HOUSE OF LORDS

Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence

Wednesday 22 October 2025

11.35 am

Watch the meeting

Members present: Lord Hope of Craighead (The Chair); Baroness Berger; Baroness Berridge; Baroness Finlay of Llandaff; Lord Goddard of Stockport; Lord Goodman of Wycombe; Lord Markham; The Lord Bishop of Newcastle; Lord Patel; Baroness Scotland of Asthal; Baroness Smith of Newnham; Lord Winston.

Evidence Session No. 2 Heard in Public Questions 14 - 28

Witnesses

I: Professor Mumtaz Patel, President, Royal College of Physicians; Professor Nicola Ranger, General Secretary and Chief Executive, Royal College of Nursing; Dr Michael Mulholland, Honorary Secretary, Royal College of General Practitioners.

Examination of witnesses

Professor Mumtaz Patel, Professor Nicola Ranger and Dr Michael Mulholland.

Q14 **The Chair:** Welcome to the second session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined in this session by Dr Michael Mulholland, Professor Mumtaz Patel and Professor Nicola Ranger. You are all very welcome and we look forward to your evidence. We would be grateful if you could introduce yourselves briefly in a moment the first time you speak. Today's meeting is being broadcast and a verbatim transcript will be taken for subsequent publication. It will be sent to you for you to check and we would be grateful if you would draw attention to any errors you may find. I refer again to the list of Members' interests, as published on the committee's website. I wonder whether, Dr Mulholland, you would like to say who you are and what your position is, very briefly, please.

Dr Michael Mulholland: I am a GP in Buckinghamshire, where I have been a GP partner for 28 years now, I think. I am here on behalf of the Royal College of GPs, the membership organisation for 54,000 GPs in the country. I am the honorary secretary and lead on clinical policy, and have been leading our work on the assisted dying Bill.

Professor Mumtaz Patel: Hello. I am a consultant nephrologist by trade. I have worked in Manchester for many years and for the Royal College of Physicians. I am the president of the royal college. Our college is one of the largest medical royal colleges, with a membership of around 40,000 across 30 medical specialties. It is good to be here.

Professor Nicola Ranger: I am the general secretary and chief executive of the Royal College of Nursing, which is both a royal college and a trade union. We represent over half a million nurses, nursing support workers and nursing associates. Prior to that post, I have been a chief nurse in hospitals for the past 10 years. My last clinical post was at King's College Hospital in south London, where I was the chief nurse through the pandemic.

The Chair: Unless you would like to say anything else, I think the simplest thing is for us to proceed straightaway to questions. I am going to ask Lord Patel to begin.

Q15 **Lord Patel:** Good morning and thank you for coming today. The Lord Chairman, before we started the previous session, made a statement, which briefly was that this particular committee is looking to see how the legislation, as is coming to the Lords, could be made to work or what is in it that may require amendments to change it. In that context, can I declare an interest that I am emeritus professor obstetrics and gynaecology at the University of Dundee and a fellow of several of the medical royal colleges? Most of them are freebies given to me. I am very privileged and grateful.

I will get on to my question. It is a brief question and I would like a brief answer from each of you so we can follow it on. I know that you all now

have a neutral position and that the college of nurses was the first to come out of the blocks to adopt a neutral position, but now most of the medical royal colleges have followed that. On the basis of that, what do you think is in the current Bill that is good and workable as far as assisted dying is concerned? That is the first question. Secondly—and please answer it in that order—what is in it that you think will not work. Thirdly, more importantly, what is it you suggest that needs improvement to make it work? Can I start with you, Dr Mulholland?

The Chair: Could I ask you to be fairly brief in your answers? There are a lot of people who want to ask questions, so as brief as you can.

Dr Michael Mulholland: Thank you for the question. I note that you are an honorary fellow of our college, so I am very pleased to answer. As a college, we are pleased when patients have the ability to make decisions for their own choice, health and death. That is something in general practice we have always been keen on. We have discussions, as people approach their death, as to where they want to die and how they want to do it, if they have that ability to plan in advance.

We have thought long and hard about it as a college. We moved from a position against to a position neither for nor against, but wanting to support our patients and colleagues, because we recognise the divide across the country and in the profession as to those who are for or against the process.

What we feel still needs to be looked at is that we are very supportive of a separate service. We do not want this to be part of core general practice and we want to see separate pathways that patients could go down if that is the case. We will be asking Peers to consider tabling an amendment to that effect.

We feel that it is really important that the language of the Bill is clarified a bit. We would support Baroness Finlay's amendment, in that "opt-in" is what we would like to see throughout the Bill. We noted that it was not there in the impact statement or this impact assessment. It was called "opt-out". We would just like it, if a health professional is going to be involved, to be an opt-in process, because we know that many of our members, as GPs, do not want to be part of this.

Those are the key parts that we want to draw your attention to that are concerns. We think that, if this Bill is to be passed, the oversight and regulation of the process is essential. Those people taking part, whether it is to assess capacity, as discussed previously, or anything else, will need extra training beyond what they have at the moment. It should be open to all health professionals. It is not something for just GPs. Yes, we see our patients at that moment of contact, primarily as the first people, but, once we have signposted or directed, the service can be provided by specialists who are providing it.

If we look at the numbers that have been suggested, it is around 3,000 patients per year. If you divide that across general practice in the UK,

that is about one patient per practice every two years. We do not think that an individual should have that infrequent contact. Otherwise they would have to learn everything again. This needs to be done by people who are in that.

Professor Mumtaz Patel: Similar to Dr Mulholland, our position from the Royal College of Physicians is a neutral stance. However, we continue to have concerns around the practical elements of the Bill. Particularly on what is good about the Bill, as you asked, patient choice is always wonderful and what we want to support. Patient autonomy around end-of-life care is really important.

However, with the Bill as it stands, we have concerns around the deficiencies, particularly around a number of different aspects. First, patients should be enabled to have equitable access to all services and choices around end-of-life care—assisted dying is one aspect, but the breadth of end-of-life care.

Similar to what Dr Mulholland mentioned, we have a lot of concerns from our clinicians and physicians who wish to have that option of absenting themselves from any aspect of assisted dying. People are varied in their breadths of views around the principle of assisted dying, but, with regards, again, to the practical implementation, they should have an option to absent themselves.

Then, around decision-making, decision-making is complex. All our patients have complex medical needs. We are saying that, with the Bill as it stands, the decision-making is very much made in a multidisciplinary form, with shared decision-making and clinicians involved in patient care. That is currently not clarified within the Bill as it stands.

Then there is prognostic uncertainty. That is something that we grapple with day to day, whether it is six months or different. It is so hard to make that very clear, that prognostic uncertainty, to both patients and their families, so it can be understood in that way.

There are decisions around capacity and safeguarding, particularly our vulnerable patients. Health inequalities are already there for a lot of our patients who are disadvantaged and we do not want this Bill to exacerbate that.

Last is around services being regulated and monitored, whether it is the service itself or put together with the prescription of the medications. Assisted dying as a service should not preclude and divert resources from the wider equity of access to all forms and services around end-of-life care. There are a number of things that we put within our position statement that we presented in Parliament. This was the position statement from 9 May and subsequently we had a further position statement.

Lord Patel: We all have had the statements that each one of you produced, but I would rather you focus on the question asked. Could I

move on to you from the college of nursing?

Professor Nicola Ranger: Very much agreeing with what my colleagues have said, we think that it is good that these people are going to get the opportunity to have some degree of stating what is right for them. Within that, though, we are neutral but recognise that some nurses will feel very strongly they want to support assisted dying and some will not, but we will support that individual clinical decision-making. We are pleased that people, both clinicians and the public, will get an opportunity to start getting a sense of what they want.

We are slightly worried. We think there has to be very clear language and separation between palliative care and assisted dying. They are two separate things and we worry that sometimes those two things get muddled. We have to be really clear about that, with the primary issue being that palliative care is a dignified death and pain control for everyone, but obviously for assisted dying the premise primarily is about autonomy. Those things need to be very clearly distinguished.

The other concern that we have is that we totally appreciate how this has come about but, for many patients or members of the public, the first person they will talk to is a nurse. That is the person they will talk to at 2 am when they are concerned about things. That is the person they will often have a conversation with in their own home or in a GP practice.

We want to make sure that nursing and its contribution is fully appreciated within this Bill. Much of the leadership is with the Chief Medical Officer, and rightly so, but it is important to see that the majority of end-of-life care now is delivered by nurses. Going forward, if someone is an opt-in around seeking assisted dying, they will often have that conversation with a nurse. We think that it is key that that is recognised within the set-up.

There are some challenges. We absolutely agree with safeguards, but it is really important that the public have confidence in the process. It has to be fair and have scrutiny. To ensure there is no coercion there are safeguards, but it cannot be so complicated that the principle of autonomy is lost in this. There are some key things to really focus on.

Lord Patel: Does the Bill cover the involvement of nurses and where does it not?

Professor Nicola Ranger: It does, but take the set-up of a panel. Some are feeding in, some people who know the patient, know the family and have spoken to them. I can see the panel process, but it is how you get a full, rounded picture with regard to decision-making. It is key that that is sorted.

The Chair: I am going to have to stop you there, I am afraid, because we have to move on. We have a lot of ground to cover. Baroness Berger?

Q16 **Baroness Berger:** Thank you for joining us today. The two questions I am going to ask about are one around training and one specifically

around family and carers related to the person involved. First, in all of your submissions that you have previously made in the Commons, you have talked about the importance of detecting coercion. The RCN has also talked about the importance of clear safeguards.

The Royal College of Physicians has explicitly supported the amendment tabled in the Commons to introduce mandatory training on domestic abuse, including coercive control and financial abuse. I note that, Professor Ranger, you have raised concerns that nursing staff are not currently included in this requirement at all.

My question to you all, on behalf of your members, is this: do you believe that the current training requirements set out in the Bill, and referenced in a bit more detail in the impact assessment, are adequate to ensure that coercion and abuse will be spotted, and, if not, what changes would you and your members like to see?

Professor Nicola Ranger: You can never say it is always spotted, because sometimes people make mistakes. It is the principle with regard to safeguarding that has to be hammered home. Safeguarding is not proof; it is raising concerns. You would rather have a high threshold to raise concerns that are looked into than assume you have to have the evidence before the safeguarding alert is made.

Safeguarding is a neutral act and people do not always see that. With any education process, it is absolutely key that it is, to all clinicians, made absolutely clear that, if you have a concern, you just have to report it. You do not have to prove it. That is someone else's job and that is really important in education.

Professor Mumtaz Patel: I agree with that point and, specifically, education and training. We have mandatory training for a lot of these things from our overall clinical practice, but specifically around safeguarding for coercive control, together with protecting our vulnerable patients. These are concerns that are very much raised by our members and fellows. We feel that in the Bill, in its current state, that training element is one aspect.

As you said, quite rightly, on raising the concern, you would think that that is fine. That is one part of it, but then what next and how would you manage that? The follow-through is not well defined. That is one of the things, again, with regards to practical implementation of this, that are of real concern for our members as well, and similar to what you have said. Training may address in part, but then it is the follow-through as well.

Baroness Berger: What would you like to see better defined?

Professor Mumtaz Patel: It could be better defined as in the specific aspects around the vulnerable patient groups, what kind of training would be initiated and who would do what assessment, because, currently, as it stands, there is the assessment aspect side of things and the face-to-face requirement. We have emphasised within our statements that that should be done by well-skilled, appropriate staff. Then the decision-making

around the "what next?", after things are identified, needs to be done as an MDT assessment as to what the next steps are, and that is not defined.

Professor Nicola Ranger: There is a practical bit to that, in reality. If a patient is wanting to seek assisted dying, from a clinical point of view, when they are asked what gave them that initial thought and the suggestions came from somebody else, that is a red flag. It is just being really clear that this is about self-determination, not someone else's suggestion. I think that that would raise a red flag in a practical way if someone has suggested it to an individual. That is coercion.

Dr Michael Mulholland: As GPs, we are very used to providing holistic care and trying to understand where the patient is coming to us from in lots of situations, and are aware of the challenges sometimes particularly our elderly face - You think, "Who is behind this question you are asking me?" We are used, at that level, to making decisions and weighing up evidence.

We have toolkits available from the RCGP for GPs on safeguarding that address coercion already. I think, if this Bill was to come to pass, we would be updating it for the assisted dying as well. However, we are not the only point in that chain. At every point a patient moved through a process, coercion would have to be high in the minds of the clinicians or the people involved in that, with specific training for those as they get closer to the point of a decision about assisted dying.

Some of the things that have made a difference to us over my career have been that, in maternity notes now, it is an automatic prompt when I am doing an antenatal questionnaire or postnatal check to ask a woman about whether they are safe at home and how the relationship with their partner is, in order to assess the risks of domestic violence. We would need to develop tools similar to that to be in place. If you were having assisted dying conversations, you would want to make sure it was recorded at every point that people were thinking about this on the way through.

Baroness Berger: Forgive me, just on training, but you will be aware from the impact assessment the total amount of time for training on this. I take on board your comments about how you would like to have GPs removed. On the basis that we progress as the Bill is presented, the entirety of the training will be just two days for the co-ordinating doctor and one day, or even two and a half hours, for everything for others, including GPs. I wondered what you think about that.

Dr Michael Mulholland: There have been estimates of the time involved in taking patients through assisted dying in other countries and it is sometimes up to 30 hours or more of a doctor's time.

Baroness Berger: This is about the training for your members.

Dr Michael Mulholland: I was going to say that, to be able to provide that level of care and understanding in many other areas, I have significantly more training. We would want to make sure that it was appropriate for those doctors who are most involved. For a GP who does not want to be involved, they are signposting. They would need to know the basics of it. I think it will vary significantly, depending on which level of care someone is providing.

Baroness Berger: I am conscious of time, but I wanted to ask about the involvement of family members. I am particularly cognisant of the evidence and representations made from the Royal College of Nursing and the point you just made about how your members often have those conversations with patients and their family members and carers. Can I just ask whether all of you, individually, believe that the current provisions in the Bill are adequate, specifically around the involvement of medical professionals with family members where a person is seeking an assisted death? In particular, in cases of possible coercion, do you think that there is adequate provision in the Bill for your members to engage with family members or others who are relevant to the patients?

Professor Mumtaz Patel: Involvement of family within decision-making is important. However, at different steps along the way, if there are issues around coercion, as we have said just before, that could be identified as red flags. I feel that the complex decision-making is hard. It has to be shared. It cannot be just one person or two people making a decision around these things.

That is why it has to be in a stepwise way. That is how we would do it in a clinical setting. You have a conversation. If you feel that there are concerns, you would either raise them separately with the patient and/or include family, but it is making sure, as we have rightly said before, around training, red flags being raised appropriately, but then the next step of what needs to be done thereafter. Currently, as it stands, these are the concerns our members and fellows have also raised, that they would not know exactly where to stand and who to involve at what point as well. That aspect is really important to clarify at this stage.

Professor Nicola Ranger: Family is important, but, even in the current system now, legally, a family member cannot consent for somebody else if they have capacity, so there are some principles of autonomy that would need to stay the same, actually, because that is as it is now. The family are important, but, in this particular case, the most important person probably is the person and their autonomy.

There is a really fine balance here that clinicians are going to have to strike between listening to the family and understanding concerns, also being very aware and vigilant to coercion, but actually the primary person is the person seeking, to whom this relates. There has to be a very fine balance here. The family is important, but the primary is the individual involved.

Dr Michael Mulholland: For GPs, there is no absolute answer to this. I have done palliative care visits in the past week where I have been at a patient's bed with their relatives all around, all involved, and the patient very happy that family members make decisions for them or with them. I have been to other visits in the past where the one thing the patient does not want is their family to make the decision for them. To legislate too specifically on what we should be doing at times might then be breaking the patient's choice. It will depend where that goes and which side you are on. Are you wanting the patient to have the autonomy that is talked about, or do we have an absolute that you must involve everybody?

Q17 **The Lord Bishop of Newcastle:** Good morning. Thank you very much for your time today. I particularly want to acknowledge Professor Ranger and your comment about the importance of ensuring that the role and the voice of the nursing profession is not lost. Earlier, we heard about the New Zealand context. In their five-year review, they said that the role of the nursing profession and the voice is something that had been left out in that context and that this was not helpful. You have given us some very helpful reflections today.

Can I note and ask your opinion, really, on the Royal College of Nursing being worried that assisted dying and palliative care will become muddled? My understanding is that the policy intent of the Bill's sponsors is that they should be integrated. Can you comment further on that, please?

Professor Nicola Ranger: There is a very fine practical balance here, because there is no doubt that we know that, at this moment in time, hospices in the UK are under real pressure. I have been to many hospices at the moment where beds are closed due to funding. We have to ensure that palliative care is invested in and thriving. Every patient should have the opportunity to have a symptom-free, dignified and pain-free death. That should be what we are striving for. It is shocking that, in England, 42% of deaths are in hospital. That is probably not where any of us would like to die.

That is a really important piece of work that needs to continue to be invested in and still be looked at, but that is separate from someone seeking assisted dying for themselves. That is where our members are slightly worried that those two things may get conflated and the practicality, if someone wants to end their life, of where that happens, because, whatever happens, our members feel that people have to have faith in the services. They have to trust that, if they go into a hospice for symptom control and to have a dignified death without seeking assisted dying, that is not something that is suddenly going to be offered them, and the same in hospital.

There is a practical element of how we are actually going to ensure autonomy and not create fear for anyone who is near the end of their life. That is why there is a practical bit about how this is going to work in reality, because you want, we feel as a college, people to have faith in the system. They need to know that their autonomy is going to be

respected and not be fearful. That is why there is a practical element that both respects autonomy and respects a dignified, pain-free death, and they are two slightly different things.

The Lord Bishop of Newcastle: Can I invite the other two to comment, please?

Professor Mumtaz Patel: I completely agree. I think sometimes you conflate the issues together, because, at the end of the day, you want patient choice and autonomy. It is very important. If it is a broken system, with the palliative care services as they currently stand, there is so much inequity of delivery. There are areas where it works really well and then areas where it simply does not.

For patients to be fearful that they will not get any services and then opt for an assisted dying option, if that is pure patient choice, that is not an issue. What I really fear is that people are making sometimes these choices because of the lack of provision around good palliative care. Going back to the inequity of services, it feels really wrong and a lot of our members and fellows talk about that. Just where the disadvantaged populations are, there is service underprovision and then that inequity and gap is just going to get wider and wider. Those are some of the fears that are coming through our members and fellows.

Dr Michael Mulholland: As GPs, that is why we would feel that a separate service is something that we would be looking at and wanting to support. Patients coming to us should not feel that they have one route or another. As GPs, we would continue to provide holistic care to the patient right through to the moment of death, whatever way that happened. We would not want patients to feel that, because of funding issues or anything else, they were being forced into a decision on that.

We see palliative care as part of our core general practice contract. It is what we do. It is coming to a motion in our council in the next weeks to reaffirm that palliative care is core to general practice. We want this, therefore, to be something in addition that might be offered, but not necessarily delivered as part of core general practice.

We are particularly concerned about the underprovision in some areas. We know that some middle-class areas possibly have better access to services. We know that there is inequity across social demographics of all types, and some populations go to get hospice care or in-community palliative care and others do not. We want to make sure that those marginalised groups do not feel that they are going to be moved one way or another because of that, rather than because of having an actual choice.

Q18 **Lord Markham:** I have to say that I welcome that, for all of you, at the core of this is giving people the choice. I would like to follow up particularly, though, the comments made about having a separate pathway and really understand models that you have seen that you think might work in this context, because this is one of the key issues that we

need to try to address.

Dr Michael Mulholland: I do not think that, as RCGP, we are designing a pathway. We have concerns about where GPs might find themselves. We were pleased that our opinion previously that it should be a signposted service, rather than a referral into a service, is something that GPs would have a choice about. We do not want, as I talked about with palliative care, that blurring of lines. Where is the GP sitting in this?

We have a number of concerns specifically. One is the concern in general practice always about workforce and workload. If this is going to take 30-plus hours of GP time in a subject that you are not particularly skilled in, because of the low numbers coming through per practice per year, that will take a lot of time away from all our other patients. It is not that we have a service where people can actually find 30 hours of time for anything at the moment. We are completely full, whatever we do.

We want to make sure that there is a multidisciplinary approach. Nursing care provides a lot of our palliative care. It would be anticipated that there would be nursing involvement and other medical specialties involved in palliative care[1]. Those different opinions need to be there as well. That is better done outside, where that can be co-ordinated, not through general practice, but for general practice.

Lord Markham: If I may, just probing, would you see some sort of referral? As was said in terms of the nurses as well, you guys are the front door in a lot of these instances. Would you see some sort of referral, for want of a better word, to then another service?

Dr Michael Mulholland: We would not want referral, because that implies that we send someone somewhere. For those who do not want to be part of it, we want to make sure that they have a way, but that patients can be signposted to somewhere that they can get all the information that is needed and can then be part of this if that is what they wanted. There will be a role for GPs. Patients talk to us about end of life. We will have been part of that diagnostic process that got them there. We do not want to lose that. We are part of patients' lives at that stage. We just know that there are many members who do not want to be the next bit.

Lord Markham: You are saying—this is to all of you—that, as the front door, there is a certain level and that will require a certain level of training so that you can act in that front-line role, but then, beyond that, it is signposting them to a separate service. Are there any international examples that you have seen that can help in this space?

Dr Michael Mulholland: I am sorry; I am not aware of any, but we can get back to you on that.

Q19 **Baroness Smith of Newnham:** My questions follow on very closely from Lord Markham's first question, which is really about time. Dr

[1] Note from witness: Mr Mulholland meant to say 'assisted dying' here.

Mulholland, you have pointed out that it might take 30-plus hours of a GP's time if they were responsible for being the co-ordinating doctor seeing somebody through assisted dying, on the basis of the proposals at the moment, the draft legislation. What is the average time of a GP appointment? Do you feel at the moment that you have the sort of knowledge of your patients that maybe I had when I was a child? The family doctor knew who we were. Does that still exist?

Dr Michael Mulholland: Average time, I think, is still somewhere just under 10 minutes. We are trying as much as we can in many practices to increase to 15 minutes, because we know that most patients come with more than one problem and complex worlds, where they are now living much longer or with more disease.

Do we have the same knowledge as when I started? We have a different knowledge. We have so much more detail, so much more information about the health conditions and about a course of a patient's life recorded now electronically, which, when I was doing it, was bits of paper that were illegible and unable to be read after a few years. We have this vast amount of information that would help any doctor going through it and helps the patient navigate the health bits.

We know, though, that not all GPs work out of hours and we have a separate service of general practice out of hours, so it will not necessarily be the same doctor then. In practices, many of us work part time, doing other roles as well, so again you will have differences there. In many practices, we try to maintain continuity for those patients who we recognise really need it. For patients in my practice, certainly it is those who have a cancer or a mental illness. Those sorts of things are where we want to make sure people have the same GP for that time.

As a college, we promote continuity of care because it improves the patient's life expectancy and well-being, and improves it for doctors and the way we deliver the service. It is something, as GPs, we are very keen to promote. We just, as you suggest, are overwhelmed with the demand at the moment, so it does not always occur because we have so many patients coming in, often electronically, to get that first appointment.

Baroness Smith of Newnham: Following up on that, and then turning to Professor Ranger and her comments earlier about nurses being very much at the front line, you pointed out that there was a toolkit that GPs can look at to check about coercion and so on. Do you feel that, as GPs, you have the time to understand a patient's settled will and that you would know if somebody coming in was genuinely somebody who says, "I want to exercise choice", or might actually have somebody at home exercising pressure and coercion? Is there something we would need to add into this legislation to overcome that? The question to Professor Ranger would be whether nurses are in a better position. Would they be able to add more?

Dr Michael Mulholland: Do we have adequate time to do that? As GPs, we know that our one consultation of 10 minutes is not our only

consultation. I have a lifetime of consultations with some patients, which in my case have gone on 25 and 30 years. That is many hours of discussion and understanding some patients. I do not understand them all. If a patient moves to my practice, I do not have that long-term relationship.

We need to be sure that these things are checked on many levels. It is not at a single time and point where you tick something. In practice, for many of my patients, they are now seen primarily by nurses for the chronic disease management, and so they may have a better understanding of what is going on, and teams will come and discuss it. It is a multidisciplinary approach and it needs to be checked a number of times through any process with as many people as possible.

Professor Nicola Ranger: I was going to follow with something very similar. It is probably a little bit as described. It is almost a bit of a triage process. In the 10 minutes in the first conversation you would get a sense of someone maybe highlighting their wishes, but of course you would come back to it. You would have to create separate time actually. It is one of those conversations that cannot be in a fleeting moment.

For experienced clinicians, you cannot always measure it, you cannot always write it down, but, if you are good at what you do, you intrinsically feel, "I have to come back to this. This is a comment or a conversation that I can't just let settle. I need to create the time to come back". That is very much how I think all doctors and nurses would see that. That is why, as was described, that generic knowledge has to be there and then coming back to those conversations, so that it is a progressive step really, and really checking, "What is behind this?" That is why having the panel and having safeguards is key, but actually that continuity of conversation and relationship is also key, I think.

Professor Mumtaz Patel: From a physician's perspective, from the front line, in emergency medicine, acute medicine and then into the hospital wards, an issue that we have is continuity of care, again because it is so hit and miss in how that happens day to day. The interactions in out-patients are 10 minutes but in hospitals are even shorter at times because of the number of patients you see.

Also, the temporary care environment, sadly, is such a reality. We have published this week around how, any time of the year, corridor care is a huge issue. I have had end-of-life discussions on a corridor. It is awful and it is not the right place. That is desperation sometimes, because people just want something out because that is how they feel. The pressures on the system currently are such that that is one of our concerns as well: system pressures, workforce pressures in the same way with many gaps, and then the training that goes with it as well. That is the day-to-day reality of what we face, sadly.

Q20 **Lord Goodman of Wycombe:** Baroness Berger earlier asked Dr Mulholland about training in relation to GPs. I would like to ask the same question to Professor Ranger in relation to nurses, given the centrality of

nurses, as discussed, in dealing with patients and delivering assisted dying. According to the impact assessment, nurses will receive tier 1 training—a 90-minute e-learning module and 60-minute online interactive session—not tier 2 training and not tier 3 training. Do you feel that this is appropriate? As a follow-up, are you happy that even that level of training is actually not specified on the face of the Bill?

Professor Nicola Ranger: I think that it needs strengthening, if I am honest. That 90 minutes, to me, is that basic triage. It is that basic signposting. If people are really going to be involved in listening to people's autonomy, being able to help advocate or in any way be a part, as in Scotland, where nurses are actively, potentially, involved in the assisted dying, the training would absolutely have to change and go up and increase. That would be absolutely key.

Lord Goodman of Wycombe: You would like to see, if it has to be tier 1, it set on the face of the Bill, presumably, so it cannot be watered down later by future Governments.

Professor Nicola Ranger: I think so, absolutely, because it is key. The public have to have faith in the people potentially involved in assisted dying, but also in the expertise. That is key.

Lord Goodman of Wycombe: Dr Mulholland, in your evidence you say, "Any assisted dying service should be seen as a standalone specialised service that healthcare professionals may opt to provide with additional training and should not be deemed core GP work". I am on the Delegated Powers Committee, which has made a great deal of the matters that are not on the face of the Bill, but are simply left to Ministers to put forward by regulation. This is all covered by Clauses 41 and 42 of the Bill, which will enable them to deal with the whole matter by regulation. In other words, by regulation this could become core GP work. Are you satisfied with the legislation being dealt with in this way?

Dr Michael Mulholland: No. As a college, we would hope that this goes on to the face of the Bill that we would have a separate service. We will seek Peers' support for an amendment to that effect. We think that, if it is there for regulation and later amendment or change, there is no protection long term, and that is what we would like to be there from the beginning.

Q21 **Lord Goddard of Stockport:** Thank you and welcome. It is good to speak to people who actually are on the coalface and interacting with the patients, which is the heart of this Bill. I welcome the comments that choice is to be welcomed and about the need to respect autonomy and faith in the system. My question to you about the system is this: what would give you the confidence to embrace the system and embrace the process? Would it be putting it on the face of the Bill? Would it be on more recognition of nurses' and doctors' responsibilities and training, and the cost that goes with that, or is it a bridge too far? Is it something that you think your members, on principle, would not embrace?

What we are trying to do here is to cross the hurdles. One of them—and

you have explained extremely well this morning—is the concerns of doctors and nurses and the system. Is it possible that there is a way we can—and it might be with those amendments—actually cross those bridges? I am just reaching out to ask whether that is possible.

Dr Michael Mulholland: As a college, we have wrestled with this. It became very clear to us, when we talked to members about what they felt about it, that no one opinion was going to respect every member's view. While I could say, "We are for assisted dying" and get some support, 40% of our membership were on the other side. We needed to say, "We're not about the Bill itself. We're about what's right for patients, general practice and general practitioner members".

I do not think that there is one thing that would fix it for everybody. There will always remain GPs who are firmly against assisted dying for whatever reason. That is why we would like the opt-in clause, so that they do not feel that they have to be part of it, or they do not have to be part of it.

We need to make sure then, on the other side, that our patients have the protections they need for the vulnerable, and they also have the ability to exert their autonomy and their choice when that is something they want, if this is to become law. We are looking at the protections for both the GPs and the patients, rather than trying to make everything work with a form of words, because we are aware that there will be different opinions whatever happens.

Professor Nicola Ranger: That is exactly the same for us and our membership. We have strong people in favour and who would really support assisted dying and an equal number who are opposed. We would want protection for any clinician, particularly nurses, and that respect for their decision. As a college, we would support our members making either decision, and we have been really clear on that.

The Bill will never cover everything, but something really important as a principle with the Bill is about respect for autonomy. When we get it wrong in healthcare, it is usually because we are being paternalistic. It is really important that, whatever safeguards are there, whatever process or system is there, the underlying basis, we believe as a college, has to be autonomy of individuals and patients as a bedrock. Legally now, patients and people are allowed to make an unwise decision. That is already in the law.

We just have to be really careful that we do not have such a high threshold that actually the principle of autonomy gets lost. We will never be able to have a Bill that covers every risk and every potential. We have to have strong safeguards, something that people have faith in, whatever side they are. That is what I think the Bill has to be able to do. If you are against it, you feel comfortable. If you are for it, you feel safe. That is the bit that the Bill needs to try to be able to create, but the principle is to have autonomy and respect for individuals.

Professor Mumtaz Patel: I agree from a physician's perspective, with the same principle aspect side of things as well. We have a breadth of views within our membership as well and it is really hard when you are having the conversation of how you make it practically implementable. If you have one position, people will want to make it work and others may come up with more things. It needs to be practically workable, ethically robust and make sure that that compassion, empathy and care for the patient is not lost along the way because we feel differently about it. If it goes through, we want to make sure that all those safeguards and protection aspects are there for the patients, but also for our staff. We cannot have people feeling as though they are excluded or not supported along that journey as well.

Q22 **Baroness Finlay of Llandaff:** Thank you for coming. Dr Mulholland, you raised the issue of a separate service. That is really interesting, because there have been papers written about having a separate service. The University of Lancaster, I think, has produced quite a lot of thought on that.

I just wonder, particularly from the hospital end and the nursing end, how you feel that a completely separate service might help, given that currently our hospitals are running at over 90% capacity most of the time. We have patients in corridors, as you have said. We have high staff sickness rates, because the staff are already pushed beyond the limit, not just to the limit. I just wonder how you feel that, in our current system, you could manage patients having lethal drugs in, for example, a four-bedded ward with curtains drawn around, or with a side room. There is such pressure on side rooms at the moment. How would you decide to move the patient who is perhaps septic, or an infection risk to others, or a risk because they are so confused, out in order to move such a patient in?

I am intrigued at your suggestion of something that is quite separate, because it may also solve the problem. Some people expect this to be done in hospices and have even suggested hospices would take this over, and yet, as you have said, there is a great deal of fear already around hospices, and they often get labelled as death houses. They did in the past. Forgive me; I should have declared at the beginning of the session that I am a consultant in palliative medicine with a session at Velindre Cancer Centre and an honorary professor of palliative medicine at Cardiff University. Sorry, I apologise for that coming late.

Dr Michael Mulholland: There is a risk of blurring of whatever it is, whether it is a hospital service, a GP service, or a hospice. We want to make sure that patients know where they are and that they do not fear that coercion, even within the system, from being in a place that maybe has a mixed role.

If a patient makes a choice, this is going to be an enormous decision for any member of the public to go ahead with. They will have weighed it up. They want to know that their pathway is clear, I think, as well. There are lots of reasons that I talked about earlier, but something that is a

separate pathway within medicine has to be probably the best and safest way for patients and clinicians.

Professor Mumtaz Patel: I agree in principle with having separation of pathways. However, again, the practical delivery aspect is huge, is it not? You do not want diverting of resources to make one happen at the compromise of another service, and that comes back to, again, the equity of access and support. We are already underresourced from a system perspective, but also from our staffing perspective. As you said, vacancy rates and not just staff recruitment and retention but also morale within our workforce is huge, and there is the moral injury aspect.

Separate pathways, yes, in principle, but then adequate resources to back that up so that one is not compromising the other. The palliative care services are already underresourced and the last thing I would want to see is that the current situation or direction of travel makes that even worse. We have produced some reports, as you probably know, around the palliative care services this summer, highlighting that in detail.

Professor Nicola Ranger: Whatever pathway—and I agree with my colleagues—it would need to be very carefully thought out. It has to be good quality. You get to die once and it has to be done well. It is heartbreaking if we think that, if you were seeking assisted dying, it would be in the middle of a four-bedded bay in a hospital. That is a failure. The whole point of this is to do this well, respecting autonomy. It has to be practical, but also brilliant. If someone is seeking to die earlier than maybe nature would have intended, it has to be a comfortable and dignified death.

It has to be a practical application, but, if someone is seeking assisted dying, there has to be something, in whatever setting, that is really done well for the individual and their family. Being stuck in the middle of a medical ward with alarms going is not what I think this Bill intended, or the individual seeking assisted dying would intend. There has to be practical application, but striving to do this well.

Baroness Finlay of Llandaff: I think you wanted to come back in, doctor.

Dr Michael Mulholland: Sorry, if I could just make one more comment that Mumtaz prompted there, the moral injury, the psychological distress to people, is tough with palliative care anyway for every person. Within the system there is provision to support those colleagues. Colleagues who are involved in assisted dying will need that and that training as well, but it is not just our clinical colleagues. It is our whole staff.

If it happens in general practice, it is my receptionists, the management and administrators. We, as a medical royal college, obviously focus on GPs, but, as the GPs, we are part of a team. Hospitals are part of a team. If it happened in that side ward, who are the administrators who are having to do it, the pharmacists, everybody else who is coming in and out, the clinical and non-clinical teams?

Baroness Finlay of Llandaff: Could I ask you one more question? With the Bill as it is written and from the impact assessment, the panel must hear from and may question the co-ordinating doctor or the independent doctor. Similarly, they must hear from and may question—they do not have to—the person to whom the referral relates to the panel.

From the impact assessment, this could be a very junior doctor who is involved. I wondered whether you are comfortable with that level of inexperience, or whether you feel that it must be a very experienced doctor, and whether you feel that the nursing staff involved must have the ability to have some input into whatever report goes to the panel, because they are often the person who has been most with the patient?

Sitting suspended.

The Chair: We are now resuming the session, which was interrupted by the Division, and I am going to return to Baroness Finlay to put her question. It was partly put, but perhaps could be put more fully.

Baroness Finlay of Llandaff: Thank you very much, Lord Chairman. I apologise. I am going to repeat it, in case we have all forgotten some of it. It related to the panel. The panel must hear from and question the co-ordinating doctor or the independent doctor and, similarly, must hear from or may question the person to whom the referral relates, but they do not have to hear from anybody else at all. They do not have to hear from both doctors. They do not have to hear from nurses who have been involved. They do not have to hear from the GP or anyone else.

I wonder whether you feel comfortable with the role of this doctor, who might potentially be a very newly qualified doctor, as outlined in the impact assessment, or whether you feel that there must be much more information gleaned in order for the panel to take a decision. I would be interested to know what you feel.

Dr Michael Mulholland: On this one, it is difficult. The whole question of making decisions for assisted dying is against everything that I have been trained in and I have practised for 30-plus years. The outcome at the end of life has been that we will support and care for you and provide palliative care, as best we can in the circumstances. In my mind, it is a difficult decision. It is something that you would need a lot of evidence and support for, particularly as it comes in as a new service.

In terms of who the doctor is, there is often a process of senior decision-making in healthcare, whether it is in hospital or general practice. More difficult decisions are often referred to someone with more qualification or more experience to help this. With a patient in general practice who has a difficult decision, we often refer back to the colleague who has the best relationship or knows the patient best to help with those decisions.

Whatever way a decision is made, it is going to rely on people who have the experience to make difficult decisions and the knowledge and the understanding of the patient. If that requires you to get information from

nursing colleagues, from patients' families, from whomever, that is going to be important in that. Then it is also going to be a difficult decision for those who are actually making the final bit, which probably requires some more senior decision-making than new people, but that would depend on their training.

Professor Mumtaz Patel: Similar to that, in clinical practice, complex decision-making is shared. We take away the onus from an individual because things can go wrong. Particularly in this kind of critical decision-making, we would see in normal clinical practice an assessment, follow-through and then a wider MDT discussion around a patient and what is best for the patient, involving the patient within that care.

In the way that the Bill is currently placed, clinicians being experienced is really important. Face-to-face assessment is really important and then the wider decision-making has to be done as a team, through shared decision-making and with somebody who knows the patient well. It goes back to the continuity, et cetera, but the experience is important, together with the shared decision-making.

Any assessment has to be done face to face. Remote panels, who do not know anything and are just faced with paperwork, we have discussed as an issue previously. It is so important to have that connection with the individual patients.

Professor Nicola Ranger: There is going to be a balance between experience and skill or ability. Experience should not trump everything, because you could have someone very experienced who is not a brilliant decision-maker. It is a combination of both experience and good decision-making.

When I look at this about the panel, there is real potential that the voice of the person to whom the decision relates could be a bit lost there, especially where it relies on paperwork, without the ability to advocate for themselves. As we all know, you can read something on paper and then meet the person; it is completely different. The potential worry is that, if it is just seen as paper and a little bit bureaucratic, people may not feel that the process was fair or totally representative.

There is a balance both of safeguards—getting the right people with the right experience—and of the person or the public who are seeking a decision having confidence that they were fully understood and their issues were understood.

Q23 **Baroness Berridge:** You have referred mainly to having had training to do with coercion and safeguarding. The Bill does refer to the fact that at least the independent doctor will need training in coercion or pressure. Have any of you had training related to pressure—not coercion, but pressure?

Professor Nicola Ranger: So I completely understand what you mean, is that pressure from ourselves or pressure from other people?

Baroness Berridge: It is not defined in the Bill, so I am afraid I cannot help you. We have no definition in the Bill. You are going to need training, though, in pressure. Has any of you received any training like that?

Professor Nicola Ranger: No.

Professor Mumtaz Patel: No.

Dr Michael Mulholland: No.

Baroness Berridge: Thank you. Particularly to the Royal College of Nursing, you picked up the inconsistency in the Bill regarding the conflict between Clause 31 and Clause 5 in relation to the ability to opt out. Can I just clarify? Forgive me if I did not understand you. Are you supporting the opt-in model for your membership? You have quite a global membership from places in the world that are much more religious than the UK.

Professor Nicola Ranger: We feel that, if you wanted to be involved in assisted dying, you would have to choose to be involved. Then you must also have the potential, if you do not want to get involved, to opt out. We want to be absolutely clear that nurses can say, "I want nothing to do with this", as they do with abortion.

Baroness Berridge: Just finally, this is not clear to me, but maybe I have misunderstood the Bill. If you have not been involved, but you happen upon information that leads you to believe that the person has been coerced, pressure has been put on them or circumstances have put pressure on them, is it clear to you the avenue you would go through—maybe it is your professional body—to intervene in this process, raise the alarm and say, "Stop the panel. There's additional information that is needed"?

Professor Nicola Ranger: As it currently stands, that goes back to a safeguarding process. Personally, I do not think we should set up something completely different. There is a process that is understood since Victoria Climbié. Keep going with the same process. People should know to phone a number, make a referral and say they have concerns.

Q24 **Lord Patel:** Both the GP and nursing representatives referred to community palliative care. Can I support that? From my own experience, there was brilliant palliative care provided to a member of my family, from both GPs and nurses. I concur that we need more community palliative care.

Can I come back to the question that was just raised about the panel? You made the point that face-to-face decision-making is best and I have to agree with that. How do you think it would work in the current context of the Bill, if a panel has to make a face-to-face decision? How do you think that would work?

Professor Mumtaz Patel: I would presume that the panel would be informed by the face-to-face assessments of individual experienced clinicians who have been involved with the patient care. They are then part of the panel. I appreciate that not every single member of the panel may know the patient—

Lord Patel: We are talking about the panel speaking to the clinicians who were involved.

Professor Mumtaz Patel: Yes, or to the teams involved and with a representative who has informed them following assessments in that way. That was how I envisaged it to work.

Lord Patel: You are nodding too, so you agree.

Dr Michael Mulholland: I agree. As we talked about, the workload pressures and the infrequency of this occurring mean that the panel is unlikely to be on-site beside where this decision needs to be made. They need to talk in some way as close to face-to-face as possible with those involved in the care.

Lord Patel: If I were to use the word "pressure" and if I were to use the word "coercion", how would you interpret the two?

Professor Mumtaz Patel: It is grey. That is what we were saying. Again, with regards to training and things—

Lord Patel: Apart from training, how would you regard the two words? Are they the same? Are they different? If they are different, how are they different?

Professor Nicola Ranger: For me, coercion feels like it is something over time. Coercion feels like you get the person to think it is their idea. That is a simple way I would see coercion. You lead someone to feel it is them, whereas pressure is a bit more obvious. You have to probably know a bit about both.

Lord Patel: I have a very simple question next for each of you. In your everyday work, are you able to decide whether the person, the patient you are talking to, has the capacity to make a decision or not, even those who are near the point of death?

Dr Michael Mulholland: Yes, in the decisions that we are asking people to take. "Do you want to have antibiotics, near the point of death, for your chest infection?" Some of my patients will say no. Some will say, "No, I have had enough. I don't need more treatment on that", but that is a straightforward decision. We have talked it through. It is a very different decision—

Lord Patel: You make a judgment that they have the capacity to make that decision.

Dr Michael Mulholland: On a straightforward thing, where I can explain the risks, the benefits, the outcomes and not, we have a shared decision. It is not my decision. It is a shared process. As the decision gets more complex, the safeguards you need to put in around that increase. If it is a surgical procedure, we see the long lists of things that patient must have gone through and discussed before they do that.

Going through it with assisted dying, you would anticipate the list would be longer and would require a much longer process but, effectively, for every person who comes in to me wanting me to listen to their chest and give some antibiotics, I am judging their capacity to take them or not take them as we go along.

Professor Mumtaz Patel: In hospitals, we do the same. For patients who come in, the clinical judgment would be, "What is in the best interests of the patient? They presented with this. This is the treatment". When there is more complex decision-making, even the Mental Capacity Act as it stands assumes capacity and decision-making around that for giving treatment or not giving treatment.

That is one aspect, but then using the same principle to assess a patient and say, "Are they capable and do they have the capacity to make those decisions about ending their life?" is a separate matter. That is what we are saying we would then want a wider assessment on. My clinical judgment—

Lord Patel: What wider assessment would you require?

Professor Mumtaz Patel: That is where our position statement with the Royal College of Psychiatrists was quite clear. The Mental Capacity Act in itself does not give the framework for assessing capacity for this particular aspect. The wider capacity assessment would be more multidisciplinary, with people specifically trained to assess capacity. I do some capacity assessments for some of my patients, but that would not be—

Lord Patel: You are saying that, ordinarily, your members would not be capable in that situation.

Professor Mumtaz Patel: No.

Lord Patel: What about the nursing side?

Professor Nicola Ranger: I agree with what has been said. There is an assumed capacity, unless shown otherwise. That is the principle with which you would enter this. There is a danger, though, with capacity and that is why it does need certain assessments. I used to be a nurse consultant in critical care and people used to say, "I've had enough", and then you would get, "They're depressed". There is a fine line between respecting autonomy and that assessment. That is why you would have to seek that panel and that second-level capacity, if required.

The Chair: Before this session finishes, I just have two points on

declarations of interest. Lord Goddard, you want to correct what you said earlier.

Lord Goddard of Stockport: I need to correct my declaration of interest. I am, in fact, the vice-chair of the All-Party Group for Choice at the End of Life. I said Dignity in Dying. That is the secretariat.

The Lord Bishop of Newcastle: I should have said that I have no relevant interests to declare.

The Chair: There is a little time. Two people want to come in, Baroness Berger and then Lord Winston.

Baroness Smith of Newnham: Lord Chairman, do I need to say that I have no relevant interests to declare, then? I did not declare them, because I did not have any.

Lord Markham: Same here.

The Chair: Did you? I cannot remember.

Baroness Scotland of Asthal: I did not declare, but I do not have any.

Q25 **Baroness Berger:** To clarify, I also have nothing relevant to declare. I have a very short question, just for clarification, and then another very short question. Professor Ranger, just for complete clarity, you mentioned again a moment ago the safeguarding system. Can you share with us whether you think this already adequately covered in the Bill? If it is not, what should be added?

Professor Nicola Ranger: It has to be simple with regards to the referral. If you have concerns, that would need to be a referral in—

Baroness Berger: Forgive me, but, specifically on the question, do you believe it is adequately covered in the Bill or not? You are saying it is not and, therefore, it should be added in the referral.

Professor Nicola Ranger: The basis of being able to refer to the safeguarding hub is okay. With regard to extra scrutiny, it comes back to what you said earlier and the "what if?" Once that referral is made and the due diligence is done in the investigation, that will probably need to be strengthened. There is a practicality. If you think someone is being coerced for financial gain or whatever it is, the referral needs to be simple. That should probably stay.

The issue is, potentially, once you have made that referral, the investigation into what has actually happened or is happening. That happens now in child exploitation, trafficking or whatever, but it will be another area that may need extra training. Does that make sense?

Baroness Berger: Indeed, it does. Thank you so much. Also, in two of the earlier contributions from both the Royal College of General Practitioners and the Royal College of Physicians, you mentioned the potential serious issue of moral and psychiatric injury to your members.

That also applies to the wider staff body.

How do you believe that we should support GPs, physicians, nurses and that wider health staff body if it turns out afterwards that somebody has been subject to coercion or pressure? I am thinking about some cases that have emerged in other jurisdictions, where this has been the case.

Professor Nicola Ranger: We need to be really honest about the current environment that many clinicians work in. We are becoming incredibly intolerant of mistakes and intolerant of the fact that clinicians are human. Any kind of healthcare is not an exact science. You see people's lives ruined on social media. You see that their career comes to an end.

This has to stop generally, because it is poor for healthcare. It is absolutely vital and exactly the same in this circumstance. Sadly, whether we like it or not, we do not keep doctors and nurses safe now. That is the honest truth. For anyone involved in any kind of decision at the moment, if it turns out that a mistake happened or there is scrutiny, it is very difficult for them. With or without assisted dying, we have to do better than we are doing.

Baroness Berger: On the issue of assisted dying, where someone's life has ended, can I ask specifically in that context what you think should happen?

Professor Nicola Ranger: There would need to be that support: peer support—

Professor Mumtaz Patel: Yes, and longitudinal support.

Professor Nicola Ranger: —psychological support, peer review sessions where they get to reflect and support. It is important that we recognise that right from the beginning. People are making difficult decisions and it is not an exact science. It never will be.

The Chair: Sorry, can I interrupt? Various people want to ask questions. You have had your shot.

Q26 **Lord Winston:** I have a very brief question with a very brief answer. I may have misheard, because I am at the top end of the table and it is not very good acoustics in this room. I heard the suggestion that a dying patient would have to be removed from a hospice and put into a separate place for treatment. Do you think that is feasible or humane?

Professor Nicola Ranger: I do not think you would have to be removed. Whatever process there is, people have to recognise that this is about autonomy. If it is in a palliative care or a hospice setting, it has to be really clear that that decision for assisted dying comes from the person. It is not a treatment option that will be suggested to you. If it is in a hospice, in someone's home or in hospital, that is important.

The most important thing is that patients and the public feel safe that this comes from them, not a treatment option that is put to them. If that means it is in a hospice, I know that would be difficult, but keeping someone where they are feels more humane. It is about person-centred care.

Q27 **Baroness Finlay of Llandaff:** Can I just pursue that slightly? The suggestion has been that patients could be moved to a hospice from a busy hospital ward, which cuts slightly across that. I am also hearing you say that you do not see this as a treatment option. If the doctor is raising this with any patient for whom this might be an option, where does that sit in relation to the Montgomery ruling and the requirement that you raise issues that may be options for that patient's management, if this is viewed as a treatment option?

Dr Michael Mulholland: I am struggling a little bit with why the patient would be in a hospice if they were going to make another decision. Hospice care is end of life, generally, and this is not a process, as I understand the Bill at the moment, that can be rushed through. It is not a two-week process. It is not a one-week process or an overnight change of mind. It is something that will require time, panels, consideration and a lot of evidence.

Our argument about a separate service would helpfully separate that. That does not mean a patient would not die at home, if that was their choice. We know that the majority of people would like to die at home and that could still be possible under assisted dying or palliative care, if the services are there for both.

The Montgomery ruling is an interesting bit. That is probably going to come much earlier down the line. As GPs or nurses in the clinic, we will be signposting people one way or another. We will say, "These are all your options. You can make choices at any stage, but understand the process that goes with it". It is something that we will have to address, whether through signposting or otherwise, but it is not something I would see very close to the end of life, at hospice time.

Professor Mumtaz Patel: It needs to be a continuous, compassionate process, does it not? End-of-life care is meant to be supportive, compassionate and what the patient wants. Moving patients from A to B just because a decision has changed on one aspect is not the right, compassionate thing to do for patients.

You want that continuity of care to be preserved and for the care to be preserved in whichever setting the patient chooses it to be. That is the ideal that we are wishing for, rather than swapping and changing. It is not meant to be a bad thing for the patient. It is meant to be what they want to happen.

The Chair: Professor Ranger, I think you wanted to add something.

Professor Nicola Ranger: I agree with what has been said. There will be some grey areas. You are right; it would tend to be a plan. There will

be a lead-up to someone's death. With regard to treatment options, the whole principle of this is that it has to come from the person. It is not something that you would suggest. "Do you want chemotherapy or do you want assisted dying?"

A treatment option is exactly that: a treatment. This is about the principle that comes back to autonomy. This is one thing that needs to be driven by the person and then facilitated. It is absolutely not something you suggest to somebody else. "Have you thought of assisted dying?" Having a good death, symptom-free, and good palliative care should always be a treatment option for everybody. There is a slight difference.

Baroness Berridge: I am just following up from your helpful comments, Professor Ranger, about the culture that we are in. It may be that you need to come back on this, because it was from evidence in the previous session. We had the clarification from Lord Falconer that if a nurse or doctor, without any mental intention whatsoever—it might just be through circumstances or not providing a hospice bed, because it is not defined, and there is no time period; this can be way before terminal diagnosis—inadvertently puts pressure on and induces a person to either make a declaration or self-administer the substance, there can be a prosecution, with the consent of the DPP, with a sentence of 14 years or life imprisonment.

I hope I have summarised accurately, looking at everybody on the committee, what Lord Falconer's evidence was.

Lord Markham: I do not think he was saying that with regard to doctors.

Baroness Berridge: It applies to anyone. It is "a person" in Clause 34. You may want to come back to me after asking your members but, because you are talking about the culture, we now have relatives able to say, "Blank amount of time before they were even diagnosed, there was pressure put on my mother", and they can go to the DPP and ask for a prosecution here.

Lord Markham: Sorry, I do not think—

The Chair: We have to be a bit aware of the fact that we have gone well beyond our time now and there are limits to how far we can engage in that discussion. Bishop of Newcastle, very shortly and finally, please.

Q28 **The Lord Bishop of Newcastle:** Very shortly, picking up on the earlier discussion about inequity in access to palliative care services, I wondered whether our medical professionals think it is unwise to proceed with the Bill until we have equity of palliative care access.

Professor Nicola Ranger: That is a difficult question. I believe the principle of this, when you read what many people asking for this are seeking, is autonomy. Whether there is a good palliative care service, if the primary driver is autonomy, should not make that much difference. The primary driver is not pain and symptom control. For many people, it

is the autonomy. Whether you have a good palliative care service or not, if that is the primary driver, the two things should not be conflated. That is a difficult question to answer.

Professor Mumtaz Patel: Our college, in our position statement, referenced in a similar way that patient autonomy and choice are really important. It is the equity of access to all the choices that they would wish to have in services for end-of-life care, and that includes very good palliative care, but also other options. It is about equity of access. We have also supported and published reports around how palliative care services in general could be better. That needs to be done in tandem—

Professor Nicola Ranger: It does.

Professor Mumtaz Patel: —rather than one following the other.

Dr Michael Mulholland: Very quickly, we would support that palliative care services are not deprioritised in any way. We always want to have more for palliative care. We do not want this to mean that people do not look at palliative care funding and deprioritise it in any way. We would hand it back to parliamentarians, like you, to make the decision.

The Chair: We will have to leave it there, I am afraid. You have been extremely patient with us. You also will grasp from the questioning and the amount of questioning you have had from right across the committee how valuable we have found your presence today. We are extremely grateful to you. We end, really, with those words of thanks.

As a final word, do look at the transcript. It is important to us to know whether it is an accurate reflection of what you were trying to tell us. Thank you all very much indeed. We finish the session at that and we will meet tomorrow for the next public session at 10.15 am.