

Assisted Dying for the Terminally Ill Bill: Select Committee Report

3.9 pm

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

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

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

The Bill introduced by the noble Lord, Lord Joffe, which lapsed with the dissolution of Parliament in April this year, sought to provide medical assistance with suicide to adults who had been diagnosed as terminally ill with a few months to live, were suffering unbearably and wished to end their life prematurely. Effectively, it would have authorised a doctor to write a prescription for lethal medication that it would then be up to the patient to take—or not, should he or she have a change of heart. In the case of people whose physical condition was such that they could not use such medication, the Bill provided that a doctor might administer a lethal drug to the patient at his or her request.

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

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

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

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

We considered whether there were good grounds for believing that changing the law to allow medical assistance with suicide or voluntary euthanasia was tantamount to stepping on to a slippery slope, with any new law becoming more widely applied than

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Parliament intended and with medical practice undergoing a subtle but significant shift as a result. As in so many areas of the debate, we heard arguments in both directions. On the one side, it was argued that there was no hard evidence of "slippery slopes" in countries that had legalised such acts or of people other than those for whom the law was designed being drawn into assistance with suicide or euthanasia through subtle external pressures; and, on the other side, it was argued that the Abortion Act 1967, which is perhaps the nearest parallel to a law of this nature, had produced an unintended situation of abortion on demand; that the Bill was seen, as the noble Lord, Lord Joffe, told us, as simply a first stage in relaxing the law; and that in Holland there were already pressures, three years after the passing of the law permitting euthanasia, to extend its provisions to new categories of people.

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

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

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

So what conclusions did we come to after all this work? As I said, there was no consensus in the committee on the acceptability of the Bill introduced by the noble Lord, Lord Joffe. Therefore, bearing in mind that because a Dissolution of Parliament was in prospect the Bill would be unable to proceed, we agreed to present a report that summarised the

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evidence that we had heard in such a way as to avoid drawing conclusions and provided a readable and intelligible guide to the subject. In that way, we hoped to provide a basis for a reasoned debate in the House and for the development of informed opinion in the country as a whole. I hope that the House will agree that, although we did not succeed in coming to clear conclusions on the Bill itself, we succeeded in that respect at least.

As for the future, we recommended that the House should debate the subject again at an early opportunity in the light of our report, and that is why we are here today. We also felt that, in the event that another Bill was introduced, its author should take account of a number of concerns that had been raised with us in the course of our inquiry. The first and perhaps the most important is the need to draw a clear distinction between assistance with suicide and voluntary euthanasia. We recognised in our report that, while the most careful attention must be paid to the views of the professions that would be in the front line of implementing any change in the law, a decision on whether assistance with suicide or voluntary euthanasia should be legalised was one for society as a whole to take through its legislators in Parliament and that we should give due weight in that process to public opinion. However, we also recognised the corollary: there is a need to look behind the results of opinion polls in order to ascertain the extent to which the views expressed are based on informed opinion and, if we are to avoid the risk of damage to the ethics of a profession that is vital to all our needs and that is—not wholly, but largely—opposed to a change in the law, we must consider how best the implementation of any change might be managed. We also felt that the qualifying conditions that appeared in the Bill introduced by the noble Lord, Lord Joffe, would need to be revisited in any future Bill.

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

prosecution. If a prosecution is successful, the court must consider whether a custodial sentence or some other sentence is called for. That flexibility in our law was recognised recently and commended by the European Court of Human Rights.

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In the circumstances, as chairman of the committee, I have refrained from expressing a personal opinion, either in the committee or in the House; and I do not propose to express any such opinion now. We have tried to produce a report on which all the committee could agree as a basis for today's debate.

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

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

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

3.21 pm

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

In my view, three key recommendations were made by the committee. First, if a Bill similar in nature to the existing Bill were introduced, it should, following a Second Reading, be sent to a Committee of the Whole House for examination. Secondly, while the most careful account must be taken of expert evidence, at the end of the day the acceptability of assisted suicide or voluntary euthanasia is an issue for society to decide through its legislators in Parliament. The evidence to the committee was of an apparent groundswell of public agreement with the concept of euthanasia and a shift from opposition by many professionals.

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

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

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

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

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

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

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I realise that I am fast approaching the end of the recommended time for speeches. However, I have been advised by experienced Members of your Lordships' House that, as it is my Bill which is the subject of the committee's report, it would not be unreasonable for me to talk a few minutes longer. I hope that your Lordships will bear with me as this is not a timed debate.

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

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

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

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

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

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

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naturally, will consider all the matters raised in the Select Committee report, the speeches that are made in this debate and any other feedback that I receive.

In conclusion, the Select Committee report recommended that in any future Bill a clear distinction should be drawn between assisted dying and voluntary euthanasia. Having discussed this recommendation with seven of the 13 members of the committee—a

majority—I established that all seven would support the principle of a Bill which limited its application to assisted suicide where the patient takes responsibility for the final stage of ending his or her life. Extrapolating from experience in Oregon, that would be likely to result in about 650 deaths a year. Accordingly, I am minded to recast the new Bill to provide only for assisted dying. I will make a final decision after considering what is said in this debate.

3.31 pm

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

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

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

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

If the law changed, the extent or compass of euthanasia would change. The noble Lord, Lord Joffe, and others have made it clear that this Bill is only a first stage. The logical extension of the argument can be found in Appendix 6 of the report, which is the Euthanasia Statement of the Dutch NVVE. It sets out the Criterion for requesting euthanasia. The medical

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conditions that would come within the Criterion are quadriplegia, dementia, blindness and/or deafness, motor neurone disease, multiple sclerosis and other crippling but non-terminal conditions. I am not exaggerating when I say that there are many older and disabled people who are genuinely fearful of the change in the attitude of society towards them if assisted dying is legalised.

One aspect of disability is rarely mentioned. There is an unspoken fear, except to each other, among parents of disabled children, whatever the age of the children may be. They ask, "What will happen if we die first? Who will take life and death decisions if we are not there?". Last week, at the RADAR conference which debated assisted dying, one mother described the concern expressed by her son who had a progressive and terminal condition that

stretched over 30 years until he died. He required 24-hour care for most of his life. When he died he was fully competent, but, for a long time, had been concerned about the burden that he placed on his parents. Of course, they were there to reassure him.

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

I turn to what may seem to be a technical point, but is very important. The noble Lord, Lord Joffe, has indicated that he would amend his Bill to exclude Scotland. This would raise exactly the same dilemma that faced the Government when considering whether abortion should be a reserved or devolved matter in the Scotland Act. It was reserved to the Westminster Parliament on the ground that it would not be in the best interests of society to have different regimes for abortion in the two countries. The same argument applies to euthanasia. We have heard of suicide tourists to Switzerland. I imagine that we would not wish to have suicide tourists crossing Hadrian's Wall.

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

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

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

In conclusion, I have one important question about the progress of the Bill that I wish to put to the Minister and about which I have given him notice. We all know that Private Member's Bills which start out in

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this House have no chance in practical terms of reaching the statute book unless the Government co-operate over the allocation of time when the Bill reaches the Commons. If the Bill the noble Lord, Lord Joffe, intends to introduce is agreed to by this House—and that is by no means certain—and it does reach the Commons, will the Government help to find time for it there? I am sure that noble Lords will agree that the attitude to the Bill of this House as it passes through its various stages would certainly be influenced by knowing whether, to put it bluntly, it is going nowhere or whether it has a chance of reaching the statute book.

3.37 pm

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

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

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

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

One of the aspects of the Bill—to which the noble Lord, Lord Carter, referred—which I found unsatisfactory was the lack of attention paid to the role

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of nurses in end-of-life care. Their role might need more recognition in a new Bill. The evidence from Oregon and the Netherlands does not suggest that nurse-patient relationships have been damaged or changed by legislation in those countries.

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

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

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

My last point is a simple one. The Bill considered by the committee forces no one who disapproves of it to take advantage of it. Experience elsewhere suggests that not many people would take advantage, but it does give some people in specified and desperate circumstances the freedom to choose to die, even if they are not able to commit suicide unassisted.

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I hope that the House agrees the Motion before us today and that, in due course, we may return to debate a new Bill which will change the law. I would prefer that the Bill contain provision for both assisted suicide and voluntary euthanasia, if only to test the opinion of the House of Commons and to make it think as hard as we have thought on these matters. It is time for Parliament to face up to these issues.

3.44 pm

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

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

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

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

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

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

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

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

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

The report ends with an interesting warning:

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

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

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

It goes on to say that the Oregon health department,

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

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

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

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

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

Let us be crystal clear about what "assisted dying" really involves. It is not giving a little more morphine or sedative so the patient can relax and let go of life. No, it is a massive overdose of barbiturates—50 times the therapeutic dose—and, in the case of euthanasia, the Dutch protocol advises an injection of curare to paralyse the patient completely to prevent breathing.

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Where the overdose is taken by mouth, as in Oregon's assisted suicides, those who ingest it sometimes do not die for more than 30 hours and a few even wake up again.

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

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

3.51 pm

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

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

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

I remind the House of what the noble and learned Lord, Lord Mackay of Clashfern, said:

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

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

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

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

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

I shall briefly address some of the concerns of palliative care which the noble Baroness, Lady Finlay, has just raised. I believe that doctors in her specialty remain more adamantly opposed to the change in the law than many of their colleagues. I shall précis their arguments, again in headline terms. They argue—and the noble Baroness argued this most articulately throughout our hearings—that their specialist services can solve all the concerns of a dying person and therefore remove the need for assisted suicide or voluntary euthanasia.

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

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

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

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

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

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

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my noble friend Lord Carter in asking the Minister to receive this report favourably and for the Government to give the Bill a fair wind.

3.57 pm

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

Your Lordships will well remember the arguments when the Abortion Bill 1967, known as the Steel Bill, was first debated in another place—that it would affect very few people, that there would be very strict conditions, and so on. The exact opposite has turned out to be the case, with more than 5 million deaths of pre-born children since 1967. So, too, the arguments in Holland and Oregon over euthanasia and assisted dying have run. Once the laws have been passed, contrary to the stated aims of those legislators when the legislation was debated, the

recognised duration of terminal illness has been unofficially extended, according to evidence of which I have been made aware. New reasons, such as dependency or isolation, have been introduced and then accepted as reasons for legitimately offering people the opportunity to hasten their own death.

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

"Without protection, people cannot exercise true autonomy".

I say "hear, hear" to that.

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

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way—who does not recognise that the exercise of personal autonomy always has to be limited, if only to some extent, to enable us to live together in reasonable harmony.

Baroness O'Neill of Bengarve: My Lords—

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

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

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

That brings me to my third point, which is the need not to destroy our trust in the medical profession, for patient autonomy can oh so quickly give way to medical and to state power. I trust my medical advisers, at least at present. I think that they will never harm me and that they will do their best, although, of course, everyone is fallible and mistakes can be made. However, that trust comes about not because of my belief that doctors have some superior

moral quality but because of their tradition of doing no harm, held by those of faith and of no faith. In the face of that, and with great respect to the Select Committee, I would have wished that the committee, which quite properly considered the conscientious objections of doctors and nurses, had addressed the conscientious objections of patients and the rights of patients to know about the attitudes of their doctors. That is an oversight. Should the Bill of the noble Lord, Lord Joffe, reach the statute book in some form, we would *de facto* have to make provision for patients who wished to know what kind of doctor was going to treat them: a doctor who cared to preserve life and a doctor who, in shorthand—or in "headline terms", to borrow the excellent phrase of the noble Baroness, Lady Jay—was really a "vet" doctor prepared to take part in the end of life. There would need to be separate training, and separate registers of the two classes of doctors would have to be made public. The Select Committee might have usefully considered a little more the pragmatic and conscientious feelings of patients themselves as well as those of doctors.

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

Finally, I admire no one more than the long-running Minister who will reply to the debate at about midnight. I have a couple of questions for him, as I have sensed a certain amount of news management in

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

4.4 pm

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

The Council of Europe report was presented by a Swiss called Dick Marty. It did not recommend euthanasia, but recommended that in all member states a debate should be opened to consider how best to approach a very real, deep problem, which at the moment in

most countries is unregulated or covered up. The *rapporteur* said that he was especially pleased that his report was supported by the international committee of nursing staff in the European Union.

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

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

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

Baroness Knight of Collingtree: My Lords, while the noble Lord is talking about that particular debate, he should tell the House that the Council of Europe turned down the Marty report.

Lord Russell-Johnston: My Lords, I shall come to that. Noble Lords might like to know that those opposing the report put down 50 amendments about two days beforehand as a blocking measure, the like of which had never been seen before. I am quoting from Erik Jurgens, who said:

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

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

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

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

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

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

4.10 pm

The Lord Bishop of St Albans: My Lords, I had the privilege of being a member of the Select Committee and, with other members, I put on record my gratitude, particularly to the noble and learned Lord, Lord Mackay of Clashfern, who chaired us with remarkable and judicious fairness and wise good

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humour. As a committee, we were all agreed about one thing—that no one should suffer unbearably. We all recognised that, in circumstances where someone is suffering unbearably towards the end of their life, we would want medicine to intervene. But it was at that point that some of us parted company.

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

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

would be required, if logic has anything to do with it, to offer you a series of options—palliative care, euthanasia or assisted suicide. Just thinking about it is chilling. To call that a therapeutic option, as some proponents have done, is to see language and values twisted out of all recognition.

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

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that capital punishment should be back on the statute book. If not that, why this? It seems to be special pleading.

Thirdly, whose autonomy would be exercised here? If you imagine someone, as we leave this Chamber, about to jump off Westminster Bridge, would we not all automatically seek to prevent them doing so? Then we would all be intervening, and rightly so. But what about the patient who wants to commit suicide and we agree to that? Surely, we are making a value judgment between two people who are suicidal. We are saying to the person who wants to jump off the bridge, "Your life is of enormous value", but to the one that does not, "Actually, we agree with you". The minute you say that, you are then influencing their autonomous decision.

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