may not have such protection in future because their next of kin is the state. When they feel that they are a burden or they feel under pressure, who will coerce them and who will feel the budgetary constraints involved in looking after them? I will end with that concern.

11.10 am

Jim Shannon (Strangford) (DUP):

It is an honour to speak in this important debate. This debate affects each and every one of us, and will set a precedent for many future aspects of society across the whole United Kingdom of Great Britain and Northern Ireland. The most important aspect is to remain compassionate, as we are built with the desire to live.

I am proud to say as a Christian that my fundamental belief is in the intrinsic value of every human life, and I just cannot see any tangible evidence to support assisted suicide. I still find myself very much in line with the majority of Christians in so thinking. That is my personal belief, but it is only one of the reasons why I do not and cannot support the Bill on Second Reading. However, I understand and respect the fact that not everyone will share this belief because of their own faith.

One of my greatest issues is with the slippery slope that the proposed legislation will undoubtedly create. I have been contacted by many doctors in my constituency who share the fear that people will feel pressurised into ending their life early so as not to be a financial or care burden on their loved ones. Indeed, one local doctor informed me that, during his time practising, he often encountered this problem, particularly with older patients or those requiring specific treatments and care. There should never be a reason for ending a life, and that is precisely why many of the doctors and nurses who contacted me are against such a practice.

Chris Moore, a former editor of the Telegraph, has noted that assisted suicide does not just affect the person who dies, but creates problems "for the wider society" and

"undermines the motive that sustains all medicine."

He does not think that it will do anything to safeguard the most vulnerable people in society, especially the elderly and the disabled.

What would assisted dying do to the NHS? All of us in the Chamber are responsible for the running of the NHS—whether or not it is a devolved matter in Scotland, Northern Ireland or Wales—and that is something we must consider. What type of pressure would assisted dying put on our NHS doctors and nurses, given that one person's need always has to be weighed against that of another in apportioning expenditure? I am extremely concerned that assisted dying might be suggested to families and patients to ensure a smooth and efficient running of the service. The NHS is already under enormous pressure, and patients with a poor prognosis are in great need of NHS facilities and assistance for a long period, if not for the rest of their lives. That is another example of when assisted dying is not right and not fair. I believe that we must safeguard such people.

On a further medical point, I want to quote the columnist Melanie Phillips. [Interruption.] I am glad that hon. Members are appreciating this. She has warned:

"If assisted suicide is permitted for the terminally ill, it will inevitably be argued, why not for those with chronic or progressive conditions? And if for them, why not for disabled people? This slide is already on display in Britain… The slide into the moral quicksands is inevitable once you cross it".

We have to be careful about what this legislation might lead to in future.

My concern is that a society that allows voluntary euthanasia will gradually change its attitude toward allowing non-voluntary and then involuntary euthanasia. If we ask doctors to abandon their obligation to preserve human life, the very basis on which medicine is practised, we could damage the doctor-patient relationship. The British Medical Association has noted that

"the principal purpose of medicine is to improve patients' quality of life, not to foreshorten it."

Patients need to know that doctors have their best interests at heart, and that everything that it is physically possible to do will be done for them in their time of need.

Sir Peter Bottomley:

I pay tribute to the hospice movement in Northern Ireland. A study in the Journal of Medical Ethics has shown that 25% of patients in one of the few hospices in the Netherlands wanted euthanasia, but less than 2% actually went through with it. Most people can be looked after very well with palliative care.

Jim Shannon:

I thank the hon. Gentleman for his very wise comments.

A poll conducted by Christian Action Research and Education in Scotland has showed that when people are presented with both sides of the argument, support for assisted dying falls dramatically from 73% to 45%. Ending a life is not something that we would ever want our children or anybody else to consider.

Moreover, medical predictions are not always accurate. I want to cite just one example. Everyone in the Chamber knows many such examples, and we could cite large numbers of them. I have a friend who has just lost the battle with cancer after 13 years. When she was diagnosed, she was told that she had six to nine months to live, but she defied all the odds. At the time, her son was 11 years old, but she saw him pass exams, learn to drive, graduate and settle down. She saw him grow from a small boy into a bright young man, and she loved life right until the very end. I wanted to tell that story because it is not unheard of, given the pioneering research that is continually being carried out, that cures to many illnesses and diseases will be found, as I have no doubt they will.

That brings me to another concern, which is the suffering that families will go through when a cure is discovered after their father, mother, son or daughter has chosen to end their life. Advances in medication and health care are taking place. For example, 50% of those with cancer will survive. We are making vast strides towards curing diseases that were once thought to be incurable.

The vast majority of UK doctors are opposed to legalising assisted suicide or assisted dying, as are the British Medical Association, the Royal College of Physicians, the Royal College of General Practitioners, the Association for Palliative Medicine, the British Geriatrics Society, Disability Rights UK, Scope, the United Kingdom Disabled People's Council and Not Dead Yet UK.

Let us not ignore the advances in palliative and mental healthcare. Let us not support this Bill; let us vote against this Bill today. I believe we have to do so for our people.

11.16 am

Dr Liam Fox (North Somerset) (Con):

I completely understand the motives of those who have introduced the Bill. Anyone who has watched a loved one die in terrible suffering will entirely under-

stand why they have introduced their proposals, and no one should impugn their motives. I have to say, however, that it is all too easy to open a Pandora's box, with utterly unintended consequences that may be very different from the primary intentions of those promoting the Bill.

I want to make a few comments based on my experience as a doctor. Doctors can come under enormous pressure from relatives and from their own emotions to hasten the death of a patient whom they believe to be suffering too much. I worked in Glasgow Royal Infirmary during the early days of the marrow transplant programme. We had to give patients huge doses of sometimes very crude treatments, and when I was sitting with a young patient, there was very often a strong temptation to end their suffering. Some of them went on to survive, which is a lesson to doctors not to make judgments too hastily. I believe that anything that increases such pressures on doctors opens up an ethical trap that we do not want.

We already have laws relating to the concept of double effect. If a patient is suffering, we can give them medication whose primary aim is to alleviate their suffering, even though its effect will be to shorten their life. That is very different ethically and morally from giving a patient something that is primarily designed to kill them.

We need to understand that assisted dying can have an effect on the medical profession. Studies from the Netherlands and the United States on doctors who have performed or assisted at assisted suicides have shown that the medical professionals concerned had

"high levels of emotional discomfort, distress and feelings of overwhelming burden".

There is also a fundamental change in the doctors' relationship with patients. The No. 1 rule is "Do no harm". If a patient arrives unconscious or in a coma, their family needs to know—as the patient themselves would want to know—that the doctor will do them no harm and will not come under any pressure to do so for one reason or another. I fully understand that the Bill does not cover that, but it does fundamentally change the relationship between doctors and patients, and that change cannot be undone once it has been made. We are talking about overturning 2,000 years of the Hippocratic oath.

The hon. Member for West Ham (Lyn Brown) made an absolutely wonderful and emotionally charged speech. It set out very clearly the risks for another group of patients that doctors deal with—the vulnerable. In his moving article at the weekend, the Archbishop of Canterbury spoke about the Age UK research and stated:

"It is impossible to ensure that they and other vulnerable people would not be placed under pressure to end their lives prematurely in ways that proposed safeguards cannot hope to detect."

It was noted earlier that people feeling that they are a burden when making a decision to end their lives prematurely is only one factor, but that is one reason too many. The answer is not to make it easier to kill people; we need societal change to prevent people from feeling a burden in their elderly years.

Finally—I am aware of the time—there has been an argument about whether the Bill would make it easier for euthanasia to be introduced in this country. Doctors in the Netherlands who have experience of assisted suicide recognise that failures will occur from time to time. Those failures make up around 7% to 16% of cases, and include failure to induce coma, or patients who come out of coma before the process is finished. The Royal Dutch Medical Association recommends that a doctor be present when assisted suicide is performed in the manner proposed in this Bill, precisely so that euthanasia can be performed, if necessary, if the process fails. In practice it is impossible to differentiate between assisted dying and euthanasia. If we have one, because of the failures of process we will inevitably get the other. I do not believe that that is an improvement to our society. However well-meaning the proponents of this Bill may be, they will open a Pandora's box that will fundamentally change who we are, how we are as a society, and how we relate to the medical profession. I believe that none of that will be to the benefit of future generations.

11.21 am

Sarah Champion (Rotherham) (Lab):

I know death. I understand death because before coming here I used to run a hospice, and I firmly believe that everybody deserves a good death. That is possible, and the bigger debate that we need to have and bring back to this Chamber is about ensuring that everybody in this country has access to 24/7 palliative care and more hospices that are better funded. In reality, most people do not have a good death.

I am very supportive of this Bill, and I am also mindful that it will apply only to a very small percentage of the population. That is not just because of how specific the safeguards are, but it is from looking at 18 years of experience and data from Oregon. In Oregon, 0.3% of deaths per year are under the assisted dying legislation. The most recent data are from 2013 when 22 per 10,000 deaths were under that legislation—0.22%. In 18 years in Oregon, 1,173 prescriptions were written, and only 752 were actually enacted. This Bill will enable people to have peace of mind. We do not know—we do it only once—what our death will be like, but I would like to give people the peace of mind that if the situation becomes intolerable, they can make an informed choice about their own life.

There seem to be five main counter-arguments to the Bill. The first is about someone being given a six-month terminal diagnosis when perhaps they will live for nine or 12 months. Perhaps they will recover—that is fantastic; I want to celebrate that—but some people die after two days. The Bill is not about march-

ing someone to a darkened room the second the paperwork is signed; it gives them the choice so that if during the deterioration of their condition towards death they choose to end their life earlier, that is their choice and they have that right.

Another argument is about disabled people. I find that quite insulting because disabled people are living full, wonderful, happy lives. Why do people want to include them in the Bill as though their lives are not fulfilled? Of course, once someone reaches a terminal position, if they want to enact the legislation that is their choice, as it is for everybody else.

On coercion, I do not doubt that perhaps there are evil relatives out there who will seek to coerce their elderly mother. However, that elderly mother will then have to persuade two doctors and a judge that this is her choice. I do not think that someone who is vulnerable enough to be coerced by their evil relatives could persuade a judge that they are taking such action from their own choice.

We then come to the argument about the thin end of the wedge. I am sorry, but we legislate for a living here. We know that if anything was to happen, the issue would have to come back to the Chamber and we would have to agree it. I do not accept at all the argument that this is the thin end of the wedge.

There is the argument that it is God's will that we should suffer, if necessary, and that it is God's choice how we end our lives. I have 100% respect for that view. If that is someone's position and choice, this Bill is not for them and I do not expect them to seek to make use of its provisions. I feel, however, that I should be able to make a different choice and that others should not be able to stop me.

I feel strongly that this Chamber does not have moral superiority over those who we serve and have elected us. Eighty per cent. of the population are in favour of this Bill.

Fiona Bruce:

Will the hon. Lady give way?

Sarah Champion:

I will not. I find it patronising that we think that our opinion should carry more weight than that of the general population we serve.

Finally, I say to hon. Members: let us make this personal; let us make this about you. If you are suffering, if you have a terminal diagnosis and cannot cope with the pain or situation any longer, would you want this legislation to be in place? I certainly would.

11.26 am

Steve Brine (Winchester) (Con):

In my five years in this House I have found that a great deal of what we do here tests our nerves as well as our politics and faith. Some days test them far more

than that, and today is one of those days. Legislating in this place is, of course, about the principle and the big picture, and that is what Second Reading is all about. We must also ask ourselves whether the practicalities of the Bill match the principle.

I mentioned faith, and it is no secret that I am a Christian. That is not something that is said often in this House, and I was not elected as a Christian Conservative in May. That is part of who I am and it guides me in what I am saying today, but it is not the whole story. Indeed, at least in part, I surprise myself with how I intend to vote today, which is against Second Reading. I say that because I am hugely sympathetic to many of the arguments that have been put forward, not least by the Bill's promoter who I thought spoke with dignity. I have received a huge mailbag on this issue, as have many Members, and it has been a pleasure to receive genuine letters and emails from constituents, instead of click-send robotic emails.

I understand that there is not insignificant support in the medical community for this Bill, and that there is nothing compassionate about someone having to travel far from their loved ones at great cost in order to die, if that is the awful conclusion they have reached. I am aware of the published opinion polls among the public, but I use the word "published" deliberately because as Winston Churchill said:

"There is no such thing as public opinion. There is only published opinion."

There was just one opinion poll, and as we know from this year, opinion polls are not entirely always accurate.

Andrew Bridgen:

Will my hon. Friend give way?

Steve Brine:

I will not because it is only fair that I crack on and give everyone a chance to speak.

Ahead of today, I read widely and I have thought about this issue deeply for a long time. I have met constituents who urged me to vote in support of the Bill, and those on the other side of the argument. Those supporting the Bill include members of Dignity in Dying in my constituency whom I met before the recess, and I could feel their sense of optimism and hope that many years of campaigning were finally coming to an end and that this is the moment that they had hoped and campaigned for—it certainly would not be the last moment during this Parliament.

If I was going to vote in support of the Bill, I would have to be 100% sure that it replaced the law we have with something better, and I genuinely do not think that that is the case. I spoke in the Back-Bench debate in March 2012 to express support for the then DPP's guidance on applying the Suicide Act 1961, and I

still think—I listened to every word from the hon. and learned Member for Holborn and St Pancras (Keir Starmer)—that that strikes the right balance. The public interest factors that he set out tending in favour and against prosecution were widely consulted on, as he said, and it was a successful consultation that received strong support from this House on that day. In my opinion—and having the opportunity to express it is why we are elected as Members of Parliament—those public interest factors remain fit for purpose.

The question for me is this: should we allow a small number of high-profile cases, no matter how tragic—of course, any human being with any element of faith and compassion understands that they are tragic—to pressurise us into changing a law that I believe is working as intended?

Given that that is my view, how can we improve the current law? Does the Bill and its 13 clauses show a better way? I do not believe it does. There has been much talk of Oregon today and there will be much more. We are told by the campaign group, Dignity in Dying, that medical opinion is divided. It says to me that some 57% of doctors feel that assisted dying legislation, with up-front safeguards, would be the best way to protect terminally ill patients who want to die. But that presumably means 43% do not, if we take those figures at face value.

If a terminally ill person decides to make a declaration for an assisted death using a schedule to the Bill, they would reasonably expect to ask their doctor to be one of the two signatories they require. If the said doctor is one of the 43%, what then? Clause 5 rightly contains provision for conscientious objection, so will we see in this country what we see in other jurisdictions, which is known as "doctor shopping"?

We then have the new safeguard in the Bill, namely the High Court judge confirmation. I agree with my hon. Friend the Member for Congleton (Fiona Bruce) about this issue being so serious. How would it work in practice? The Bill sets out a timescale for court decisions that would make robust scrutiny almost impossible. What would the judicial signatory require? Would there be a hearing with evidence presented, or would it just act as a rubber stamp? On those two points, the practicalities of the Bill do not convince me.

Let me return, in closing, to the principle of changing the law to legalise assisted suicide. Many of those who have written to me ahead of today's debate warn that the Bill will create a slippery slope. I do not necessarily buy that argument. As the Bill's promoter said, any amendments to the Bill would have to come back to the House and undergo parliamentary scrutiny, but come back they surely would. I note in Oregon earlier this year that there was a move to change the six months to a year. The Bill proposes six months, but I can see that being moved. Of course, all this runs up against the evidence I have heard from palliative care consultants in my constituency that, as many other Members have outlined, six months is a long, long time to determine a death.

It seems to me that we live in a world today obsessed by choice and consumerism. We want to have a career and the perfect family life. We want to shop every hour of the week. I find myself agreeing with the Bishop of Bristol, who said last month how the supporters of the Bill present it, in part, as a simple matter of individual choice with

"choice being the great God of a consumerised society."

I think he hits the nail on the head. I believe that choice creates the burden; it does not set you free. We must significantly up our game in respect of how we provide end-of-life care, rather than handing out the right in law to take a life away.

11.33 am

Norman Lamb (North Norfolk) (LD):

I thank the hon. Member for Wolverhampton South West (Rob Marris) for giving us the opportunity to debate this most profound of issues, one that concerns so many people across our country, whichever side of the debate they may be on. I also thank the right hon. Members for Meriden (Mrs Spelman) and for North Somerset (Dr Fox) for expressing the importance of us demonstrating mutual respect in this debate, and for acknowledging the profound importance of this for people on both sides. We should be able to debate it in a decent way that fully respects that.

I have changed my mind on this issue. I used to oppose change, but I am now very clear in my mind that reform is necessary. We are all shaped by the conversations we have and by our own personal experiences, sometimes within our own families. Talking to people who are terminally ill has forced me to think about the principles at stake and led me to change my mind. I came to this view through one man in particular, Douglas Harding, who, for six years, has lived with terminal cancer, and is now very close to the end. When I hear him argue the case to me about his right to decide when to end his life as he faces the closing stages of a terminal illness, I find it impossible to reject that right. When I ask myself what I would want in those circumstances—whether I would want that right—I am very clear in my mind that I would. I do not know whether I would exercise it, but I would absolutely want it for myself. How can I then deny it to others?

I speak as a former Care Minister and I was driven in that job by an absolute determination to improve end-of-life care and to ensure people are treated with absolute dignity in the final stages of their life. One of the issues I had to deal with was the Liverpool Care Pathway and the abuses that sometimes took place under that name. I had many conversations with the hon. Member for Congleton (Fiona Bruce) and we found ourselves on the same side of the argument. We both had deep concerns about some of the things that had happened under the Liverpool Care Pathway and, as a result of the review that I called, the Liverpool Care

Pathway is no longer used. The approach taken is that it is the individual's own priorities that are paramount. Are we really saying that that principle, which applies to issues such as resuscitation where one wants to die, suddenly does not apply when we get to the most profound of questions? At that point, the individual has no right and is left at the mercy of the state's decision. As the hon. Member for Reigate (Crispin Blunt) said, this is a matter of personal freedom. For me, that is very clear.

Barry Gardiner (Brent North) (Lab):

Will the right hon. Gentleman give way?

Norman Lamb:

I would prefer to make my case, because I want to ensure that others can make their case, too.

Questions have been raised about whether implementing this proposed legislation would have a negative impact on palliative care. For goodness' sake, it is up to this House and the Governments we elect to ensure that there is decent palliative care in our country. It is up to us to make that decision. It is a dishonest argument to suggest that it would undermine palliative care. In the United States, Oregon is one of the best States for access to specialist palliative care. It is totally consistent with the principle I expressed earlier that in those last stages of life it is the individual's priorities and wishes that should be paramount.

I just want to say a word about the current law, which puts families in the most invidious position. I applaud the former Director of Public Prosecutions for the guidelines that advanced the position very considerably. However, if someone acts out of absolute compassion, they are still left with their home being declared a crime scene and with a police investigation. As the guidelines point out, the person is referred to as a "suspect". Someone who has acted out of compassion for a loved one is treated as a suspect, waiting perhaps months to know their fate—whether they will be prosecuted—while they are experiencing bereavement. That is surely an intolerable position. We then have the grotesque situation where those people who have money are able to go to Dignitas, an alien clinic in another country. Someone who is dying is expected to travel to another country to exercise their right. Those who do not have money are left with the invidious choice of struggling on regardless, perhaps in the face of impossible pain, or committing suicide in very difficult circumstances. I find that absolutely intolerable.

J.S. Mill said:

"The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."

We should respect that sovereignty and pass the Bill.

11.39 am

Nick Herbert (Arundel and South Downs) (Con):

In 1933, just hours before the death of King George V, Lord Dawson, the king's doctor, issued his famous bulletin from Buckingham Palace. He said that the king's life was drawing peacefully to a close. Dawson had good cause to know that, because he had just administered a lethal dose of morphine and cocaine to the king, in an action that remains controversial to this day. He undoubtedly brought the king's life to a speedier close, yet, despite that act, just a short time afterwards, Dawson spoke against a Bill introduced to enable euthanasia, drawing the clear distinction between efforts that doctors may make right at the end of somebody's life to ensure they have what has been described by some hon. Members as a good death and to ease suffering, and actions intended to bring someone's life to an end, even though at their behest, that amount not to assisted dying, as someone has said, but to assisted suicide. That is surely an important distinction.

Some hon. Members, including the right hon. Member for North Norfolk (Norman Lamb), have couched their defence of the Bill in the right to choose. My hon. Friend the Member for Reigate (Crispin Blunt) also talked about the right to choose. Others have talked about the right to die. The language of rights is one we should be careful about using in this space. If there is a right to die, why is it constrained by a six-month time period? If there is a right to die, why is it constrained simply by the fact of having a terminal illness? We accept in this country that people have the right to commit suicide, in the sense that it is no longer a criminal offence, but the law has always been clear that should somebody assist that, particularly a medical professional, a line has been crossed.

We have focused a lot on the unintended consequences of the Bill, which are indeed highly problematic. Hon. Members on all sides are concerned about the possibility of coercion. We already know there is concern about how elderly people can be treated, and there is a clear danger that vulnerable people might be drawn into having the Bill applied to them. That concerns everybody. However, I want to raise the question about the intended consequences of the Bill. Is it the wish of the House that there be more assisted suicides or fewer? Do we think that assisted suicide, or suicide itself, is ever a good thing? Several distressing cases have been adduced. It is undoubtedly true that people might suffer and that, as the hon. and learned Member for Holborn and St Pancras (Keir Starmer) said, some people might therefore be forced to go to another clinic—a very few people, as a matter of fact. It cannot be a sufficient justification for changing the law, however, simply to say that people are suffering. The House cannot expect to legislate away all suffering. We have to be absolutely sure that no more harm will be created by the legislation we pass. If we enable more people to take their

own lives—something that society and the law has judged should be a bad thing—will we have done a good thing? Is that a good outcome for the Bill? In seeking to alleviate suffering—a noble ambition—we will potentially enable more lives to be taken, and that surely cannot be a good thing.

I have the gravest concerns about the Bill. I am concerned not just that people might be coerced into taking their own lives, with someone else's assistance, but that any more lives will be lost at all. The law has always regarded it as wrong to assist in someone's suicide because, in the end, we think that suicide is wrong, even if we think that it should not be a criminal offence. That is why we should take the very greatest care before taking this fundamentally different step.

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11.45 am

Paul Flynn (Newport West) (Lab):

"I will make sure your loved one does not suffer." I think that many of us have had that assurance from doctors, and what they usually mean is that they are going to operate the principle of double effect commended by two Government Members. It means they will give the patient a lethal dose, usually of morphine, that will kill them, but they play a mind game of self-deception, pretending that the lethal dose is to relieve pain. It is not; it is too kill the patient. It was practised on a king some time ago, and it is widely practised and defended throughout the world, including in many Catholic countries. I would suggest that that is far more dangerous than the Bill. People are being killed without their permission and without rules or regulation.

Mrs Anne Main (St Albans) (Con):

I sat next to my husband as he was dying of cancer and in extreme pain. Yes, he was given a large does of morphine—because it was impossible to control his pain without it. I absolutely object to the hon. Gentleman's assertion that every time a doctor helps a patient with extreme pain, they are in fact just shuffling them off a bit quicker. I think he needs to moderate his remarks.

Paul Flynn:

I will do nothing of the sort. I think it is an act of deception by doctors and the church. They are allowing one doctor to make the decision and administer the lethal dose without any of the protections in the Bill. I have been to Oregon and discussed their law with them, and I believe we should follow their experience

carefully. All the fears expressed in the House were expressed in Oregon in 1994. They had a referendum. We could follow their example and ask the public by attaching another question to the EU referendum question. In Oregon, the result was 51% to 49% in favour, but after experience of the Act—[Interruption.]

Madam Deputy Speaker (Mrs Eleanor Laing):

Order. The hon. Gentleman is entitled to be heard.

Paul Flynn:

After experience of the Act, it went from that narrow majority to an overwhelming majority, and so it has remained since 1997.

We need to listen to our constituents. I want to read a letter sent to me by a constituent who asked me to read it to the House. I am going to find it difficult to read, but it is an example of the result of our lack of boldness in bringing in a Bill such as the one in Oregon. This gentleman writes:

"I have had to watch my dear wife, very old, very much in pain, very weak and desperately wanting peace, but she continued to suffer because I couldn't do the one thing she really wanted. I was helpless to assist her to die. Her words were, 'I don't want to leave you my love, but I'm very tired and I want to go now. I know you understand. Please help me to die.' Every day of her life she said prayers for other people, but when she pleaded, 'Please God, take me now'; for once in that long life, she prayed for herself, but there was no one to answer.

Such a simple humanitarian act is just not permitted, so I watched my dear wife starve herself to death for three weeks—the only way she could help herself to die. I watched a lovely lady struggle without food until she grew so weak that she was unable to lift her arms, to even squeeze my fingers. She had strangers to change her, but she grew to the state where the shame and the humiliation were no longer an embarrassment. But she remembered the humiliation of those last weeks.

I held her close in the days when I could no longer understand her mumbled words. I could only reply, hoping she would hear when I said, 'I love you darling. I understand.' I hope she knew that I was there with her. I held her when her eyes no longer opened, when she could no longer see. I knew she could hear my words when a tear dropped from the corner of her eye. I held her until she had no touch, no sight, possibly no hearing, but I still said, 'I know darling, I love you. I understand.' I watched her beautiful face become a skeleton. I held her when this poor love finally died. I hope she knew that I was there, but I doubt it. And now for the rest of my life, I will remember the poor wracked body and the once so beautiful face, which became a hollow mask."

11.50 am

Sir Edward Leigh (Gainsborough) (Con):

The hon. Member for Newport West (Paul Flynn) has read us a very moving letter, and I think the whole tone of the debate does the House credit. This is an extraordinarily difficult issue, and we are all going to face this awful journey—I use "awful" in the old-fashioned sense of the word. We are frightened of dying, although perhaps for religious people it is not so much of death but of dying, and we have to respect each other's opinions.

When my good friend Father Philip Bailey of Holy Rood Catholic church was dying—he had kidney failure—he was sent to Scunthorpe hospital, which offered him very painful and very intrusive treatment to try to enable him to live a few weeks or days longer. He, a Catholic priest, chose not to take it. I was with my best friend Piers Merchant, a former Member, when he was dying of cancer. His body was filled with morphine, which probably killed him in the end. It was not designed to kill him, however, but to relieve his suffering. My friend Father Philip Bailey took that choice as well.

My view is that we do not need an assisted suicide or an assisted dying Bill; we need a movement for natural dying. We have to come to terms with death as a society and recognise that it is a journey we are all going to take. We have to promote the hospice movement and palliative care, put much more resources into them and be honest with people that increasingly intrusive, difficult, painful operations and medications may not be the way. In that sense, I think we can resolve this issue and emerge with credit from what I regard as a moral maze.

I have one important issue to mention. I suppose people would expect me to do so, but it really has to be underlined. As we embark on the Bill and reflect on what it will mean if it becomes an Act, many of us feel that history will repeat itself. For all the controls that we are told will be there—I am not sure that the High Court's consideration on paper for a couple of weeks or a couple of doctors in a dying clinic signing for it are much of a control, particularly when most doctors are opposed to it—more and more people will take this route, and as they become ill this general question will increasingly be put to them, "Do you want to end your life now? It is the law; you have the right to do it." That contrasts with what happens now, where the whole emphasis is on trying to let people die naturally.

What sort of society do we want to create? Do we want to create one in which we solve our problems by killing? I admit that my religious belief informs my view, and people could ask what right I have to impose my religious beliefs—seen in opposition to abortion or capital punishment or to war or to assisted dying or death—on them. I would at least ask them this question: "What sort of society do we want to create when we feel that we can solve problems by hastening death rather than promoting life?" What sort of society are we creating if we say that we value people who are healthy, fit, beautiful and young more than

we value people who are poor, old, crippled, ill and dying? We feel that in those people there is an eternal soul waiting there—a beautiful soul that needs to be nurtured. Even if people do not share this religious belief, surely they can come to the conclusion—even as humanists with a humane point of view—that we must promote a society that respects the old, the ill and the dying and gives them every chance of life.

11.55 am

Helen Jones (Warrington North) (Lab):

You have asked us to be brief, Madam Deputy Speaker, and I shall try to do so out of courtesy to my colleagues.

I oppose this Bill on two grounds. The first is that it asks us to cross a line in our attitude to life, which I believe as a decent society we should not cross. At the moment, our law strives to protect life. We regard murder as one of the worst crimes; we seek to deter people from suicide; we do not execute criminals. But if we cross the line, deciding that some lives are less valuable than others, we shall be opening ourselves up to a process that I think we would deeply regret.

Those who have said that this would require more legislation are, I believe, quite wrong. Our law works on case law and precedent, and it would undoubtedly be the case that people would go to court for equal treatment, to put their own cases—and gradually and insidiously the law would be extended. People need to look at what has happened in other jurisdictions—not just in Oregon, but in the Netherlands where assisted suicides have gone up by 60% over five years and where the law has been extended to include in the definition of "unbearable suffering" not only physical but mental suffering. It covers dementia and psychiatric conditions. In Belgium, the law covers children who cannot give consent. That is my first reason for opposing the Bill.

My second reason is that I think the Bill is badly drafted. My hon. Friend the Member for Wolverhampton South West (Rob Marris) asks us to allow those with six months or less left to live the option of assisted suicide. As has been made clear by many doctors, however, it is impossible to predict the length of time that someone will live. He says that lawyers decide this on the balance of probabilities. In criminal cases, though, the decision has to be beyond all reasonable doubt. What he offers in this Bill is a lower standard of proof for those who require assisted suicide than we allow to those charged with a criminal offence.

The Bill provides that people must have a settled intention. I ask how long does it have to be "settled" for? People with serious illnesses often go through periods of depression. Palliative care specialists know that people often request to die, but when their fears are addressed and their process towards death is discussed with them, it often changes their minds. It also has to be voluntary, but there is no safeguard against the insidious pressures that can be put on people to want to

end their lives—fear of being a burden on their friends and family, for example. No two doctors can know what goes on beyond closed doors. We no longer have the family GPs who knew people and their families from birth. Doctors will simply not be able to tell. And the High Court having just 14 days is not sufficient to investigate the case properly.

Robert Flello:

My hon. Friend will be aware that in Oregon, which is the example most cited, almost a quarter of all cases are seen by just three doctors—and they do not know anything about them.

Helen Jones:

My hon. Friend is exactly right. Most of the lethal prescriptions in Oregon are written by a very small minority of participating doctors—something that we would want to investigate very closely if the same applied to prescribing in this country.

This Bill is not just about individual autonomy; it is asking us to take a decision that will have a profound effect on society.

Nick Thomas-Symonds (Torfaen) (Lab)

rose—

Helen Jones:

If my hon. Friend will forgive me, I want to wind up.

This Bill is not simply about those who have a terminal illness and are expected to die within six months, because it will inevitably be extended. It is a Bill that will in future lead to consequences for this society that in my view no civilised society should contemplate. For that reason I will vote against it.

12 noon

Dr Sarah Wollaston (Totnes) (Con):

So many of us bring deeply personal perspectives to this debate. We also bring the voices of our constituents, and I thank everyone who has written in telling of their experiences both for and against.

I would like to add a clinical perspective. There are two conflicting principles here. There is the fundamental principle that doctors should do no harm—and this House must think very carefully before we remove that cornerstone of ethical medical practice—but that comes up against another very important principle: the principle of self-determination about which so many Members have spoken very powerfully. If we are to apply that principle, however, I ask where it will take us. If we are to argue that Diane Pretty, for example, had the right at a time of her choosing to end her life because of intolerable suffering—a quick death, without pain, at home, surrounded by her family—why should we deny

that to somebody with mental capacity with locked-in syndrome such as Tony Nicklinson, or indeed a young man who has a high spinal injury?

Also, if we are to apply that principle further, what is intolerable suffering? Intolerable suffering is what is intolerable to us. We have seen that definition extend in Switzerland. Indeed, a British citizen—a retired nurse— took her life in Switzerland last year because she was afraid of getting old. We have seen the definition applied to people with depression, and in other countries to children. That starts to bleed into questions about capacity.

As a clinician, I have had the privilege to sit with many people at the end of their lives, and often people contemplate taking their life. People have asked me to help them do so. They do that because of fear or a deep depression, or sometimes a profound sense that they are a burden on their families. With time, I have seen many people come through that to find real meaning in their lives. We need to think very carefully before we take that away. Of course people say to me, "Who are you to say whether or not they should take that journey?"—or even whether they would come through that period, because some of course do not—but I say to the House that we have to consider the harms as well as the benefits.

We have to consider the impact on wider society, too. I believe it is inevitable that we would slide towards the Swiss position, and we must consider what message it would send to people if we say that it is all right in society to end one's life from fear of growing old. In Switzerland there is a high preponderance of people who live alone, who have been divorced, and who are women, and we have to think about why they have come to that position. What does it say if we have an attitudinal shift in our society, as I believe is inevitable, which changes the way we feel about the value of life? We have to consider not just the rights of the individual to self-determination, but the inevitable wider effects on society, and the pressure people will inevitably feel at the end of their life.

I hope that Members will look at the report on end-of-life care by the Health Committee, which I was privileged to Chair, and think again about how we can refocus on what the duties of a doctor should be. A doctor's duties should be to improve the quality at the end of life, not shorten it.

Let us look at how the House can work together to improve access to high-quality specialist palliative care, and how we can address variations in that access, and put the funding of our hospices on a long-term sustainable footing. I would like us to provide free social care at the end of life, so that more people can be at home surrounded by their loved ones in a place of their choosing if that is what they want.

I would also like us to bring forward discussions about dying, because there are many ways in which people can express their preferences at the end of life. Let us bring forward better care planning, bring forward those conversations, and

bring forward access to specialist care, but please let us also consider the wider consequences and vote against this Bill.

12.5 pm

Dr Philippa Whitford (Central Ayrshire) (SNP):

I do not think anyone doubts the views that have made all of us give up a Friday to be here; everyone is here because they are concerned about the suffering of others and we want to alleviate it. We just do not agree about how we should go about it.

I believe that this is not just a tidying up of a small legal anomaly. It is, rather, a crossing of a Rubicon, as was mentioned earlier. It is changing and legalising the killing of one person by another, regardless of the reasons why we would want to carry that out.

The Bill's weaknesses have been mentioned, such as the problem of finding general practitioners who would write a report. In actual fact, quite a lot would be willing to do that, but not so many would be willing to be involved in the act of assisted suicide. Where would the independent expert be found? Some 96% of palliative care specialists are utterly against this Bill. They object to the name of it; they consider what they do is assisted dying, and what this is is assisted suicide.

I do not want to talk about the small print, however. That will be explored over the day. My objection is basically in principle. Many Members will be aware of my interest; as a breast cancer surgeon for 30 years, I have been involved in the journey to death of many patients, but as a doctor I have never considered that death was a good treatment for anything, no matter what was wrong with anyone.

People would choose such an option for lots of reasons: the fear of being a burden, the fear of dying, and most of all the fear of suffering. The responsibility to deal with that lies with us. Who is making them feel that they are a burden—is it their family or their friends, or is it society? Who is letting them down in their palliative care? It is us. As the hon. Member for Totnes (Dr Wollaston) mentioned, the services are patchy in some areas. Not everyone has access to palliative care, but I started out in 1982 when women did not know when they went into theatre that they had breast cancer because we did not have the ability to diagnose it. I worked for an eminent professor in Glasgow, and we lived in the ward in those days, and I watched patients come back from theatre having had the lump removed. If it was cancer their breast was removed, and that was it—no choice. They found out they had cancer by groping themselves on the trolley, because if they had a lot of bandages and a drip, that meant they had lost their breast and they had cancer.

Watching people die of cancer was awful at that time. They were cachectic, they were in pain, and we had very limited hospice and very little palliative care sup-

port in the hospital. But 30 years later that has changed. Whereas 40% of patients would live 10 years then, now 80% do so. Our patients know exactly what operation they are going in for. They have hours of discussion with us, and until a few years ago I would have been involved in their journey if that cancer came back, in their palliation and in their terminal care.

That journey can lead to a beautiful death. The event that had the biggest impact on me as a junior doctor was the death of a lady whom I had looked after for many months. When I came on to the ward that night, the nurses said, "I think Lizzie's going." She was curled up in her bed, obviously quite upset, and when I asked her what was wrong, she said she was frightened and she did not know what she had to do. I said, "You don't have to do anything. You just have to relax. You just have to let go." We had the family in. West of Scotland male is not good on emotion or openness, so I took her son in and I spoke to her again about what was happening to the point where he could tell her that he loved her and how much he was going to miss her. I went for my tea, and when I came back she was sitting up holding court with the whole lot of them. I thought, "Oh no, we've called it wrong", but she was gone in an hour, and it was beautiful. That made me commit to working with cancer patients. If I had not made it as a surgeon—which, as a woman at that time, I was told flatly that I would not—I would have gone into palliative care.

I have seen change in the journey for patients. We heard the hon. Member for Mid Bedfordshire (Nadine Dorries) describe the last two weeks of the life of her friend, and that is something that we see repeatedly—that the patient is ahead of the family. We are always utterly open with patients. We no longer have a situation in which a family member says, "Don't tell my mum. Tell me, but don't tell her." The patient will always know, because the fear is that when they see their death coming, they will know that everyone has lied to them and they will be on their own.

My job was not just to look after the patient; it was to look after the whole family. All these illnesses are diseases of the whole family, and we want the family to be left with the knowledge that they did everything they could and were able to express their love at the end of their loved one's life. Things have changed for cancer patients. I have not had a cancer patient ask me for a quick way out, an escape, for decades. We need to ensure that palliative care is offered to people with degenerative illnesses, of which we are all afraid.

When the public support this measure, they are not actually thinking about the last six months of a terminal illness; they are thinking about Alzheimer's, about motor neurone disease and about Parkinson's, none of which the Bill would address. It is therefore inevitable that this would migrate. As the hon. Member for Totnes said, we should support palliative care and we must ensure that it is available to people who are dying, regardless of their illness. We need to change

our tone towards the people who live in our society, so that old and vulnerable people no longer feel that they should get out of the way.

All our horizons will narrow as we get older. Someone who was hill walking when they were 20 might not manage to do so when they are 80. I have seen patients who are grateful to be at home being wheeled out on to the patio in the sun and having a good blether with their son who has come home from London. They consider that a good day. We might consider it horrific, looking at it in advance, but when we get there we will have changed. We should support letting people live every day of their life until the end, and make sure that, as legislators, we provide the means for them to live and die with dignity and comfort. We should not say, "When you can't thole it, take the black capsule." We should vote for life and dignity, not for death.

12.12 pm

Karl McCartney (Lincoln) (Con):

I should like to inform the House that I am the president of the Lincolnshire branch of the Motor Neurone Disease Association. I commend the hon. Member for Central Ayrshire (Dr Whitford) for her moving speech, and all those who have spoken this morning. I also commend the hon. Member for Wolverhampton South West (Rob Marris) for choosing an emotive issue for his private Member's Bill. It is no small achievement to have populated the House so well on a Friday, but my praise for him stops there.

Many of us fear that the Bill will induce uncertainty and suspicion and have the potential to fracture the doctor-patient relationship at the most critical time, when patients with the most severe illnesses are at their most vulnerable and in desperate need of sympathetic encouragement. Further, assisted dying would devalue any extra development or funding for advances in palliative care, reducing the quality of care that those wishing to receive it could and should receive at the end of their life.

Rev. Ian Silk of St George's church in Swallowbeck in my constituency is a good friend of the Bishop of Carlisle, who is leading on this issue in the other House. The bishop believes that a change in the law would come at the cost of placing many thousands of vulnerable people at risk, and he has stated:

"Terminally ill people deserve to be surrounded with love, compassion and care, not called to make a choice between dying prematurely and being a burden. The only effective safeguard against this pressure is to keep the law as it is."

Bob Stewart (Beckenham) (Con):

I have one comment to make to my hon. Friend. If there is just one mistake, and one person dies who should not have done, this House will have failed in its duty.

Karl McCartney:

I thank my hon. and gallant Friend for that intervention.

Many hon. Members consider the Bill to be misguided and dangerous. Baroness Campbell has observed that for the Bill

"to pass into law would be a triumph of despair over hope. It says, don't try to make things better—that's just too difficult and, anyway, would be futile. It is far better to die now. It will be better for you, your family and society. You are defined by your diagnosis, which is also your death warrant. Society doesn't want you around any more."

Like the good baroness, I do not want to live in that kind of society, and I hope that the majority of Members do not want to do so either.

Several hon. Members

rose—

Madam Deputy Speaker (Mrs Eleanor Laing):

I call John Woodcock.

12.15 pm

John Woodcock (Barrow and Furness) (Lab/Co-op):

I have not put my name down to speak, Madam Deputy Speaker, and I did not stand up to catch your eye. I have been listening to the debate carefully, however.

Madam Deputy Speaker:

If the hon. Gentleman would care to wait, that is all right with the Chair.

John Woodcock:

I am delighted to be called. This is the first time in my parliamentary career that I have been genuinely undecided when coming into the Chamber and I therefore wanted to listen to the entire debate. I have listened to every contribution so far, and I am still undecided.

I have been affected by the views of my constituents on both sides of the argument, and by the people who have spoken today. I have been particularly privileged to spend time with Clare Coulston, who is listening to the debate today. Her husband Paul died of motor neurone disease just two weeks ago, and she herself is in remission from a serious cancer and has two young children. She believes passionately that this Bill should pass, and has stated her views with wonderful eloquence, given the grief that she is suffering now. It would be easy for me to say that I of course agree with her, because she is my friend, but I am still utterly torn and still struggling. Thank you for calling me to speak, Madam Deputy Speaker, but I will let others who have prepared a speech take the Floor now.

12.17 pm

Maria Caulfield (Lewes) (Con):

I come to this debate as a nurse with more than 20 years' experience in the NHS, most of which time was spent working in cancer care. I have looked after many patients with metastatic disease and many who needed end-of-life care. As a result, it has been my humble privilege to share the last few days, hours and minutes of many people's lives and, on numerous occasions, I have held the hand of someone as they have breathed their last.

Having experienced dying at first hand, I can say that death can be one of the most rewarding parts of life. It does not have to be as painful or distressing as the supporters of the Bill have described. The reason behind my positive experience of death is the availability of good palliative care, which tackles symptoms such as pain and enables people to have a good quality of life right up to the end. In the field of cancer care, we are fortunate to have access to some of the best palliative care in the world. However, many patients living with other illnesses are not so fortunate. Patients with cardiac failure, multiple sclerosis and Parkinson's—to name but a few—often have little or no access to palliative medicine, but instead of tackling the lack of palliative care, the Bill promotes assisted dying as a solution. Death today has become medicalised, and it is seen as a failure or as something to be feared instead of as a normal part of life. The reality is that a natural death can be a moving and peaceful experience for all involved.

Therefore, not only do I disagree with the rationale behind this Bill, but I have severe concerns about the lack of safeguards it contains. The first relates to its requirement to give someone a diagnosis of less than six months to live. It is almost impossible accurately to predict a person's prognosis in months. In my experience, that is not something a consultant would readily do, as someone's prognosis can vary greatly according to their disease, general health and response to treatment. This part of the Bill gives the false impression that having a terminal illness means life is over—nothing could be further from the truth.

If assisted dying becomes law, it will remove the incentive for science and medicine to find treatments for illnesses. Metastatic prostate cancer was a terminal illness 10 years ago but is now a chronic disease, whereby men, although not curable, are treatable and often die of other causes long before their prostate cancer ever becomes a problem. The same is true of metastatic breast cancer, with many women now able to live long and healthy lives even though they cannot be cured. HIV used to be a death sentence, but thanks to advances in medicine it is now a chronic illness that people live with, rather than die of. Would these treatments have been discovered if assisted dying had been legalised 10 or 20 years ago?

My third concern is that with so many doctors against legalising assisted dying—the Royal College of Surgeons, the British Medical Association, the Royal

College of Physicians and the Association for Palliative Medicine are almost unanimous in their opposition—who will be left to assess the patients who wish to discuss assisted dying? The Bill requires both the attending doctor and the independent doctor to advise a patient on diagnosis, prognosis and treatment alternatives to assisted dying before giving consent. Most general doctors, however, would struggle to provide such specialist information. Are we certain that if we change the law, this will be carried out properly?

My final concern relates to the experience of places where assisted dying is already law. If the death rate in Oregon, where assisted dying is legal, were transposed to this country, 1,500 deaths a year would occur here from assisted dying. In Oregon, patients with lung cancer and prostate cancer are already being denied treatment on their state health insurance plan and are instead being offered assisted dying, as we have heard today. Is that what we want for patients in this country? Do we want them to be denied cancer treatment but offered assisted dying as an alternative?

Before we change the law to legalise assisted dying, we need to see serious evidence to prove, first, that the current law is not fit for purpose and, secondly, that what is being proposed would be better. On neither account has any convincing evidence been presented. Our current law is not perfect, but it does what it is designed to do: it holds penalties in reserve to deter malicious assistance, while allowing discretion not to prosecute, where appropriate. What is needed is not a change in the law, but better access to palliative care for all.

12.23 pm

John Pugh (Southport) (LD):

I am unpersuaded by the promoter of the Bill. I agonise over this issue, because death and the manner of our death should trouble us all. I do not entirely trust my own instincts on this, so I took the trouble of going to my local hospice, Queenscourt hospice, to hear from staff there what their advice was on this Bill. After all, they see death on a regular basis—daily, hourly, weekly. They oppose this Bill strongly, emphatically and definitely, and endorse the stance I shall be taking.

The thing we must recognise is that we all have a terminal disease called life. None of us get out of here alive, and some of us are nearer the door than others. It is hard to imagine how we would feel if the exact timing or manner of our death became more clear. We must admit that there are, perhaps rarely, bad deaths and troubling deaths, although, as anyone in medical practice will tell us, they are decreasing and are far less in evidence than they used to be. But the weakness of the Bill is that it provides no real solutions to the issues that concern most people and it creates a raft of other problems we do not currently have.

It is a misnomer to refer to the Bill as proposing assisted dying. Dying is legally assisted in a range of ways every day—physically, emotionally and spiritually, and specifically by the hospice movement. The Bill is about assisted suicide. My intervention on the hon. Member for Wolverhampton South West (Rob Marris) was not trivial, because the language is crucial here. If we are to understand the moral facts and look reality in the face, we have to call things by their proper name. I am reminded of the Americans in Vietnam referring to dead civilians as "collateral damage". We are talking about assisted suicide, and there is no essential right for people to demand of the state that it assists them with their suicide. In fact, it is the policy of Governments to reduce the number of suicides, and normally it is our moral duty to discourage suicide.

Lucy Allan (Telford) (Con):

Does the hon. Gentleman agree that anyone who has any knowledge of suicide sees it as a desperate and tragic act, committed by somebody in extreme emotional distress? It is usually committed alone, leaving families and loved ones devastated. The desire of a dying person for a peaceful death is so different from what I have just described, and anyone who has any knowledge of suicide would share that view. I believe the hon. Gentleman's argument to be null and void on that point about suicide.

John Pugh:

The default position is to discourage people from committing suicide, because suicide is most frequently the action of desperate people who are not getting the help they require. I believe that is acknowledged by the sponsors of the Bill, because they are suggesting that assisted suicide should take place only in special, carefully defined circumstances. Their Bill would put in place a series of provisions, which we have all read, to explain how we can be sure that these conditions actually apply. They are talking about this being a relatively limited exception and it is seemingly tightly drawn.

Let me make some huge, bold assumptions that I would not naturally make. Let me assume that these provisions, although not so far fully defined, would work perfectly, without abuse or uncertainty, and that this Bill is all that its sponsors want or are contriving. Therefore, this will not be like what happens in Switzerland, Belgium or Holland, and people will still have to go to Switzerland if they feel that their life is intolerable, unless they are likely to die anyway within six months. People may also still die undignified and unfortunate deaths, regardless of their prior wishes, if they cannot display current mental capacity. Those would be the consequences of the Bill. Paradoxically, the more likely it is that someone's end would be undignified, the less likely it is that they will be judged to have the capacity to comply with the legislation. In reality, what this Bill permits is for a strictly limited number of people to have their suicides assisted,

regardless of whether their anticipated end is painless or pain-free, dignified or not. That is what the proposals actually amount to.

Tom Tugendhat (Tonbridge and Malling) (Con):

Does the hon. Gentleman also recognise that except for in its exclusion, the Bill does not contain any recognition of the patient's family? Therefore, this Bill would do exactly what we are seeking not to do: it would force the individual to be on their own and the family to be excluded.

John Pugh:

It is fair to say that regardless of what people may expect of this Bill—we saw some mistakes in the contribution made by the hon. and learned Member for Holborn and St Pancras (Keir Starmer)—what it will do is not what most of the supporters of the Bill expect it to do. What it will do is generate certain very obvious risks, which have been well highlighted by other Members and so I will not go over them again. The risks are simply that the elderly and infirm will be pressured, doctors' motives will be questioned or confused, palliative care will be progressed less and suicide will be seen as a solution more, and life will be treated more casually—more as a disposable commodity. The social consequences are, to say the least, incalculable; we cannot be certain about them. But even if there is just one poor old soul—and, strangely enough, it is usually the old who die—who, under pressure, seeks a quick dispatch, it does matter. The hon. Member for Wolverhampton South West could not rule out that possibility, and clearly recognised that that could be a consequence.

In conclusion, this week started for most of us with the haunting picture of a single child drowned on a beach. It was just one life and it affected the whole country. The consequence that can be drawn is that, as a civilisation, we cannot be casual about life without becoming a different sort of civilisation.

Several hon. Members

rose—

Madam Deputy Speaker (Mrs Eleanor Laing):

Order. Before I call the next speaker, let me say that it will be obvious to the House that there are well over 50 Members who still wish to speak. We have had some heavyweight speeches. I am sure that the whole House appreciates that sometimes it takes some time to make a complicated and difficult argument, but I challenge Members of the House this afternoon to try to test their powers of rhetoric and see whether they can make their arguments in two or three minutes. I can assure individual Members that anyone who manages to make their arguments in two or three minutes rather than five minutes will be considered a much better orator for it. I know that we will have an excellent example from the next person to speak. I call Sir David Amess.

12.31 pm

Sir David Amess (Southend West) (Con):

It has been a privilege to listen to so many fine speeches this afternoon. Undoubtedly, this is the House at its best. As far as we are concerned, deciding whether to legalise someone assisting another person to take their life is the most profound issue that we could debate.

I congratulate the Bill's promoter, the hon. Member for Wolverhampton South West (Rob Marris), on his good fortune. In 2000, I had a similar success and the Warm Homes and Energy Conservation Bill is now an Act of Parliament. I empathise with him on the difficult course that he is following. None the less, I must say that as a long serving Member, I have heard all these arguments before, because we have debated the issue very many times. Indeed, in 1950, the Lord Chancellor in the other place made the two-minute speech that I am about to make now.

At the heart of all this is the concept of a good death. Colleagues who have been present when someone has died have told us how they feel about a good death. For my part, I say that a good death is dying peacefully.

The proposer of the Bill is making three points. The first one is about choice. We all have the choice over whether to commit suicide. Sadly, in the time that I have been here, a handful of colleagues have committed suicide. I wish that we could have done something to dissuade them from that action. I am against legalising another person in assisting someone to take their own life.

The second point is about compassion. I so agreed with the comments on compassion and palliative care made by my hon. Friend the Member for Totnes (Dr Wollaston) and the hon. Member for Central Ayrshire (Dr Whitford). All Members have been pressurised by hospices in their own area, and I believe that the House should concentrate on the delivery of good quality palliative care.

The final point concerns safeguards. I am not persuaded by the arguments of the experiences in Switzerland and in the state of Oregon. I remember only too well when, in 2000, the House heard about Harold Shipman who had murdered 15 of his patients, never mind how many more. I am not at all persuaded by this Bill when I think about the bureaucracy that will be involved.

We applaud the medical profession whose very work is to help people to live. We all came into politics to help improve people's lives. I, along with all colleagues, want to assist people to live, so I urge the House to reject this Bill.

12.34 pm

Robert Flello (Stoke-on-Trent South) (Lab):

Madam Deputy Speaker, I have dispatched three quarters of my speech, and will try to keep to your time requirements. First, let me pick up on something that my hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer) said. He did not allow interventions, which was a shame because we could have teased this matter out. The cases he cited would not be covered by this Bill. The

people would therefore still be going to Dignitas, and would still come across the desk of the DPP for decisions on whether to prosecute. Secondly, in the Oregon example, the drugs are issued to the people wishing to take them, but it is amateurs who are around when they are administered. I would love to have had a proper debate with him about this, but, sadly, time is against us.

Before I get into the detail of the arguments, it is important to highlight exactly what we are talking about with assisted suicide. Members can call it assisted death if they wish, but we should be specific. Not surprisingly, more than half the people polled think that assisted suicide involves no pain or discomfort. Well, assisted suicide can take two forms. The first, which this Bill says it advocates, is as follows. The person is given a powerful medication to stop them from being sick. That is because the barbiturates that are used to kill them are a powerful emetic. The urge to throw up is strong and can be distressing and uncomfortable. The barbiturates are then dissolved in a tumbler full of water and have to be drunk. It takes between one minute and 38 minutes until the person falls into a coma. In around 7% of cases, the person suffers from vomiting or spasms. In one in every 10 cases there can be problems with administering the barbiturates. In Oregon, it takes, on average, 25 minutes for the person to die. But the longest period before someone died was four days. In addition, in about 1% of cases, the person has woken up.

In the Netherlands, where an injection is administered to end life, it normally takes the form of thiopental or similar to put the patient to sleep followed by pancuronium, which is used to kill the person. Most terrifyingly of all, the person at this point is completely paralysed so cannot communicate if they are still awake or in distress. They then suffocate to death. How can either of those be described as a dignified death? That is not putting someone to sleep or easing their passing. It is wrong to say that it involves no pain or discomfort and it is not necessarily quick—it is up to an hour on average before the person dies.

I know that the people who are promoting this Bill are motivated by the desire to alleviate suffering and by compassion, and we have heard some very powerful speeches on both sides of the argument today. Of course we are all moved and saddened by what we hear and want to act with compassion, but that compassion is misguided if we think that by prematurely ending someone's life, we are alleviating suffering. There are ways to alleviate physical, mental and emotional suffering and they are done extremely well in this country. We hear those in favour of helping someone to commit suicide say that they do not want themselves or their loved ones to die in pain, but that fear should galvanise us to ensure that there is good quality palliative care not just from hospices but from across the whole health and social care system. That does not exist at the moment, and the report in 2011 highlighted that.

What does the law say about suicide? The 1961 Suicide Act as amended said that it was no longer a crime to commit suicide, and that was for a very good

reason. It is not because society now thinks that everyone should have the right to commit suicide, but because society rightly thinks that someone who has tried to commit suicide needs help and support, not criminal punishment. But the Act quickly goes on to make the point that if someone helps another to take their life, then that is tantamount to murder, punishable by sentence of up to 14 years. There is a very important caveat. As the law wants to ensure that people are kept safe, it imposes that threat of severe punishment, but at the same time it wants to be merciful, which is why the DPP will decide whether a case goes to court. That is an important point.

Let me conclude with a letter from Jane, one of my constituents. Her husband, Richard, was diagnosed with cancer in 2012. On 11 September 2013—two years ago today—he passed away. She said:

"I was able to care for him and the last few weeks we had together helped us to come to terms a little with the inevitable…At one stage because I was caring for him seven days a week, Richard began to feel he was a burden to everyone to which I assured him he was not a burden. I can understand totally where he was coming from. I think changing the law would place pressure on vulnerable people. Those who are elderly, disabled, sick or depressed could feel an obligation to agree to end their lives for fear of being a burden on others. From the bottom of my heart, Mr Flello, I would ask that you could be there…to oppose this piece of legislation."

That is one constituent of mine. I know that others have written to me, asking me to support the Bill, but for Jane's case, we cannot let it go through.

12.39 pm

Ben Howlett (Bath) (Con):

I must admit, Madam Deputy Speaker, that this will be a test of my oratory skills, as I have changed my speech three or four times based on some of the speeches that have been made and it is now unrecognisable. I admit that I came into the House thinking that I would support the Bill, but listening to the speeches made by other Members, particularly the hon. Member for Central Ayrshire (Dr Whitford) and my hon. Friend the Member for Totnes (Dr Wollaston), has completely changed my mind. I must say to those constituents who have got in touch with me on this issue over the past few weeks that listening to the arguments in this place has lain heavily on my shoulders.

It is clear that this is an enormously emotive issue. I watched my grandmother pass away after eight years of having dementia and strokes. I understand that the Bill would not have applied to her, but I could not look into the eyes of someone in her shoes and expect them to go through the pain and suffering that has been discussed, based on the evidence we have been shown.

My brother is a palliative care registrar. He wrote to me recently from New Zealand, saying that every time he is asked whether there is a way of speeding up

the dying process the question normally comes from patients who have never seen a palliative care specialist. He normally says that he will help to improve the symptoms and the question of assisted suicide ends up dissipating.

I have a number of serious concerns about the Bill after what I have heard today. I have two key concerns that I hope will be considered before the suggestion is put before the House again. First, if an individual is reasonably expected to die within six months, I hope that the hon. Member for Wolverhampton South West (Rob Marris) will clarify whether a voluntary, clear, settled and informed wish as well as a two-week wait for the High Court judgment and a two-week wait for the administration of the medicine will be enough to enable the individual to have a dignified end of life. I hope that he will realise that that is an awful lot to squeeze into a very short period of time.

My second concern relates to the code of practice and the individual's mental health. If someone has just been given a terminal diagnosis and only six months to live, are we suggesting that they will have neither depression nor any other psychological disorders that might impair their decision making?

After listening to the arguments made today by many people who are much more experienced in this field than I am, I have to say that I will oppose the Bill.

12.42 pm

Albert Owen (Ynys Môn) (Lab):

It is the convention in this House on a Friday morning to congratulate the promoter of the Bill on coming top in the ballot. Although I disagree with the Bill being proposed by the hon. Member for Wolverhampton South West (Rob Marris), we owe him a debt of gratitude for this debate. I want the debate to continue.

It is interesting to hear the different views that have been expressed today and in the lead-up to the debate from leading legal and medical experts, and I pay tribute to them. Today, those views have been echoed in this Chamber by people with huge amounts of experience, whether in the legal field, like my hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer), or the medical, like the hon. Member for Central Ayrshire (Dr Whitford). This House is at its best when it debates like this and when we others—I include myself in this category as I am not an expert—have the opportunity to add our weight to the debate on behalf of our constituents.

None of us has the right to say that we are more compassionate than others, whether we are for or against the Bill. We all want to see dignity in end-of-life care. That is important, and that argument has been echoed in this Chamber today. We need to turn the debate into a positive. Those of us who will never support assisted dying, assisted suicide or euthanasia and have a strong and principled view on that need to be joined by those who want to alleviate suffering, whether or not they have a different opinion on the Bill. We must channel that

energy into improving palliative care. We must talk about the national health service as being from cradle to grave. In doing that, we have to be brave and we have to say that palliative care is patchy in this country and that young people and older people do not get the care or dignity they deserve. We must channel money and resources into training people to help in end-of-life care in the future. Our health service must merge prevention and care; social care and health must come together to help young people and those who have terminal illnesses. We must do that in a positive way.

Conor McGinn (St Helens North) (Lab):

We have rightly heard today of the concerns of medical professionals about how the Bill would fundamentally change their relationship with those in their care. Does my hon. Friend agree that those concerns are reciprocated by many patients? We trust and rely on doctors and nurses to improve the quality of life, not to bring it to a premature end.

Albert Owen:

Absolutely, and that has been eloquently spoken of by many people, including those with huge experience in the medical profession.

I believe that if the Bill is passed today, it will be a slippery slope. People would come back, not solely because we have the legislation in this House but, as has been said by my hon. Friend the Member for Warrington North (Helen Jones), who is no longer in her place, because the case law would be altered to reflect the wishes of society. We are here as representatives to reflect both sides of the argument. I do not accept that a snapshot poll showing 82% support reflects the will of the British people, but I do not think we will get an accurate poll. We have to make up our own minds and base our decision on the evidence and on compassion. Let us together improve the national health system from cradle to grave to help those in an impossible situation alleviate pain and improve long-term care. I thank my hon. Friend the Member for Wolverhampton South West for giving us the opportunity to have this debate. Let us move forward in a positive way.

12.46 pm

Mr Nigel Evans (Ribble Valley) (Con):

It is a privilege to follow the hon. Member for Ynys Môn (Albert Owen), and I agree with everything he has just said. I believe in dignity in death, but I also believe in the sanctity of life. We have heard powerful speeches from both sides today and we have all received many emails from constituents arguing both sides. We cannot agree with both sides. I remember that the hon. Member for Barrow and Furness (John Woodcock) said that he was torn, but we must finally take a decision.

Like my hon. Friend the Member for Bath (Ben Howlett), I found the speeches of the hon. Member for Central Ayrshire (Dr Whitford) and my hon. Friend the Member for Totnes (Dr Wollaston), who both spoke with experience and authority, incredibly powerful. It is rare for people to be swayed in this Chamber—they come in with their minds made up—but my goodness me, what powerful speeches. I am sure that they have had an effect today.

When my father was diagnosed with cancer in 1978, the family watched him die a painful death. It was a bad death, and when he died, I said, "Thank God he has died." As the hon. Member for Ynys Môn has just said, we should be putting far more resources into palliative care. We should admit that it is patchy and that some people have bad deaths, though that is not acceptable. I know that we put many resources into finding a cure for all sorts of diseases and conditions, but at times we have to recognise that a cure might be some time off and sufficient resources ought to be put in to ensuring absolutely the right amount of palliative care so that when people come to the end of their lives they are not in unnecessary pain. We must remember the relatives around them and the pain they feel in seeing someone who has looked after them for all their lives—their father, a strapping person—wasting away over a period of months and then dying. I went to get his last shot of morphine and I am absolutely certain that that was what pushed him over the edge, but at least he did it without unnecessary pain at that final juncture.

We say that people should not be put under undue pressure or feel they are burdens on their family. They should not feel, "Well, I have the choice, perhaps I should exercise that choice." It is almost impossible to say that people with terminal conditions will not be pushed into an earlier death simply because they have that choice. At the moment, they do not. It is impossible to calculate how many people will say towards the end of their lives, "I think I am going to take that poisonous cocktail because I do not want to be a burden on my family and because it is costing them to keep me in a nursing home, with all that that entails."

I pay tribute to Macmillan nurses, Marie Curie nurses and the hospice care in this country. I do not believe that Dignitas brings dignity to death; I think it brings a speedier death, and I ask the best minds that we have in the world: is that the best that we can offer?

12.50 pm

Barbara Keeley (Worsley and Eccles South) (Lab):

I do not support the Bill. We should maintain the clear principle that this Government, the justice system and the medical profession have upheld for many years—that we do not encourage or help people to commit suicide, and that we should work to prevent all forms of suicide. The Assisted Dying (No. 2) Bill would be a departure from that principle, and I believe that we would start to see

people in very difficult circumstances becoming even more vulnerable if the Bill were passed.

Clearly at present—we have heard a former DPP, my hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer), lay out the current situation—committing suicide is not illegal but encouraging someone to commit suicide is illegal, and I firmly believe that that protects us all, and that that basic principle against suicide should be upheld. Wednesday was world suicide prevention day. Many moving messages appeared on social media about the importance of preventing suicide, so it is ironic that we should today be debating a Bill that drives our society in the opposite direction.

I have significant concerns about the detail of the Bill, and whether any regulatory regime surrounding the introduction of assisted suicide would be fit for purpose. I would argue, as others have done in this debate, that making assisted suicide legal creates a pressure on people to take their own lives rather than giving them greater choice, because it creates a fundamental shift in people's perception—that our society accepts suicide. One of the major risks in the Bill has been eloquently outlined by my hon. Friend the Member for West Ham (Lyn Brown), and it is that people will feel under pressure to take their own life if they feel they are becoming a burden to their family or society. That would grow from an illness-related reason to encompass financial ones and even mental health reasons. People in my constituency have written to me about their concerns, saying:

"If this Bill is passed it will put greater pressure on vulnerable people, the elderly and the sick, who will increasingly see themselves as a burden to society. I don't want to see that."

Stuart Andrew (Pudsey) (Con)

rose—

Barbara Keeley:

If we are to live in a society that values and cares for each individual regardless of the state of their health and disability, it is difficult to see why we should be relaxing our stance on suicide. The Not Dead Yet UK network of disabled and terminally ill people tells us that not one organisation of disabled people supports assisted suicide, and Richard Hawkes, the former CEO of Scope, has said:

"Why is it that when people who are not disabled want to commit suicide, we try to talk them out of it, but when a disabled person wants to commit suicide we focus on how we can make that possible?"

The campaign to legalise assisted suicide reinforces deep-seated beliefs that the lives of disabled people are not worth as much as other people's.

We must also consider the question of the involvement, through the Bill, of the doctors who would have to assess the person and administer the drugs to assist

their suicide. The British Medical Association has a clear policy against physician-assisted suicide and the Bill before us, as do the college of GPs and the college of physicians. The BMA says that it opposes all forms of assisted dying, supports the current legal framework, which allows compassionate and ethical care for the dying, and supports the establishment of a comprehensive, high-quality palliative care service. Many of us here today have spoken very strongly about our support for palliative care, and the hon. Members for Totnes (Dr Wollaston) and for Central Ayrshire (Dr Whitford) have given us their reasons, as a former GP and former surgeon.

I want to end on that point about social care, because much of my work here has been focused on social care and carers. I believe I agree with the hon. Member for Totnes: improving palliative care is a real alternative to the Bill. We should bring in free social care at the end of life, because the denial of care should not be driving people to take their own lives.

I want to make a final point about the last implications of changing this law. At the moment, it is clear that we want to prevent people from committing suicide and that society should help and support those reaching the end of their life. Passing the Bill would change that and set a dangerous precedent.

12.54

Andrew Bridgen (North West Leicestershire) (Con):

It is a great honour to speak in a debate, as brief as it is, on a matter of life or death. It is one of the hardest things for this Parliament to deal with, because the passions of the speakers and the strength of the arguments on both sides are compelling.

I have been lobbied about assisted dying since my very first month in this Parliament, and consistently. I have listened to all the speeches today on both sides of the argument, but I will vote against the Bill because I am very concerned about coercion. Any Member of this House who does not consider that coercion could happen, forcing vulnerable people to take their own lives, has perhaps an over-optimistic view of the human nature of a small but significant section of our society.

I spoke to an A&E consultant in my constituency who raised concerns about his Hippocratic oath and the change in the doctor-patient relationship that the Bill could engender. He had a shocking experience when he was resuscitating an elderly lady in A&E while her relatives were sharing out her assets at the foot of the bed. When the old lady was resuscitated, he saw the look in the relatives' eyes, and he would certainly not be in favour of assisted dying legislation whereby vulnerable old people could be coerced into taking their own lives by unscrupulous or heartless relatives or beneficiaries.

The safeguards in the Bill are inadequate, and as a responsible parliamentarian I cannot bring myself to support a change in the law with such gaping holes in it. It is a blank cheque, as has been mentioned.

Stuart Andrew:

Will my hon. Friend give way?

Andrew Bridgen:

I will not, if my hon. Friend does not mind.

Supporters of the Bill have said that 80% of the public favour medically assisted suicide. I am not sure how much understanding those respondents had at that time, but when participants are exposed to the counter-arguments to legalisation, support wavers, in one poll dropping from 73% to only 43%, and among palliative care doctors 90% oppose the Bill.

I am a trustee of a local hospice charity, Hospice Hope, in Ashby de la Zouch. I am a great supporter of and believer in the hospice movement and palliative care sector. I would like to quote Dr Robert Twycross, a retired palliative care specialist, who recently stated that

"despite upsetting 'horror stories'…palliative care does not…leave patients to suffer unbearably. In extreme situations, increasing the dose of symptom relief and sedative drugs is already permissible as a 'last resort option'. The most appropriate response to horror stories is to increase the availability of specialist palliative care"—

not to kill people.

As has been said, many people are desperate when first diagnosed with a terminal illness. It is completely understandable, and it is easy to make a rash decision. Many feel a burden on their family and wish to die to alleviate that burden, when actually that family love them, want to care for them and do not want them to die. The way to alleviate distress in dying people and their families is to care for them properly with good palliative care, not to murder them.

I am aware of time pressures. I would ask hon. Members to bear it in mind that we fund, to a huge extent, the national health service. It is not the national death service. In a recent survey in May of 1,000 GPs, only one in seven was willing to get involved with this Bill. I feel that for vulnerable people the right to die will quickly become the obligation to die. The only thing that deserves a quick death is this Bill and I shall vote against it.

12.58 pm

Kate Green (Stretford and Urmston) (Lab):

I shall make a few brief points in the light of the many conversations I had over the summer with disability organisations and disabled people. They are well aware that I support the Bill and will vote for it this afternoon, but I want them to know that I have listened very carefully to some of the concerns that they have expressed.

Of course, not all disabled people are terminally ill—we should not equate the two—but it is true that when we become terminally ill, we will almost all by definition fall within the terms of the Equality Act's description of disability. It is also true that the social context in which disabled people live their lives today means that they suffer inequalities and injustice, and that accompanying the Bill must be a whole-hearted commitment by the House to address that structural inequality and to make the right to an assisted life equal to that of assisted death.

**I was a little horrified to hear the Second Church Estates Commissioner, the right hon. Member for Meriden (Mrs Spelman), for whom I have enormous respect, imply, I think, that she would prefer such deaths as already take place to do so outwith the law, rather than to shed the light of regulation on a situation that we live with today. I would prefer to see this difficult situation governed by legislation—legislation for which we as legislators take responsibility.**

To the disabled people who have raised issues with me, I would say that I am very open to hearing suggestions for further safeguards to be placed in the Bill. Having listened to the debate this morning, I am sceptical about the role of the High Court in this matter and we may have to look at this again. I invite the proposers of the Bill to amplify what sort of audit process and regulatory framework they think can properly protect people, and I echo the calls all around the House for proper investment in both palliative care and mental health care to address the very important point that at the end of their lives many people will suffer also from severe depression.

1 pm

Glyn Davies (Montgomeryshire) (Con):

I had written a 40-minute speech for today's debate, Madam Deputy Speaker, but you will be pleased to know that I have no intention of having you stop me five minutes into that. [Hon. Members: "Two minutes."] Indeed, two minutes.

I am very opposed to the Bill. I shall make two general points and then give one or two more reasons why I oppose it. First, it is important for us to realise that this is not a competition in compassion. Both sides of the debate are driven by compassion and what we are looking for is the best solution for those who are approaching the end of life. End-of-life care is not satisfactory and we need to find ways of improving it.

The second issue relates to the Bill itself. When it came top of the ballot of private Members' Bills, I was disappointed that we would be debating the topic again. I have changed my mind about that, because it is hugely important that we as a nation take palliative care much more seriously. The Bill has probably helped to achieve that. I am still opposed to it, but the interest in the wider public and among MPs will lead to a greater awareness of what we need to do in that field.

The three main reasons that I oppose the Bill are, first, the normalisation of suicide. Society disapproves of suicide, and if it becomes normalised it becomes an issue of debate for everyone who reaches the end of life. The speech from the hon. Member for West Ham (Lyn Brown) made a great impact on me when she talked about her own experiences. It is true that there may be issues of coercion and malevolence, but the real concern is the self-imposed pressure—people asking themselves, "Is my life over? Should I remove myself from society?" That is my biggest worry.

The second worry that I have about the Bill is that it puts different values on the lives of some members of society—the people approaching the end of life, the terminally ill, the mentally disabled, the severely mentally disabled and the severely disabled. We have never put different values on the lives of different people; I think the Bill does that. The third reason that I oppose it is that it inevitably changes the relationship between doctors and their patients. A doctor's job has always been to do no harm. People go to the doctor because they want the doctor to help them and make them well. If assisted dying will always be part of their discussions, it will interfere with their relationship for ever. For those three reasons I oppose the Bill.

1.3 pm

Jonathan Reynolds (Stalybridge and Hyde) (Lab/Co-op):

I cannot support the Bill and I intend to vote against it. In doing so, let me first recognise the good intent and the compassion of those who support the Bill and who have brought it here today. Their motivations are honourable and I appreciate that considerable numbers of people in this country want these issues to be discussed. Many constituents on both sides of the argument, as I am sure is the case for all Members of the House, have shared incredibly personal stories with me—stories of great courage and of great pain—and I am extremely grateful for that, but I do not believe that the change in the law that is proposed in the Bill is either desirable or necessary.

There is a right to die under UK law. Any of us has the right to refuse further medical treatment in such a way as to bring our lives to a natural end. Furthermore, a person making that decision can usually obtain pain relief to ease their suffering. However, the Bill proposes a fundamental change, for the first time allowing medical practitioners to prescribe drugs that would enable the person actively to end their life. I believe that once we crossed that Rubicon, we would have radically changed our conception of life and of the rights and responsibilities of individuals and of society at large. We would have fundamentally changed the role of the medical profession and we could never truly ensure that there were sufficient safeguards to prevent abuse.

I am sure the House will appreciate that the prospect of doctors legally prescribing fatal doses of drugs causes considerable distress in my constituency, where

the majority of the families of the victims of Harold Shipman reside. This proposal would for ever change the nature of the medical profession in the UK, and I note that the British Medical Association is fundamentally opposed to it.

Many people who are in favour of the Bill have made the case to me that in situations where the Bill would apply, the quality of life of the people affected by it is so poor that it justifies such a change. I understand that point. The levels of funding for social care in this country are a disgrace. The wages, conditions and zero-hours contracts of some of the people who are asked to care for our loved ones near the end are a disgrace, but to move towards a system of assisted suicide justified on the basis of that poor care and provision would also be a disgrace. We can offer people dignity and comfort at the end if we are willing to devote sufficient political and financial capital to that end.

Any legislation of this kind changes the way we as a society see the elderly and makes the limitations that come with age and illness something avoidable. It will become selfish to be old or ill, to be asking things of people or to be in need, whereas this time should be a time of great importance, of healing relationships and of saying thank you for everything that has been given to us in the lives we have led.

Another argument cited in favour of the Bill is that it merely codifies the existing guidelines of the Director of Public Prosecutions, but there is no way in which we can ever sufficiently codify the circumstances that these guidelines cover. There are situations where there is no public interest in prosecuting a person for breaking the law, but that does not mean that we as parliamentarians should change to law to legalise that behaviour in future. Hard cases make for bad law.

Finally, all the evidence I have seen from Holland and elsewhere suggests that this is one of those occasions where the slippery slope argument holds true. Just as in the UK, in Holland everyone was promised that there would be a specific and narrow application of the law, but now that is not the case and it is often used for very narrow reasons. None of the safeguards promised in the Bill could ever be sufficient. We will keep on revisiting them and weakening them, and practice will constantly push at them too. So let us oppose the Bill today. Let us reaffirm our determination to find better solutions to the problems that we have discussed today, but let us keep the fundamental respect for and sanctity of human life and the protection of the vulnerable that are rightly at the heart of the current legal position.

1.6 pm

Tim Loughton (East Worthing and Shoreham) (Con):

Debating issues such as this is one of the most challenging things we have to do as MPs. We are expected to exercise the judgment of Solomon on behalf of our constituents. Indeed, many speakers on both sides have made speeches worthy of Solomon today.

I will come to the point quickly. I oppose the Bill because I have fears about the safeguards against the pressures from family members or friends with their own agendas and different priorities. There are difficulties over the definition of mental competency. Are we placing too great a responsibility on our doctors to play God? That would change the whole dynamic of that doctor-patient relationship. My prime concern, and why I will vote against the Bill, is that we risk engendering guilt among elderly people and those with serious disabilities about being a burden on their families, their carers or society. Bringing a Dignitas-style solution to their doorstep implies that that is what is expected of them and the most unselfish course of action to take. As our population lives longer, that pressure will become greater.

Rather than re-rehearsing the arguments, I want to close on a very personal story. My mother was diagnosed with cancer at the end of 2013. At the beginning of January 2014 she reacted badly to her chemotherapy and became very poorly. She was taken to hospital and after a few days doctors decided that there was little they could do for her and she was transferred to the new St Wilfrid's hospice in Eastbourne. Staff there were brilliant and we cannot thank them enough. As a patron of St Barnabas House hospice in Worthing, I know the fantastic work that hospices do. Doctors told us that our mother would be unlikely to make the weekend. It was a shock that it had happened so quickly when she apparently had been receiving good treatment.

My brother, my sister and I mounted a vigil. She was in great pain and discomfort but my mother kept telling us that she really did not want to be a burden, and that if she had known that things would turn out like this, she would have taken herself off to Dignitas to make sure she was not a burden. I do not know whether she would have gone through with that, but she was convinced that she did not want to be a burden. We will never know what she might actually have done.

The weekend came and, incredibly, my mother was still there. Fortified by a range of exotic fruits and fruit juices to quench her thirst, she actually started to improve. A few weeks later, she was still there. She had rallied sufficiently that she was deemed to be too fit to stay in the hospice and so was evicted. It was a great triumph for her; people are not normally evicted from hospices. We found her the most wonderful nursing home in Eastbourne, the Queen Alexandra Cottage home. Far from being a burden, she played an active role in helping the staff of the nursing home. She was looked after brilliantly. Her quality of life was excellent. My brother, sister and I spent much quality time with her and enjoyed trips out to favourite family places, and at family get-togethers she was surrounded by her grandchildren.

Sadly, my mother died last October, but eight months after leaving the hospice. She died peacefully and comfortably, and with her family around her, a few days short of her 77th birthday. Those bonus eight months were some of the

happiest times we enjoyed with my mother, despite her illness and the limitations it placed on her. It was quality time that allowed her and us to prepare for the inevitable, but in a positive and organised way—my mother was very organised.

For my part, those eight months were just a small compensation for the missed opportunities and family neglect that the job of being an MP inevitably entails. If things had gone differently and my mother had chosen another route, completely oblivious of what was actually to happen, and if that alternative option had been readily available and state-approved, she and we would have missed out on a lot. We were lucky to have that valuable extra time, and she valued it greatly.

That is just one example, and I know that many other people's experiences will lead them to other conclusions, but it is a major personal reason why I think that the risks and the potential loss of human experience and sensitivity outweigh the potential advantages that some people might enjoy from a change in the law, and that is why I shall be voting against the Bill.

1.11 pm

Mark Durkan (Foyle) (SDLP):

We have heard many compassionate and compelling words today, and the voice of conscience has come through on both sides of the debate, just as it has come through on both sides of the correspondence we have all received from our constituents. I will be opposing the Bill. Some of the constituents who have written to me have suggested that I am being Church-whipped. I am no more Church-whipped in opposing this Bill's Second Reading than I was when I voted for the Second and Third Readings of the marriage equality Bill.

Like all Members, I come here today as a conscientious legislator dealing with difficult issues. I acknowledge the sincerity of the Members proposing the Bill, but as a legislator I cannot satisfy myself that the compassion with which it has been proposed is adequate to allow it to pass. I am not convinced by the so-called safeguards that it is claimed to have, and I do not believe that it would be enough to rely on codes of practice that might or might not be introduced in future.

In that regard I am moved by what I have heard directly from many medical professionals. We have been privileged to hear today from Members with medical experience and insights about some of the difficulties that they see arising from the Bill. They are concerned about not only the professional compromises that would be created, but the pernicious conditioning effect that would result. Many Members have rightly raised concerns about incidents of coercion arising in the discharge of this legislation, but there are also concerns about the wider conditioning effect, and many medical professionals have voiced those to me. They are concerned that it would affect their relationship not only with patients, but

with colleagues and other professionals, because of the quandaries and difficulties that would arise.

I am also not convinced by people making the case for the Bill by focusing on what would not be covered by it. I cannot take from them the assurance that the Bill draws a line and could not be used to take us on a travelator towards more legislation. If the compelling cases which motivated Members to propose the Bill would not be covered by it, I find it hard to see how those same cases would not be used to take us on a further journey, so I accept the slippery slope argument.

It has been suggested that relying on the prosecution guidance as adequate would be a dereliction of duty on our part as legislators, but let us remember that those who are proposing the Bill would still be relying on the guidance for all the cases that fall outside the scope of the Bill. If it is okay for people to rely on that guidance for cases that fall outside the scope of the Bill, why would it be wrong for those of us who oppose the Bill to rely on it as well for people in that situation?

I do not claim that we have moral superiority over anyone in the decisions that we take today, but as legislators we are compelled to make those choices. I know that the choice I make as a legislator might not be the choice I would make as a terminally ill patient, or as someone who receives a strong and emotional request from a loved one who is terminally ill, or as a juror if a prosecution took place at some time; I must make the decision today as a legislator. That is why I must vote against what I regard as poor and dangerous legislation.

1.15 pm

Mr David Jones (Clwyd West) (Con):

I have the most profound concerns about the Bill, most of which have already been rehearsed by other hon. Members. In view of the shortness of time, I do not intend to repeat them. However, I also consider it to be a deeply flawed Bill. I will focus on three concerns that I believe are sufficient to persuade hon. Members not to support it.

First, although clause 1 provides that the person seeking the consent of the court must have

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

the Bill is completely silent on what inquiries should be undertaken to establish how that wish has been arrived at. The right hon. Member for Knowsley (Mr Howarth) made the perfectly reasonable point that it is possible to come to a rational decision that one does not wish to be a burden on one's family. Equally, it is possible to be coerced, cajoled and browbeaten into that position, and the Bill provides no safeguards in that respect.

Andy McDonald (Middlesbrough) (Lab)

rose—

Mr Jones:

I will not give way, as we have very little time.

Secondly, the Bill provides that the person seeking the order should have a terminal illness and

"as a consequence of that terminal illness, is reasonably expected to die within six months."

Medical experts have pointed out that it is very difficult to ascertain whether an individual will die within three months. One is reminded of the Scottish case of Abdelbaset al-Megrahi, who was convicted of the Lockerbie bombing and discharged from prison on compassionate grounds because he was not expected to survive a further three months, and that was on the evidence of highly respected oncologists. In fact, he survived a further two years and nine months. Irrespective of the merits of the release, that illustrates how difficult it is to assess how long a patient might live.

Thirdly, the Bill is totally silent about what inquiries should be made by the court on whether an order should be made. I intervened on the hon. Member for Wolverhampton South West (Rob Marris) on that point, and he replied that it was a matter for the court. I venture to suggest that when one is talking about whether or not a declaration permitting assisting dying is to be made, there should be strong guidance in the Bill on how the court is to make that decision. In other words, it looks very much like a rubber-stamping operation, which cannot be right.

Ethical questions are notoriously difficult, and most of us here in this House are not medical professionals. We therefore have to rely on medical ethicists and on medical practitioners and clinicians. We should all have regard to what the BMA and the royal colleges have to say. We should listen to hospices such as St David's and St Kentigern, which serve my constituency. In this House, we should listen to people such as the hon. Member for Central Ayrshire (Dr Whitford) and my hon. Friend the Member for Totnes (Dr Wollaston), who clearly understand the issues. I urge all hon. Members to oppose the Bill.

1.18 pm

Mr Gordon Marsden (Blackpool South) (Lab):

We debate this subject on the anniversary of 9/11, the day on which over 3,000 people had their lives snuffed out in an instant, so it is not surprising that we are debating many deaths in this Chamber and citing our personal experiences, such as my experiences with my parents at the end of their lives and of seeing people in Trinity hospice in Blackpool, and so many other individual examples. Of course there are good intentions on all sides, but good intentions are not enough.

The balance of probability that my hon. Friend the Member for Wolverhampton South West (Rob Marris) mentioned is not enough to prevent us from going down a road not to hell but to dangerous and difficult decisions.

I listened with great respect to the comments of the former DPP, my hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer), but drew a very different conclusion—that hard cases may make bad law, but they do not necessarily make bad individual judgments. That is the point. It is not right, in my view, that we should assume that we should just accept the right of Parliament to delegate to the DPP these difficult decisions where the detail has to be tried and tested to a generic principle.

The issue of capacity is clearly worrying many people here, and rightly so. I was a Parliamentary Private Secretary in the Lord Chancellor's Department when that was brought up. It is a fluctuating issue, and that is why Scope and Mencap are very concerned about it.

We have already heard about the large proportion of medical professionals who would not be prepared to take forward the procedures in this Bill, even if they were not flawed. What does that say about the small pool of people who will have to deal with this? Words matter, as George Orwell said, so we should be using the appropriate terms. This is about assisted suicide, not assisted dying. It is not about medication—I am not going to use the word "poison"—but administering something to someone that will kill them. These are important issues.

John Donne famously said,

"No man is an island"—

and no woman, for that matter. It has been suggested today that the decision that we make is simply for the individual. It is not simply for the individual—it is for the families who are impacted by it, for the doctors who have to go through agony trying to decide what to do about it, and for all of us in society who will take the consequences on board. That is why I shall vote against the Bill.

1.21 pm

Lucy Allan (Telford) (Con):

I am very grateful to the hon. Member for Wolverhampton South West (Rob Marris) for bringing this Bill to the House today. It is incredibly important that we are discussing this issue. I have been incredibly moved by many of the speeches that we have heard. This is a matter of public interest. We all know from our postbags that there are passionately held views on all sides. I am also very grateful to all Members of the House for the manner in which the debate has been conducted. It is a very sensitive, difficult issue, and people have dealt with it with respect. That is absolutely the way in which the debate should be conducted.

I am in favour of the Bill. Parliament may decide today to kick it into the long grass, but even if debate is closed down on the issue of assisted dying, we cannot make it go away. People will go on taking their loved ones to Dignitas. Doctors will go on giving just that little bit more morphine to a dying patient to relieve unbearable pain, knowing that it could lead to death. Ex post facto, the Director of Public Prosecutions will continue to be able to exercise discretion if they so choose.

I believe that is wrong. We need legal clarity on this issue. The law needs to be brought up to date to reflect modern, contemporary Britain and the way in which advances in medical care have accelerated and social attitudes have changed.

Rachael Maskell (York Central) (Lab/Co-op):

Will the hon. Lady give way?

Lucy Allan:

No, I am sorry—I only have two minutes.

A vote against this Bill will not stop assisted dying; it will simply send the message that we in Parliament will not debate the issue further.

I want to add something from a constituent that I found particularly moving. She is talking about her dying mother, and she says:

"It broke my heart on a daily basis watching her suffer…My darling Mom would scream from morning till night "please Lord, help me, let me die, please take me". She was in so much pain, her tiny body was racked, worn and exhausted…I prayed that God would make me strong enough to gently place a pillow over her face to end her torture, but, sadly, I could not as I loved her too much, and selfishly wanted her to stay…it destroyed me because my Mom was my world, and I could see and feel her pain yet could do nothing.

Although it has been 3 years since Mom's passing, I cannot move on or forget because all I see, and all I remember is her terrible suffering…It is impossible to erase her last days as they were horrific, no human being should EVER have to endure."

This Bill is about principle: it is about freedom and choice. Although I respect the views of everybody who has spoken today, it is not for us to deny people a say in how they die. It is their life, not ours.

1.25 pm

Ian Paisley (North Antrim) (DUP):

I believe that Parliament should be in the business of giving people reason to live, not of creating laws that facilitate and accelerate people's death. I say that with respect to those who have today given their own personal, trying and solemn examples, but I believe that the balance is all wrong in this Bill and that is why I will vote against it.

We all know that it is not necessary to change the law in order to have dignity in death. That has existed from the very beginning of time. Indeed, it is in the natural order of things.

I understand what pastoral care is like. I grew up in a manse. People would come every day to my father's manse and witness people with illnesses and sicknesses who needed to be comforted.

I also have a more personal story to tell. A year ago to this day, my father passed away, and tomorrow we will celebrate his anniversary. Eighteen months prior to that, he had been in hospital. He had suffered a very serious illness and ended up on a life support machine. On his fifth day on that life support machine, the doctors indicated to us, "Look, your father's probably going to die in the early hours of the morning. You should prepare yourselves and be ready for the eventuality." We did. We prepared his funeral. We sat as a family and talked about what we should do over the next few days.

That night, amazingly, my dad sat up in bed and demanded a cup of tea. He went on to enjoy another hearty year, and we went on to enjoy his company and lovely presence for another year. We planned his funeral with him, and it was a very different plan—it was noted publicly for being very different—from ours. Some people may say, "We have a right to do this and to tell people, 'It's now time: this person is now a burden on society'," but that is not what we as legislators and as a Parliament should be doing. We should be taking stock and saying, in his voice, "No."

1.27 pm

Mark Field (Cities of London and Westminster) (Con):

So much has been said by those who, like me, oppose the Bill, and we have heard some profound and personal stories, so I do not want to go over all that ground.

Fundamentally, I believe that the way in which any society looks after its most disabled, most vulnerable and the elderly says something about it. I fundamentally worry that we are starting down a path of saying, in essence, that the lives of those who are profoundly disabled and who are getting old and are a burden are worth less than those of others. That is an incredibly dangerous path to go down.

I am a former lawyer, albeit a rather less distinguished lawyer than the hon. and learned Member for Holborn and St Pancras (Keir Starmer), whom I first came across in a college library in Oxford about 30 years ago. I am now a legislator and I profoundly believe that the law's empire should not be extended into this highly contentious sphere. We should let common sense prevail. Perhaps we are living in a much more litigious society. That is regrettable in many ways, because we need to let guidelines cover the ground that perhaps the former Director of Public Prosecutions was reluctant to cover. I think it is fair to say that

close friends and relatives of those who are terminally ill instinctively know the wishes and desires of their nearest and dearest. They should be protected by compassionate understanding rather than by delusory legal safeguards.

I am not a terribly religious person and I certainly do not stand behind many of the religious aspects that influence many colleagues who have spoken, but when all is fundamentally said and done, I instinctively believe that to support assisted dying or euthanasia is simply wrong.

1.29 pm

Mrs Madeleine Moon (Bridgend) (Lab):

The Motor Neurone Disease Association holds no stance on the Bill. I speak as the chair of the all-party group on motor neurone disease.

I am also the chair of the all-party group on suicide and self-harm prevention. I must say that grave offence will have been caused today to the many people who have lost loved ones to suicide. To talk of this as a suicide-prevention Bill when people have lost loved ones who had much to live for is harmful and hurtful. To use the term "commit" is to wound people who have lost loved ones to suicide. I ask Members never to use the word "commit" in relation to suicide. Suicide is not a crime. You commit murder or you commit an act against the law, but suicide is not against the law.

There has been much talk about how individuals affected by the Bill may be a burden on their families, but nothing about how life may be a burden on those who are dying. I cared for my husband for the last five years, while he was dying, and I saw when life changed to being a burden. He had no capacity to speak, to lift a hand to his mouth or to get on a train or a plane to go to Switzerland, so the Bill would not have affected him in the way that a letter that came to me affected me when somebody said that I should vote for the Bill because of my husband.

I believe that it is Parliament's job to look at the will of the people and to consider the difficult choices in front of society. Therefore, consideration of the Bill should not be ended in the Chamber today; it must go into Committee and be debated. We must be honest with the people and have a full and frank debate.

I am aware of the time, Madam Deputy Speaker, but my one concern about the Bill is in relation to the DS1500. For those who are looking confused, the DS1500 is the form that your GP gives you that says you are terminally ill. It is a passport to benefits that are absolutely critical for the dying. Do not allow GPs who are opposed to the legislation to use it as a way of withholding those benefits from people who desperately need them. We must find something else.

We must have this debate, and we must carry it on.

1.33 pm

Chloe Smith (Norwich North) (Con):

I think I speak for the whole House when I say that it is an honour to follow the highly personal statement by the hon. Member for Bridgend (Mrs Moon).

I am proud to take part in this debate. I, too, favour the Bill. We are thinking about what we would want for our loved ones or, indeed, for ourselves, although, professionally speaking, our personal views are not the prime focus of this debate. In part, I am speaking to bring in a few of my constituents' views.

One constituent who is in favour of the Bill, said:

"I am a nurse and believe everyone has the right to die when they feel it is right for them".

Another constituent spoke to me about his father's death from a brain tumour. He said that his father was, in his words, "fogged by morphine", and he wished that his father had been able to have a more meaningful time with the family. Other constituents have told me of their concerns about the measurement of terminal illness, the pressures in the NHS, the concept of utilitarianism and—as other hon. Members have mentioned—the respect accorded to palliative care. One constituent said:

"Please will you allow these real concerns to be heard in the debate?"

Our duty today is to listen well, think carefully, and clearly explain our decisions.

The current law is unclear and often people are forced to take hidden, undignified and desperate action. Some relatives and loved ones are risking criminal prosecution. Ethical problems exist today, whether for the patient, doctor or family—they are not invented by the Bill. We should aim to bring those dreadful ethical choices into the light, giving people dignity and support. We do not have to make carers risk a murder or manslaughter charge alongside their grief.

Most of all, I believe in a person's right to determine their own life and the manner of ending it, as that is a sovereign principle. We each own our lives and no one else defines that for us. Indeed, that concept is already quite deep within the NHS when we speak of , "No decision about me without me". I also want better palliative care, and I appreciated hearing the factual evidence provided by the National Council for Palliative Care. However, I have concerns about one ethical opinion that was implied among its facts. While explaining that doctors and nurses are

"ill-placed to make judgements on whether a request for assistance to end life prematurely stems from a clear and settled intent"

it stated that such matters are

"better decided by the courts."

Those words forget the one person whose choice it really is—the patient. This is not about forcing someone, or indeed everyone, to do something; this is about ceasing to force an individual to do something that they no longer wish to do, which is to live.

Many make arguments about ethical issues and say that society is what matters, and I say that the human being is what matters most. The Church of England stated in its briefing for this debate that while an individual's sense of personal worth is an "important consideration", it

"cannot take the place of the intrinsic value of every person's life."

In other words, someone else gets to define the value of our life for us.

We all squeal when someone defines a person as worth less than we may think, but the more respectful and free response should be to resist defining a person in any way other than how that person wishes. We should trust people's choices. This debate is not only about an individual's wish to die but about the limits that ought to be placed on others, and the Church has been right to highlight that latter point. In my view, because the drugs in this Bill would only ever be self-administered, that aspect is controlled by what we are scrutinising today. Just as importantly, we should not be criminalising grieving families and friends. This right cannot mutate of its own accord. It is to give a small number of people who are suffering terribly, and their carers, the freedom not to suffer according to their stated wishes.

I cannot walk in everybody's shoes—none of us can—but our job is to listen and to try to empathise and bring those points to the Chamber. The law must allow for different people's positions. It is a matter of compassion, so let us have the courage to do that today.

1.38 pm

Karin Smyth (Bristol South) (Lab):

We all come to the House in our different capacities today, and we have heard some emotional and impressive personal experiences. Our purpose here is as legislators, and as such we cannot continue to turn a blind eye to a situation where people with financial resources can make a choice about how and when they die, and travel to Switzerland, while those without resources cannot. My view has been profoundly influenced by my work as a manager in the national health service. A few years ago I worked on a project with some excellent doctors and nurses who were trying to build, improve and develop their communication skills and those of patients, in order to talk about and get a better understanding of respiratory disease. They were committed to helping patients understand how to live with their disease, and eventually how to die with it.

I learned a huge amount, especially from patients, particularly about how poorly equipped they were to talk about how to die with dignity, and how lonely it be-

comes when it is nobody's role to talk to them about dying. That insight into how little choice and control patients have, as well as the minefield being navigated by our clinicians, opened my eyes to the need for society to open this debate and acknowledge that death is a part of life. We need to end the taboo that surrounds death in our society. It also highlighted to me the need to be more open about how we respond with compassion to the knowledge of imminent and inevitable death.

In subsequent work I have done on end-of-life and palliative care services, I became more aware of the huge variability of service provision. Supporters of the Bill are not opponents of palliative care. In my parliamentary career, I will continue to work for better awareness of the need to talk about death and dying, and for better palliative care and end-of-life services. I am delighted to hear so many Members today speak about the need for better palliative care services, but at a time—this is not a party political point—when we know there will be £22 billion of cuts in our health services, I worry that that is not going to be possible in the next five years.

People who wish to choose the time of their death can do so now, but must rely on Switzerland to manage the consequences. It cannot be right that some of my constituents can afford to go to Switzerland, but the majority cannot. I respect and understand people who are worried about vulnerability, old age and disability, and I respect the concerns about safeguards, but we do deal with many similar issues. As the hon. Member for Reigate (Crispin Blunt) said, many of them would, and should, be considered in Committee. I also respect the reluctance to make what feels like a big decision to take a leap into a new area, but the Rubicon has been crossed, the train has already left the station and Parliament cannot keep turning a blind eye. Our purpose is to establish the principle that terminally ill people can be afforded choice and dignity.

1.41 pm

Kit Malthouse (North West Hampshire) (Con):

I shall keep my remarks short. I did not expect to be pitched, so early in my parliamentary career, into a conflict of morality, philosophy and the mundanity of legislation, but here we are. I have listened very carefully to many of the powerful speeches today, quite a lot of which, I am afraid to say, have been guilty of a cultural romanticisation of death. That is no surprise in a society in which many centuries of art, literature and religion have underlined that romanticism, creating a sense of nobility and grace about death. Even the murder and torture of Christ is referred to as the Passion. The reality for many people, of course, is nothing of the sort. It is anything but noble. The death bed is a place of misery, torture and degradation, a reign of blood, vomit and tears. It is often hard to see the compassion and the beauty in that.

The truth, as the hon. Member for Bristol South (Karin Smyth) said, is that the reality is already here. Doctors are hastening and helping people to their deaths every day. The Liverpool Care Pathway, and what remains of it, was about exactly that. Many people show up at hospital to find that awful acronym DNR hoisted above the bed of their relatives. The machines are turned off on a regular basis. As the hon. and learned Member for Holborn and St Pancras (Keir Starmer) underlined, the Rubicon has already been crossed with regards to compassionate assisted suicide. This is not something from which we in this House can shy away. As the hon. Lady has just said, we already have a business class carriage to a dignified death—if anyone has the money, they can go to Switzerland to achieve it. The reality is here and we should not abrogate our responsibilities to regulate, control or have some view on it.

A number of Members have raised questions about worth. I can understand and respect those with a religious belief who believe that the spark of life, however long and whatever the quality, is worth preserving. I would, however, ask people to question the notion of longevity versus quality. When my wife's sister was in the final throes of breast cancer four years ago, my wife was very frustrated and angered by her unwillingness to participate in clinical trials. She had reached the end of her life and really did not want to prolong what had been an agonising and painful five years. She was focused on the quality of her life rather than on its longevity.

Finally, we have to start at the right end of the telescope in this argument. I am with my hon. Friend the Member for Reigate (Crispin Blunt) and the right hon. Member for North Norfolk (Norman Lamb) in believing we have to start with human rights. If we decide that someone else has dominion over my body when I am in extremis, in pain, in the final months of my life, the argument is settled and everything else becomes rhetorical. If we do not, it is for the House to find solutions to the problems that might emanate from that decision. That is why I will be supporting the Bill into its next stage. We need to have that debate to come to those decisions, if we decide that I have dominion over my body in the final stages of my life.

1.45 pm

Colleen Fletcher (Coventry North East) (Lab):

The Bill deals with the most profound and emotive issues. It was notable that many of those who wrote urging me to support the Bill acknowledged—presumably because they recognised the legal and ethical significance of what they advocated—that I might have concerns about changing the law in this area. They are absolutely right.

I intend to focus my comments on three specific areas, all relating to the inadequacy of the so-called safeguards in the Bill. First and foremost, I am concerned that irrespective of how robust the safeguards are perceived to be, they can never

be completely effective in protecting vulnerable people against undue coercion or duress. Acts of coercion or duress are, by their very nature, exerted opaquely and in a targeted, underhand way, leaving the victim unable or unwilling to speak out for fear of what they perceive the consequences might be, particularly if they are wholly dependent for their care needs on their oppressor. In such circumstances, how are the two registered medical practitioners and the judge able to satisfy themselves that the decision to end life

"has been reached voluntarily, on an informed basis and without coercion or duress"?

Clearly, they cannot. As a result, the Bill does not adequately safeguard against the terminally ill being manipulated by those with an ulterior motive and forced into making a decision that they do not want to take or is not in their best interests.

Secondly, I am concerned that the definition of a terminally ill person for the purposes of the Bill is someone who

"is reasonably expected to die within six months".

It is of course impossible, as experts in end-of-life care will affirm, to know definitively how long a person will live. We are, after all, dealing with a prognosis, which is by definition surrounded by inaccuracy. This has been proven many times before by those who have outlived their prognosis, sometimes by many years. Under the terms of the Bill, we would be asking doctors to make life or death decisions about matters about which there can be absolutely no clinical certainty.

Thirdly and finally, I am concerned that the Bill does not provide adequate safeguards or an appropriate legal framework to establish whether an individual

"has the capacity to make the decision to end his or her own life".

There is no stipulation in the Bill for a mandatory psychological assessment of a patient by a medical practitioner who is registered in the specialty of psychiatry. Instead, the Bill puts the onus for establishing psychological wellbeing and capacity on the attending doctor and the independent doctor, both of whom are principally focused on, and trained to deal with, the state of health rather than the state of mind. With those who request assistance to die, there is an association with clinical depression and hopelessness, and a concern that their capacity to make rational decisions is diminished or impaired as a result.

The Bill does not make such provision and in my opinion cannot therefore be said to contain the appropriate, strong safeguards required. People say that we do not do death well in this country. We need to talk about it, but I do not want this Bill to be the start of that conversation.

1.49 pm

Huw Merriman (Bexhill and Battle) (Con):

I will be voting in favour of the Bill. Having today reached my decision, I want to set out briefly the factors that made the merits of the Bill outweigh my concerns. I have heard it argued that the Bill will not help those who are locked in a coma and are without the capacity to administer their own death. This argument holds true, and I would be unable to vote for the Bill if its scope were so wide, as there would not be enough safeguards. However, the Bill is limited in its applicability.

I have heard it said that this Bill will be subject to a much wider interpretation by the courts than that which I have described. I do not discount that, but I have greater faith in both the wording of the Bill, particularly over the need for the prognosis to be terminal and for death to occur within six months, and in the reluctance of our courts to make law where the drafting is already clear and settled.

I have also heard the argument that enacting the Bill today would make it easier for future Parliaments to amend and broaden the applicability beyond those with terminal illness perhaps to those suffering from mental illness. I hope that that does not occur, but I have grappled with the persuasive argument that if this House opens the door and leaves it ajar, it will make it easier to open the door wide thereafter. If this House failed to legislate on the basis that a future House could broaden legislation, we would never produce laws at all. Ultimately, I concluded that I should make my decision based on the Bill before me, not on a hypothetical draft that may never be read.

The crux of my reasoning, which ultimately allows me to weigh up the arguments and vote in favour of the Bill, is the desire to grant a right to those who may require it and will be impacted by exercising it. This right is not for those who wrote to me, often citing religious reasons why life should not be capable of being ended prematurely. This right is not for those who will see out their final days of a terminal illness and rely on excellent palliative care. Those people would not utilise this law. This Bill is for the smaller number of people who wish to exercise their right to die earlier in their final six months—before they fade away in front of their family, before they enter a desperate period that they feel they cannot face, before they believe they will lose their dignity. It is for those people, with their own individual reasons, that I will cast my vote today to allow them this right.

1.51 pm

Gavin Robinson (Belfast East) (DUP):

As this debate draws close to a close, it is appropriate to commend the right hon. Member for Meriden (Mrs Spelman) for the tone she struck in opposing the Bill at the start of the debate, as well as the Herculean efforts of the hon. Member for

Congleton (Fiona Bruce) in respect of everything that has gone on over recent months.

The most pronounced part of the debate this morning and into this afternoon has been the personal reflections of Members throughout the House. I was touched by those on both sides of the argument—whether it be listening to the hon. Member for Gainsborough (Sir Edward Leigh), or the hon. Members for Newport West (Paul Flynn), for Bridgend (Mrs Moon), for Central Ayrshire (Dr Whitford) or indeed for Poplar and Limehouse (Jim Fitzpatrick). They all touched me, but I have to say that from the outset of this proposal, my heart has been against it.

Although I cannot defend myself to my constituents on the basis of my heart alone, I have taken the time to consider the detailed proposals in the Bill and the plethora of information we have received over the last few months. My head and my heart are therefore at one on this issue.

Clause 1 says that nobody can initiate the process for a patient, but that does not exclude assisted dying becoming part of the panoply of options for a patient, which I think is a failing in the provisions. The figures for Oregon, much referred to today, show that if extrapolated to the UK, 17 people a year would take the prescribed medicine—yet still regain consciousness because their systems would not hold it. What an invidious position the Bill puts medical professionals in. I do not think we should remove those options, with no protection for the patient and no final assessment of capacity after the cooling-off period. The Bill is not appropriate and not proportionate; it does not have my support.

1.53 pm

Mary Robinson (Cheadle) (Con):

It has been a privilege to be here and listen to both sides of the debate, which has been based on personal and moving experience. It has been a wonderful debate. I fully recognise the deeply held moral and practical views and the differences of opinion on this issue, which, although diverging in their approach to assisted dying, acknowledge and respect the responsibility of our society to show compassion.

Good intentions, however, do not always yield good results. Legislation that allows the taking of a life should not do so at the expense of vulnerable people. One of my principal concerns about the Bill remains the possibility that pressure could be put on vulnerable people to request assisted suicide. I am particularly thinking of situations where people may feel an unbearable pressure to commit suicide for fear of becoming a burden on loved ones. One of my constituents wrote to me on this point and I would like to share her comments with the House. She said:

"If I was unable to be independent, I would immediately be under pressure to go. My only daughter is fully employed and I have been a widow for over 50

years—there is no one else I could call on. As soon as I ask help of my daughter, I put pressure on her already-busy life. She would not deliberately wish me out of the way but adding the burden of mother-care would make it very hard for her to cope."

She goes on to say:

"How could I NOT feel under pressure to get out of the way? I would be unable stubbornly to stay alive when I knew I was being the last straw in her busy life."

If this Bill becomes law there would be hundreds, if not thousands, of people who would feel themselves to be in this position.

There is a further difficulty, which is the definition of "reasonable". That has been talked about so I will not go into it again, but I will say the debate on both sides of this issue has been grounded in compassion, but the right to die, although argued for well, is not greater than the right of vulnerable people to live.

1.56 pm

Andy Slaughter (Hammersmith) (Lab):

The Government's position, as set out by Lord Faulks in the Second Reading debate on the predecessor Bill in the other place, is that

"any change in the law in this emotive area is an issue of individual conscience. In our view, it is rightly a matter for Parliament to decide rather than government policy."—[Official Report, House of Lords, 18 July 2014; Vol. 755, c. 919.]

No doubt the Minister will confirm that today. The Opposition also believe that it is a matter for individual conscience, and it is right therefore that Front-Bench comments have been constrained to allow the maximum number of Back-Bench contributions.

We have not yet had 85 speeches, let alone the 133 speeches over 10 hours the other place devoted to the subject last year, but the number and quality of speeches we have heard today leave no doubt that this is a matter of great weight and controversy. We reflect, as we should, the views of our constituents; like, I am sure, all Members, I have had hundreds of representations making a passionate and compelling case on both sides of the argument.

I warmly and sincerely thank my hon. Friend the Member for Wolverhampton South West (Rob Marris) for bringing this issue before the House after 18 years. He has had something of a rollercoaster ride of defeat and victory over the last two elections and he could have chosen a less controversial and easier life. Instead, he is totting up his staffing budget to see whether he can afford the additional assistance to deal with his engorged postbag. His aim, in his own words, is to do better for dying people.

Let me also acknowledge the work of Lord Falconer, who chaired the Commission on Assisted Dying and piloted the predecessor Bill through Second Reading and into Committee in the Lords.

There are many, including some who have spoken today, for whom the principle of assisted dying or the slippery slope argument are the start and end of their consideration. The current Archbishop of Canterbury has said that we are crossing a "legal and moral Rubicon" today, but that side of the argument does not enjoy monopoly support even among archbishops. Lord Carey has said:

"Some people have said on the issue of compassion that actually pain is a noble thing, to bear pain and to say that we are suffering with you is, in my view, a very poor argument indeed.

There is nothing noble about excruciating pain and I think we need as a nation to give people the right to decide their own fate."

Many Members have expressed concern as to the role of the medical profession, saying that there would be a fundamental change in the doctor-patient relationship. Indeed that is an important consideration, but I equally take on board the comments of my hon. and learned Friend the Member for Holborn and St Pancras (Keir Starmer), who says there is currently an inconsistency in the law as a result of his own guidelines. There is an opt-out for medical practitioners, and some would say that that heralds a more mature relationship between doctors and patients. My hon. and learned Friend explained with his customary precision the limits that he was able to achieve even with the excellent guidelines he introduced as Director of Public Prosecutions.

That brings me to my concluding point and, I think, the salient point for us to bear in mind today. Other bodies have tried to address this issue. The Director of Public Prosecutions has tried, as has the Supreme Court. We should bear in mind the words of the President of the Supreme Court, Lord Neuberger, who said that it was

"institutionally inappropriate at this juncture"

for the Court to declare that clause 2 was incompatible with article 8, as opposed to giving Parliament the opportunity to consider the position without a declaration. Lord Sumption referred to the "inherent difficulty" of the question, and to

"the fact that there is much to be said on both sides"—

for making—

"Parliament the proper organ for deciding it."

Without drawing a conclusion on the rightness or wrongness of the Bill, I urge the House to take the same course that the other place took last year, which was not to vote down the Bill at this stage but to allow it to go forward into Committee where these matters could be debated further. That was the cogently ex-

pressed view of a strong opponent of the Bill in the other place, Lord Mackay of Clashfern, who stated:

"I am deeply opposed to the Bill but strongly in favour of it being afforded a Second Reading so that we may have the opportunity to discuss the many vitally important issues that it raises."—[Official Report, House of Lords, 18 July 2014; Vol. 755, c. 778.]

We abdicate our responsibility if, after 18 years, we do not fully discuss these matters in detail and look at the safeguards and the possibilities in the Bill. It is wrong that those of our constituents who can afford to do so have the option to go to Switzerland when others do not have such options. We at least owe them the courtesy of discussing these matters more fully. I personally will support the Bill's Second Reading, but I will be doing so in order to have a stronger, fuller debate.

Robert Flello:

On a point of order, Madam Deputy Speaker. Is it in order for my hon. Friend the Member for Hammersmith (Andy Slaughter) to give his personal views at the Dispatch Box, when he is there in a party position?

Madam Deputy Speaker (Natascha Engel):

The hon. Member for Hammersmith is entitled to say what he likes from the Dispatch Box. It is up to him, and my understanding is that this is a free vote anyway. With that, I call Mike Penning.

2.1 pm

The Minister for Policing, Crime and Criminal Justice (Mike Penning):

It is an honour and a privilege to be standing at the Dispatch Box today as we show the rest of the country and the world what a Parliament should be doing. We have debated this important subject with passion but shown that we all have respect for each other. It is a shame that it has been 18 years since this matter was last debated, and I congratulate the hon. Member for Wolverhampton South West (Rob Marris) on bringing it here today. We have heard some unbelievably passionate speeches.

The House has also shown that it is not just full of lawyers and professional politicians. There are people here who bring experience of their previous professions. Some of them went off to university, some of us went off into the fire service—including me and the hon. Member for Poplar and Limehouse (Jim Fitzpatrick)—and some went into the Army. This debate has shown what we in the Chamber can do when the electorate elect people who are representative of their communities.

It is rare for a Minister to be able to stand at the Dispatch Box and get rid of their ministerial folder, but the Government do not hold a position on this Bill. They will respect the view of the House. That is exactly what happened in the

other place last year, when Lord Falconer made the position quite clear, and the position is quite clear here today. I will therefore speak from the Dispatch Box in a personal capacity, which is also unusual.

When I was 17, I was a young soldier and I had just passed out of training. I got a message from the adjutant that my grandmother had collapsed and that I had been granted compassionate leave because she was terminally ill. People do not get compassionate leave from the armed forces unless the situation is really serious. I went home and Nan was in hospital. She had had a massive stroke and was paralysed from the neck down. I am a man of faith, and that night I prayed that Nan would not make it through the night. She was in great discomfort and she was conscious most of the time. The doctors said they did not think she would make it. She saw me and she cried, as I did.

Nan lived for another 20 years. She was a feisty girl. She smoked 60 a day, which is why she had the stroke, and she had a huge mass on her lungs. She used to cough in a way that I never thought anybody could cough, and she could swear at me when she saw me smoking, even though she smoked 60 a day. The point I am trying to make is that those in the medical profession are simply fantastic people and they do fantastic things for us, day in, day out—we heard much about that from the hon. Member for Central Ayrshire (Dr Whitford), who told us not only about her work, but about the work that has been done in other areas—but they get it wrong, and the will of the human being to decide when it is right for them to go, no matter what pain they are in, is something that we should not take lightly.

Nan was not in pain when she eventually got home. Strokes are horrible things; Nan was bed-bound and my grandfather nursed her for 20 years. Interestingly, I was best man for my grandfather when he remarried at the age of 71, which is also an experience. Sadly, I lost my step-grandmother only a couple of weeks ago, when she was 99. She was just as feisty as Nan, so in many ways he bought silly twice, because she very much ruled the roost.

When Nan was so ill, a group of nurses came in to help her. This was right at the start of the hospice movement, and ever since I have been involved in the hospice movement—I declare that interest. I am patron of the Hospice of St Francis and of Iain Rennie Hospice and Grove House, which are amalgamated under Rennie Grove Hospice Care. The Peace Hospice, just outside my constituency, does fantastic work, and Keech Hospice, a children's hospice in Luton which looks after terminally ill children in my constituency, also does fantastic work.

My reasons for voting against this Bill this afternoon are twofold. First, I do not think it should be an excuse that we cannot control pain in the 21st century for people who are so ill. Secondly, I am, frankly, against suicide. I have been to too many suicides, as has the hon. Member for Poplar and Limehouse, where we

have seen the aftermath. People who wish to commit suicide need help—we should help them, not assist in killing them.

Jonathan Reynolds:

claimed to move the closure (Standing Order No. 36).

Question put forthwith, That the Question be now put.

Question agreed to.

Question put accordingly, That the Bill be now read a Second time.

The House proceeded to a Division.

Mr Nigel Evans:

On a point of order, Madam Deputy Speaker. Some Members will have sat throughout the debate today and will have decided that they will not register a vote as they cannot make up their minds. Will you confirm that outside of voting in both Lobbies, which is strongly discouraged, there is no way that a Member of Parliament can register an abstention following a debate?

Madam Deputy Speaker (Natascha Engel):

It is indeed the case that voting in both Lobbies is discouraged, so it is not possible to register an abstention. I thank the hon. Gentleman for making that point and putting it on the record.

The House having divided: Ayes 118, Noes 330.

Division No. 69][2.7 pm

**AYES**

- Allan, Lucy
- Allen, Mr Graham
- Bailey, Mr Adrian
- Barron, rh Kevin
- Barwell, Gavin
- Benn, rh Hilary
- Betts, Mr Clive
- Bingham, Andrew
- Blackman, Kirsty
- Blomfield, Paul
- Blunt, Crispin
- Brake, rh Tom
- Brown, Alan
- Brown, rh Mr Nicholas
- Buck, Ms Karen
- Burden, Richard
- Cadbury, Ruth
- Carmichael, rh Mr Alistair
- Champion, Sarah
- Clark, rh Greg
- Coffey, Ann
- Cowan, Ronnie
- Cox, Jo
- Creasy, Stella
- Crouch, Tracey
- David, Wayne
- Davies, Geraint
- Donaldson, Stuart
- Eagle, Ms Angela
- Eagle, Maria
- Fitzpatrick, Jim
- Flint, rh Caroline
- Flynn, Paul
- Foxcroft, Vicky

- Frazer, Lucy
- Gibb, Mr Nick
- Godsiff, Mr Roger
- Goldsmith, Zac
- Goodman, Helen
- Green, Kate
- Greenwood, Lilian
- Haigh, Louise
- Harman, rh Ms Harriet
- Harris, Carolyn
- Heaton-Jones, Peter
- Hodge, rh Dame Margaret
- Hollinrake, Kevin
- Hopkins, Kelvin
- Howarth, rh Mr George
- Huq, Dr Rupa
- Jenrick, Robert
- Johnson, Joseph
- Kendall, Liz
- Kerevan, George
- Kerr, Calum
- Kinnock, Stephen
- Kyle, Peter
- Lamb, rh Norman
- Law, Chris
- Lewis, Clive
- Lucas, Caroline
- Lynch, Holly
- Malthouse, Kit
- Mann, John
- Mann, Scott
- Marris, Rob
- Mathias, Dr Tania
- McCaig, Callum
- McCarthy, Kerry
- McDonald, Stewart Malcolm
- McFadden, rh Mr Pat
- Merriman, Huw
- Miliband, rh Edward
- Mills, Nigel
- Mitchell, rh Mr Andrew
- Monaghan, Dr Paul
- Moon, Mrs Madeleine
- Mullin, Roger
- Murray, Ian
- Nicolson, John
- Onn, Melanie
- Opperman, Guy
- Pennycook, Matthew
- Perry, Claire
- Phillips, Jess
- Philp, Chris
- Powell, Lucy
- Reed, Mr Jamie
- Rees, Christina
- Reynolds, Emma
- Robinson, Mr Geoffrey
- Scully, Paul
- Sheppard, Tommy
- Sherriff, Paula
- Siddiq, Tulip
- Slaughter, Andy
- Smith, Cat
- Smith, Chloe
- Smith, Jeff
- Smith, Owen
- Smyth, Karin
- Soubry, rh Anna
- Starmer, Keir
- Stevens, Jo
- Streeting, Wes
- Stride, Mel
- Turley, Anna
- Turner, Karl
- Twigg, Stephen
- Umunna, Mr Chuka
- Warman, Matt
- West, Catherine
- Wilson, Corri
- Wilson, Phil
- Winnick, Mr David
- Winterton, rh Ms Rosie
- Wright, Mr Iain
- Zeichner, Daniel

Tellers for the Ayes:

- Heidi Alexander

and

- Nusrat Ghani

**NOES**

- Abrahams, Debbie
- Aldous, Peter
- Ali, Rushanara
- Amess, Sir David
- Anderson, Mr David
- Andrew, Stuart
- Ansell, Caroline
- Argar, Edward
- Arkless, Richard
- Ashworth, Jonathan
- Bacon, Mr Richard
- Baker, Mr Steve
- Baldwin, Harriett
- Barclay, Stephen
- Bebb, Guto
- Bellingham, Mr Henry
- Benyon, Richard
- Berry, Jake
- Berry, James
- Blackford, Ian
- Blackman, Bob
- Blackwood, Nicola
- Blenkinsop, Tom
- Bone, Mr Peter
- Borwick, Victoria
- Bottomley, Sir Peter
- Bradley, Karen
- Brady, Mr Graham
- Brazier, Mr Julian
- Bridgen, Andrew
- Brine, Steve
- Brokenshire, rh James
- Brown, Lyn
- Bruce, Fiona
- Bryant, Chris
- Buckland, Robert
- Burgon, Richard
- Burns, Conor
- Burns, rh Sir Simon
- Burrowes, Mr David
- Butler, Dawn
- Cairns, Alun
- Cameron, Dr Lisa
- Campbell, rh Mr Alan
- Campbell, Mr Gregory
- Carmichael, Neil
- Carswell, Mr Douglas
- Cartlidge, James
- Cash, Sir William
- Caulfield, Maria
- Chalk, Alex
- Chishti, Rehman
- Chope, Mr Christopher
- Churchill, Jo
- Clarke, rh Mr Kenneth
- Clegg, rh Mr Nick
- Cleverly, James
- Clifton-Brown, Geoffrey
- Clwyd, rh Ann
- Coffey, Dr Thérèse
- Colvile, Oliver
- Cooper, Rosie
- Costa, Alberto
- Cox, Mr Geoffrey
- Coyle, Neil
- Crabb, rh Stephen
- Crausby, Mr David
- Creagh, Mary
- Cruddas, Jon
- Cummins, Judith
- Cunningham, Mr Jim
- Davies, Byron
- Davies, Chris
- Davies, David T. C.
- Davies, Glyn
- Davies, Dr James

- Davies, Mims
- Davies, Philip
- Dodds, rh Mr Nigel
- Donaldson, rh Mr Jeffrey M.
- Donelan, Michelle
- Dorries, Nadine
- Double, Steve
- Doughty, Stephen
- Dowd, Jim
- Dowd, Peter
- Doyle-Price, Jackie
- Drummond, Mrs Flick
- Duncan Smith, rh Mr Iain
- Durkan, Mark
- Efford, Clive
- Elliott, Julie
- Elliott, Tom
- Ellis, Michael
- Ellison, Jane
- Elphicke, Charlie
- Esterson, Bill
- Eustice, George
- Evans, Chris
- Evans, Graham
- Evans, Mr Nigel
- Evennett, rh Mr David
- Fallon, rh Michael
- Fellows, Marion
- Fernandes, Suella
- Ferrier, Margaret
- Field, rh Frank
- Field, rh Mark
- Flello, Robert
- Fletcher, Colleen
- Foster, Kevin
- Fox, rh Dr Liam
- Francois, rh Mr Mark
- Freeman, George
- Fuller, Richard
- Fysh, Marcus
- Gale, Sir Roger
- Gardiner, Barry
- Garnier, rh Sir Edward
- Gillan, rh Mrs Cheryl
- Glass, Pat
- Glen, John
- Glindon, Mary
- Goodwill, Mr Robert
- Gove, rh Michael
- Grady, Patrick
- Gray, Mr James
- Grayling, rh Chris
- Green, Chris
- Green, rh Damian
- Greening, rh Justine
- Greenwood, Margaret
- Grieve, rh Mr Dominic
- Griffith, Nia
- Griffiths, Andrew
- Gummer, Ben
- Gyimah, Mr Sam
- Halfon, rh Robert
- Hall, Luke
- Hammond, Stephen
- Hands, rh Greg
- Hanson, rh Mr David
- Harper, rh Mr Mark
- Haselhurst, rh Sir Alan
- Hayes, Helen
- Hayes, rh Mr John
- Hayman, Sue
- Heald, Sir Oliver
- Heappey, James
- Hepburn, Mr Stephen
- Herbert, rh Nick
- Hermon, Lady
- Hillier, Meg
- Hinds, Damian
- Hoare, Simon
- Hodgson, Mrs Sharon
- Hoey, Kate
- Hollobone, Mr Philip
- Holloway, Mr Adam
- Hopkins, Kris
- Howlett, Ben
- Hunt, rh Mr Jeremy

- Huq, Dr Rupa
- Hussain, Imran
- Jackson, Mr Stewart
- James, Margot
- Jayawardena, Mr Ranil
- Jenkin, Mr Bernard
- Jenkyns, Andrea
- Johnson, rh Alan
- Johnson, Boris
- Johnson, Gareth
- Jones, Andrew
- Jones, rh Mr David
- Jones, Gerald
- Jones, Helen
- Jones, Mr Marcus
- Jones, Susan Elan
- Kane, Mike
- Kaufman, rh Sir Gerald
- Keeley, Barbara
- Kennedy, Seema
- Kirby, Simon
- Knight, rh Sir Greg
- Knight, Julian
- Lammy, rh Mr David
- Lancaster, Mark
- Leadsom, Andrea
- Lee, Dr Phillip
- Lefroy, Jeremy
- Leigh, Sir Edward
- Letwin, rh Mr Oliver
- Lewell-Buck, Mrs Emma
- Lewis, Mr Ivan
- Lewis, rh Dr Julian
- Lidington, rh Mr David
- Long Bailey, Rebecca
- Loughton, Tim
- Lucas, Ian C.
- Mackintosh, David
- Madders, Justin
- Mahmood, Shabana
- Main, Mrs Anne
- Mak, Mr Alan
- Malhotra, Seema
- Marsden, Mr Gordon
- Maskell, Rachael
- Matheson, Christian
- May, rh Mrs Theresa
- Maynard, Paul
- McCabe, Steve
- McCartney, Karl
- McDonagh, Siobhain
- McDonald, Andy
- McDonnell, Dr Alasdair
- McGinn, Conor
- McInnes, Liz
- McKinnell, Catherine
- McLoughlin, rh Mr Patrick
- McPartland, Stephen
- Menzies, Mark
- Mercer, Johnny
- Metcalfe, Stephen
- Miller, rh Mrs Maria
- Milling, Amanda
- Milton, rh Anne
- Monaghan, Carol
- Morris, Grahame M.
- Morris, James
- Morton, Wendy
- Mundell, rh David
- Murrison, Dr Andrew
- Newlands, Gavin
- Newton, Sarah
- Nokes, Caroline
- Nuttall, Mr David
- O'Hara, Brendan
- Offord, Dr Matthew
- Osamor, Kate
- Owen, Albert
- Paisley, Ian
- Parish, Neil
- Paterson, rh Mr Owen
- Pawsey, Mark
- Pearce, Teresa
- Penning, rh Mike
- Percy, Andrew
- Perkins, Toby

- Phillips, Stephen
- Phillipson, Bridget
- Pickles, rh Sir Eric
- Pincher, Christopher
- Pound, Stephen
- Pow, Rebecca
- Prentis, Victoria
- Prisk, Mr Mark
- Pugh, John
- Pursglove, Tom
- Quin, Jeremy
- Quince, Will
- Qureshi, Yasmin
- Rayner, Angela
- Redwood, rh John
- Rees-Mogg, Mr Jacob
- Reynolds, Jonathan
- Rimmer, Marie
- Ritchie, Ms Margaret
- Robertson, Mr Laurence
- Robinson, Gavin
- Robinson, Mary
- Rutley, David
- Sandbach, Antoinette
- Selous, Andrew
- Shannon, Jim
- Sharma, Mr Virendra
- Sheerman, Mr Barry
- Shelbrooke, Alec
- Shuker, Mr Gavin
- Simpson, David
- Simpson, rh Mr Keith
- Skinner, Mr Dennis
- Smith, rh Mr Andrew
- Smith, Julian
- Smith, Royston
- Soames, rh Sir Nicholas
- Solloway, Amanda
- Spellar, rh Mr John
- Spelman, rh Mrs Caroline
- Stephens, Chris
- Stewart, Bob
- Stewart, Iain
- Streeter, Mr Gary
- Stringer, Graham
- Stuart, Ms Gisela
- Swayne, rh Mr Desmond
- Syms, Mr Robert
- Tami, Mark
- Thomas, Derek
- Thomas-Symonds, Nick
- Throup, Maggie
- Timms, rh Stephen
- Tolhurst, Kelly
- Tomlinson, Michael
- Tracey, Craig
- Trevelyan, Mrs Anne-Marie
- Tugendhat, Tom
- Turner, Mr Andrew
- Twigg, Derek
- Vaizey, Mr Edward
- Vara, Mr Shailesh
- Vaz, rh Keith
- Vaz, Valerie
- Vickers, Martin
- Villiers, rh Mrs Theresa
- Walker, Mr Robin
- Wallace, Mr Ben
- Warburton, David
- Wharton, James
- Whately, Helen
- Whitford, Dr Philippa
- Williams, Craig
- Williams, Mr Mark
- Williamson, rh Gavin
- Wilson, Mr Rob
- Wilson, Sammy
- Wollaston, Dr Sarah
- Wood, Mike
- Woodcock, John
- Wragg, William
- Wright, rh Jeremy

Tellers for the Noes:

- Joan Ryan

and

- Mr Charles Walker

Question accordingly negatived.