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 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.

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