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The Terminally Ill Adults (End of Life) Bill was defeated 286-270 on 11 September 2026. Liz Kendall, the former technology secretary and a supporter of the Bill, states that it was needed “to give people the dignity, respect, choice and control over how, where, and when they die”.

It is 25 years since I entered nursing school and I have been at the bedside during many last days and final hours. It is my *professional duty*, written on the first page of the [Nursing Code](#) [2], to uphold dignity and to treat each and every patient with respect; no Act of Parliament is needed for this. The Mental Capacity Act, meanwhile, ensures that patients make choices and have control over their care to the fullest possible extent. To me as a nurse, the Bill sought to give a “licence to kill” - in the words of former Prime Minister Baroness Theresa May. It was asking clinical staff to assist suicide and was disrespectfully forgetting the role that healthcare workers, across the centuries, have played in assisting the dying patient, through physical, psychosocial and spiritual care.

Control and choice

In the dying patient, end of life medications such as morphine, midazolam and hyoscine are commonly prescribed to manage pain, anxiety, agitation, nausea and vomiting, and noisy breathing – giving some control over *how* a patient dies. It has taken years of nursing for me to learn how best to calculate and combine these drugs and their dosages, within prescribed ranges, to control symptoms. Rob George, London Consultant in Palliative Medicine, describes how [correct use](#) [3] of these drugs can allow patients to “be comfortable and able to live with dignity until they die”, and I’ve seen them do just that. In very rare cases, pain remains intractable, and death does not come easily. [Personalised medicine](#) [4] is an emerging area of research that tailors treatments to a person’s genetic make-up, environment and lifestyle. With time, renewed focus and increased funding, advances in drug treatment will surely continue.

The now-defeated End of Life Bill boasted of drugs (their names, interestingly, never publicly detailed or described) which would go a step further still and [control the timing](#) [5] of someone’s death, coming within hours of the fatal dose. But at what cost? My fear is that this desire for control could carry a risk. Death sometimes advances slowly, and I’ve seen families wait for days for the final breath. Might the sick have sought assisted suicide to speed things up for everyone else? Even then, there’s no guarantee of a quick exit. (Oregon recorded its most [prolonged](#)

[assisted death](#) [6] to date in 2023, at 137 hours.) Too often, I've seen family members who want more control than is realistic, or, with the defeat of the Bill, allowed.

Nurses can though ensure that voices are heard, and that choices are made, by the dying person. Do not attempt resuscitation orders are discussed soon after admission, where appropriate, with the process often viewed as invasive and futile in the dying person, and the order offering some protection from a procedure that is unwanted, unlikely to succeed, and where harm may outweigh benefit. Patients generally don't seek life at all costs but make an informed decision.

Control also comes through advance care planning, and I was assigned this role for local care homes during the Covid pandemic. Much more than a set of tick boxes where choices are mechanically made, advance care planning is the compassionate, collaborative, co-creation of a shared narrative between nurse and patient. [NHS England](#) [7] describes it as "a voluntary process of person-centred discussion between an individual and their care providers about their preferences and priorities for their future care". It goes beyond decisions around resuscitation, to include thoughts on whether or not to accept antibiotics (or instead allow an infection to take its course), where the person would prefer to die and, in the broadest possible terms, "what matters most" to the patient in their ongoing, and final, care.

Dignity and respect

Diagnosing dying is a combination of science and art, and nobody has mastered it. The Bill required patients to have less than six months to live; I've never been able to predict anything near as long as that. For some, death has come like a thief in the night; for many more, life has lasted long after it was thought it should. It can though sometimes be possible to predict final days or hours, and it's then that we nurses chart a careful course, feeling as if we are watching a small ship make its final voyage. We watch and wait, and when 'storms' buffet the sails through breakthrough pain, distress or indignity, we act quietly and calmly in response. We top up pain relief and gently reposition the resident on their air mattress; we plump up pillows, provide soothing mouth care, hold a hand, stroke a brow, and whisper words of reassurance or play a favourite song. We call in the family, or sit quietly with them so that they are not alone. These are the incredibly important small things that sit at the very heart of nursing.

I will always remember the resident who died unexpectedly over a matter of minutes in front of our care team and the attending paramedics. Realising at high speed that death was snatching the possibility of this lady being saved, and with family not yet present, a calm paramedic declared that the only treatment plan would be to transfer the lady from the dining room floor, where she had collapsed, to her bed for a final act of dignity. We did it together with broken hearts and beautiful compassion.

Healthcare has over-medicalised death and dying, making reaching for the death-drugs of assisted suicide a logical conclusion when life-sustaining drugs and treatments no longer work. But there's a different perspective, a different approach, which arrives at a different answer at the end of life. It's one that, in the words of the [Lancet Commission on the Value of Death](#) [8], rethinks death as "a relational and spiritual process rather than simply a physiological event"; it recognises the crucial role that families and communities play in dying, alongside doctors. When death and dying are seen in this way, space is created for something other than medically-assisted suicide:

"Caring for the dying really involves infusing meaning into the time left. It is a time for achieving physical comfort; for coming to acceptance and making peace with oneself; for many hugs; for repairing broken bridges of relationships and for building new ones. It is a time for giving love and receiving love, with dignity." *

The Commission commends [Kerala, India](#) [9], as a place where care of the dying is led by the community, with support from health professionals, rather than the other way round. The global benchmark is for whole communities, and not just nurses, to assist dying.

The Commission also recognises death as a spiritual process, and as a nurse I have seen patients reach for something beyond the seen as they die.

Supporters of the End of Life Bill called passionately for dignity, choice and control in death. Christians believe that inextinguishable dignity, and intrinsic human value, come from being made in God's image and likeness; peace comes from knowing that their days are numbered by Him who knows best. Most precious of all is the famous

Psalm of the good Shepherd, which tells that, though each will walk the valley of the shadow of death, they will fear no evil, for God Himself will walk with them.

*Commission co-author Dr MR Rajagopal.



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