HOUSE OF LORDS

Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence

Wednesday 5 November 2025

4.40 pm

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; Baroness Hayter of Kentish Town; Lord Markham; The Lord Bishop of Newcastle; Lord Patel; Baroness Scotland of Asthal; Baroness Smith of Newnham; Lord Winston.

Evidence Session No. 14 Heard in Public Questions 172 - 180

Witnesses

I: Dr Jeanne Snelling, Senior Lecturer, Faculty of Law, University of Otago; Dr Jessica Young, Senior Research Fellow, School of Health, Victoria University of Wellington; Professor Sinéad Donnelly, Clinical Professor and Module Convenor Palliative Medicine, The Otago School of Medicine; Simon O'Connor, Former Member of Parliament, New Zealand Parliament.

Examination of witnesses

Dr Jeanne Snelling, Dr Jessica Young, Professor Sinéad Donnelly and Simon O'Connor.

Q172 **The Chair:** Welcome to the 14th and last session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined at this session by Professor Sinéad Donnelly, Dr Jessica Young, Simon O'Connor and Dr Jeanne Snelling. You are all extremely welcome, but I am going to ask the Bishop of Newcastle to extend you a welcome in a more appropriate form. Would you like to extend our welcome?

The Lord Bishop of Newcastle: Thank you, Chair. Tēnā koutou, tēnā koutou, tēnā koutou katoa. Āta marie. Nau mai, haere mai ki a koutou katoa. Welcome, welcome, three times welcome. Good morning. We are delighted and grateful that you are with us. Kia ora. Thank you.

The Chair: Thank you very much. I am going to ask each of you to introduce yourself. We have already received your written materials, but, if there is anything you would like to add before we go into questions, do let us know. Professor Donnelly, would you like to begin?

Professor Sinéad Donnelly: I am a palliative medicine physician and general medicine physician working in Wellington in Aotearoa New Zealand, with 30 years' experience in palliative medicine.

Dr Jessica Young: Tēnā koutou. Ko Jessica Young tōku ingoa. I have been researching assisted dying since the Bill was nascent and have spoken to many people over the years that it has been in place, so I am well positioned to represent the patient and family perspectives today.

Simon O'Connor: Good afternoon. I am a former member of New Zealand's Parliament. I chaired the Health Committee when we had the then largest inquiry into euthanasia. I was then part of when the Bill was passed through, was very vocal in my thinking around that, and for various reasons in a former life have spent lots of time at hospitals, hospices and around the dying.

Dr Jeanne Snelling: Mōrena. I am a senior lecturer at the University of Otago. I specialise in health law. I had a prior career before I studied law, working as a registered nurse for 10 years specialising in intensive care. I have been working with Jessica on the empirical study that she is leading.

Q173 **Baroness Hayter of Kentish Town:** I will not try to say good morning to you in Welsh, but the greetings come from all around the UK. Maybe I could start with Dr Young. Obviously, you have done a review—I think it was last year now—of the legislation in New Zealand, and I wonder whether you could briefly tell us the lessons of that. You will understand why we are particularly interested in your experience.

Dr Jessica Young: Yes, and we appreciate your interest to learn from the evidence that we have collected. In New Zealand, evidenced lawmaking is extremely important. Otherwise, you will end up with a law

that makes mistakes that other countries have intended to improve on. Our review draws on empirical research with 96 people from around New Zealand. Those people are patients, family members, providers of assisted dying, other health professionals in the system, health service leaders, and community studies.

The findings from our submission are that there were a number of excellent safeguards in the Act, but that there are a number of safeguards that are operating to prohibit access to people who would like access.

The main one that we have recommended be revised, which has also been recommended by the ministry in its review, is the prohibition on assisted dying where health practitioners cannot raise assisted dying as an option with people at the end of life. We recommended that those conversations be able to be had in the context of other discussions around end-of-life choices for patients who would be eligible for the Act.

Another recommendation was that further policy guidance was needed around what constitutes a request in the light of the prohibition. If that is not removed, it would be helpful for health professionals to know what a request is.

The implementation was good. There was training for providers and other health providers, although we made recommendations about how that could be strengthened, specifically around conscientious objection duties that fall on to medical practitioners specifically, where they need to make a referral to the Support and Consultation for End of Life in New Zealand Group. Sometimes those referrals were not made effectively.

We made 77 recommendations in our submission. The top 10 and the entire submission are available for reading online. We were pleased to say that, of the ministry's 25 recommendations that it concluded from its substantive review, 13 aligned with our recommendations. I am happy to provide further information if you would like.

Baroness Hayter of Kentish Town: I think you said in your written submission that not to permit access to assisted dying would continue to protract suffering when death could be hastened or, perhaps worse, result in suicide in some instances. Has that been discussed since then by your Parliament? Is that sort of general view one that has been discussed further? In other words, what happened to your review after you published it?

Dr Jessica Young: The Ministry adopted several of those recommendations in its own review. There has been a Member's Bill put into the ballot that has not been selected, and so any process that would amend our End of Life Choice Act would have to go through a parliamentary process and have the support of Parliament to change the law.

Baroness Hayter of Kentish Town: Could I also ask Dr Snelling, who

has done a lot in this area, whether she would like to add anything about, again, the experience, having reviewed it, of how it is working in New Zealand?

Dr Jeanne Snelling: To explain our approach, we were using an appreciative inquiry approach, looking at what is working well and what can be improved. The overwhelming feedback from patients and families was gratitude for the opportunity to access assisted dying. One of the interesting findings was that even families who may not initially be comfortable with a family member's choice generally became advocates for their family member. So that was another interesting finding for us: the journey that patients and families take together.

Baroness Hayter of Kentish Town: If I could ask one more question, we have had a lot of discussion within our committee and, indeed, in wider discussions about the possibility that there are certain people—be they vulnerable by age, by disability, by any of the other normal vulnerabilities—who may be coerced or be more likely to want to take assisted dying as a way out of something else.

What is your experience of those groups? I am assuming you also have disabled people, autistic people and all the groups we have been talking about in New Zealand. Are their protections sufficient or have they been particularly pushed, perhaps, into assisted dying?

Dr Jeanne Snelling: The eligibility criteria in our Act require terminal illness, where the person is likely to die within six months, and, like your proposed Bill, we also have a provision—out of an abundance of caution—saying a person cannot access assisted dying only on the basis of age, mental distress or disability. Our research did not indicate any particularly vulnerable groups being coerced. We did have findings where people with disabilities had additional challenges accessing the service.

For example, someone who was deaf had trouble accessing because it was a process where you had to ring a number. He could not hear what was being said. So we have been made more aware of the necessity to have appropriate provisions for people with disabilities. We did have a disability adviser on our committee and a law academic who specialises in disability studies, and they have generated some interesting insights from the disability community that they have engaged with, but Jess might know more about Kate's research.

Dr Jessica Young: As Jeanne pointed out, there are specific considerations for people with disabilities. Rather than being coerced, there is more of an issue of dissuasion from family members and there are issues with health professionals dissuading patients who want to seek assisted dying from seeking assisted dying. So the coercion actually goes in the opposite direction: not coercing people to participate but stopping them doing so.

Q174 **The Lord Bishop of Newcastle:** I have a question for Professor Donnelly, if I may. As a clinician, how has assisted dying affected your

relationships with patients and what have you heard from colleagues about this too?

Professor Sinéad Donnelly: We have done a study that involved interviewing 40 palliative care doctors and nurses—about 10 in four hospices each. We thought that it was best to explore this within the end of the first year of this legislation being enacted. These are a group of professionals who, prior to the legislation, were looking after patients who were dying every day, and we wanted to know what the impact was on their practice of palliative care, so it was just speaking from their experiences.

Their experiences have been of great concern, for example inadequate assessment of capacity. Where patients admitted to palliative care services, to hospices, are clearly disorientated and have delirium, the palliative care team make the assisted dying team aware of this situation—that they would not have capacity—and that was not taken into account when the patient had assisted dying later. There were several examples of inadequate assessment of capacity because there were 40 participants.

Then there was the illusion of choice. Patients have told the palliative care team that the reason they are choosing assisted dying—and this was witnessed by the palliative care nurses and caused them quite a bit of distress—is that a family member said in front of them, "I can't look after you any more". The patient did not want to go to a rest home, a nursing home, so they applied for assisted dying, and that was the reason: that they did not have someone to look after them and they did not want to go to a rest home.

As another example of a patient with a similar reason, their partner did not want the nurses coming into their home, and the patient wanted to die in their own home because it overlooked the sea and they had built the house, but they required nursing care. As a result of not being enabled to have nursing care in the house, they chose assisted dying. It is this illusion of choice. Where a person is facing their death when they have an advanced illness, they are a vulnerable group irrespective of their social position or their disability or not. They are a vulnerable group, all of them.

The other is the undermining of the work of palliative care professionals. In all these situations in these four hospices, patients who were signing up or being assessed for assisted dying were under the palliative care service in the hospice and being cared for by the palliative care team, so the nurses and doctors witnessed these events.

One patient was on opioids for their pain and trying to get it under control, and they got advice from a naturopath who told them they should not take morphine. As a result, they did not take opioids or any analgesics, so the pain was not controlled, and they chose assisted dying. That was an acceptable reason, for this dying service.

A nurse was phoned on a weekend by a relative. The patient was having assisted dying in their home that morning at around 11 o'clock, and so that nurse was supporting the relative who was very distressed on the phone. There are many examples of families not in agreement about what the patient is doing, division in the family, and the palliative care team is left trying to support these families in that distress.

The most noticeable thing is the engagement with that concept of suffering, because the purpose of palliative care is to support people and care for them in their suffering. It is that core reason for being. In the legislation in New Zealand and your legislation, it talks about "unbearable suffering". Once you have unbearable suffering, you can apply for assisted dying, but that is a very subjective position. Patients who have signed up for assisted dying, waiting for their assisted dying day, are not engaging with palliative care and, as a result, they are actually suffering, which the palliative care team see they could help with, but there is a resistance to engagement with palliative care.

Other examples were where the palliative care team are looking after a patient, perhaps even for a year—quite some time—and they are very stable and there is no documented unbearable suffering, and they sign up for assisted dying and that proceeds. There is even an example of a family asking the palliative care team to give a patient fluids and antibiotics so that they live long enough for their assisted dying date, so it is kind of prolonging their dying.

So there are many examples of the interaction with palliative care that makes palliative care inaccessible, really, to these patients. It undermines palliative care and the safeguards, according to the palliative care witnesses who are the professionals, do not work for all.

The Lord Bishop of Newcastle: I have a very quick question, if I may, for Simon O'Connor, as a parliamentarian who was involved in the decision-making process towards the New Zealand change. Of course, the New Zealand context happened by way of referendum, which is not the case here. Simon, are you concerned that, after five years of the Act in New Zealand being in place, there is a lack of clarity around the principles that it is built on?

Simon O'Connor: Not really. It is been in effect for three years. There was a short delay from when the law was passed because, as you noted, of the referendum. The principles of the Bill are such that it is just going to continue to expand. You have actually heard that already this morning, the idea that safeguards are becoming prohibitions, and that expansion is required to ensure further access. Those were always within the Bill.

For New Zealand's law as it is now, as you hear, there are a number of recommendations for the ministry and elsewhere; there is a Bill in the Members' ballot. It is just going to inevitably expand. I am happy to discuss the underpinnings of why, but that was always part of the Bill, and maybe I could just put it very simply to each of you.

Once you start down this road as New Zealand did—to be honest, there are many parallels between just about all euthanasia or assisted suicide Bills around the world; none of us exists in a particularly unique context, I might suggest—when it hits the real world, expansion will occur. That is exactly what is happening here in New Zealand.

There is another quick point I would make, if I might. When I was chairing the committee all those years ago, we were told that we would be dealing with probably tens of people a year. New Zealand is now already at the hundreds and it continues to expand. I suppose I am really belabouring that point, but I just want to strongly suggest to you that, from the New Zealand experience, many of us knew it would expand, many wanted it to expand and it inevitably is here.

Q175 **Lord Patel:** Good morning to you and thank you very much for losing sleep on our behalf to help us. My question is for Dr Young and Dr Snelling to start with, but, if I have time, I do have questions for Professor Donnelly and Mr O'Connor. If I might start with you, Dr Young, you already referred to some of it, but I would like you briefly to tell us what is the balance that, in your view, research has suggested between safeguards and access. Further, too, is the research you have done on experiences of families who are involved in relatives with assisted dying, and of assisted dying providers who are directly involved with assisted dying.

Dr Jessica Young: Those questions really get to the heart of why this law is important, in that there are patients and families at the centre of this experience. They are expressly grateful for this service. They feel a sense of relief that their loved one no longer has to suffer and that their suffering is also relieved by no longer having to watch their loved one suffering in terms of the family experiences.

They say things like, "Mum was just so relieved. As soon as she got signed off, you could just see that she was relaxed because she had the option, she had control, she no longer had to go down the dying route where she was gasping for air". They could shortcut these experiences that they did not want at the end of life. So the families are also relieved about ending their suffering.

Sitting suspended.

Lord Patel: Sorry for that interruption. Dr Young, you had begun to tell us about the experience of families. My other question was related to the experience of those professionals and providers of assisted dying. The other one was a balance between safeguards and access. Please continue, Dr Young.

Dr Jessica Young: The family experience is one of overwhelming relief and gratitude. They do have concerns that their family members will lose capacity before the day of their death. The New Zealand system does not have any mandated reflection periods other than a 48-hour approval period at the end for the registrar to sign off to make sure that every

stage of the Act has been complied with. In comparison, the UK system seems to add in a lot of reflection periods as well as a panel, which I think will take a lot of time and become administratively burdensome for people trying to access the system, should you decide that this will be law in the UK.

In terms of assisted dying providers, we spoke to both providers and non-providers. There are about 110 providers of assisted dying in New Zealand. This is a relatively stable workforce, suggesting that they can carry on with this work. They describe it as profound and some of the most meaningful work that they do in their clinical careers. Initially, they had concerns about how they would be perceived by the communities and the institutions that objected to participate, but, as time has gone on, this concern has diminished, according to our participants.

Where they have been able to work with organisations out in the open, including hospices, they have worked very productively with other health professionals to care for the patient. They inform each other whether the patient might be going downhill and the date needs to be brought forward, and they discuss whether they have concerns that the person may be reconsidering their request. Open communication is possible with palliative care. Assisted dying and palliative care do not need to work in opposition. They can work together.

Of course, these providers need organisational peer and system support, but the patients and families who receive care from these practitioners describe them as very compassionate and very understanding. They generally prefer practitioner administration, although they appreciate that patients get to choose the method of their administration. The IV route is safer, quicker and more pleasant than swallowing the medication.

In terms of the balancing of safeguards and access, a system that is too onerous creates stress among the people it aims to serve. They individually have merit, but, collectively, when all these safeguards act together, they can make a system too complex and too protracted for someone who is at the end of life. It can be too complicated for them to navigate. If you decide that this is a legal health service, there is a duty to make that system operational. I suggest that the panel adds too many layers of complexity.

We would refer you to the excellent scholarship of Professor Ben White and Professor Willmott, which has looked extensively at the regulation of assisted dying in Australia and internationally.

Lord Patel: Dr Snelling, I have a brief question to you. In your research—and I know you carried out research because I looked at your article—have you looked at the barriers and enablers of equal access in the provision of assisted dying? What were your findings?

Dr Jeanne Snelling: Sorry, what was that to me? I did not catch that.

Lord Patel: It was about research carried out in relation to barriers and

enablers of equal access.

Dr Jeanne Snelling: One of the facilitators we have in New Zealand is the publicly funded service for private providers. This means that GPs are able to get fee-for-service payments. That means that the provision of care can be more equitable. People do not have to pay for it. That has been a significant facilitator. Another one is the clinical navigators or clinical advisers who work within Te Whatu Ora, which is our national health system. They work with the applicants and help liaise between providers, patients and families.

Definitely a barrier is the prohibition on initiating any discussion about assisted dying. Our findings show that, even though that may be well intentioned, it has unintended impacts. In particular, it can create inequitable access because it presumes a well-informed health-literate person. You need to know that assisted dying is available to be able to raise it in any discussion. We think that, in principle, it is against ordinary health law principles. It is against the right to receive information that other sick people have. It is distinguishing people with terminal illness from other people who get access to information about options.

In addition, it is difficult to apply in practice. The empirical research in our country and Australia, where they first introduced this provision, is that even providers who are not necessarily pro assisted dying object to it because they think it is 'muzzling', stifling communication and censorship of therapeutic conversations. It disempowers them from having open and honest conversations with patients at the end of life.

We appreciate that these conversations need to be had sensitively and tactfully. Our recommendation was that that prohibition be removed and replaced with a provision that would say that it can be initiated only in the context of an end-of-life discussion. Again, we would want to see more guidelines around how to manage those conversations tactfully and appropriately.

Lord Patel: What were the findings of your research and your studies related to the environment where staff are normally providing end-of-life care, including palliative care, and are involved in assisted dying?

Dr Jeanne Snelling: In terms of our interviews with providers in the palliative care sector, there was a range of views. There were people who felt very uncomfortable with assisted dying and were pleased that their institution took an objection to it. There were providers who were sympathetic to people's choices but did not necessarily want to be involved. There were other providers within some palliative care organisations who would have been prepared to provide assisted dying but were not able to because of the institution that we are working in.

There are a range of views within the palliative care community, but generally the strong suggestion that came through from our interviews, at least, was people accepting that this is law, that ultimately they have to put the patient first and provide patient-centred care, and that there is

a need for assisted dying not to be a siloed service but to be integrated in such a way that patients who want to exercise this choice do not feel like they are making an aberrant, immoral or inappropriate choice and feel they are actually supported. If they feel stigmatised, they will remove themselves.

Lord Patel: The Chairman is looking at me. If I have time, I will come back to the other two.

The Chair: Yes, I am very sorry. I am not trying to interrupt you, Dr Snelling. It is very interesting evidence, but I am going to move on to another question.

Q176 **Baroness Finlay of Llandaff:** I just wonder whether I could ask a question, first of all, to Professor Donnelly and then to Mr O'Connor. I may go on to others if time allows. Can I ask you, Professor Donnelly, about your experience of looking after vulnerable people and people in hospitals? I note that New Zealand's ranking for palliative care has actually dropped. I wonder whether you find that this legislation has made it easier or more difficult to explore those conversations around distress rather than conversations only around the very endpoint, which is death. With the information that you get, how much do you find that the assessors, who may have met the patient only once, are actually taking that into account?

Professor Sinéad Donnelly: There are several questions in that. I will try to allude to some of them. Palliative care in New Zealand is funded about 50% through the Ministry of Health. Otherwise, it depends on charity, unlike the assisted dying service, which is fully funded, as we have heard. Already there is inequity in that.

Also, the availability of palliative care is different throughout the country. Particularly in rural areas, there will be less availability of palliative care. It is interesting that, in the review group, at one stage in the last few years it was noted that there was a cluster of more assisted dying occurring in a rural area, which was not investigated further. It would be noted that palliative care is less available in rural areas as well. That is of interest.

I work in the hospital setting. In relation to skills, I cannot comment on what the medical skills of assisted dying doctors are, but recently I looked after a patient who was admitted to the hospital who clearly had delirium, which meant they were not able to make a decision. That afternoon I was contacted by the assisted dying doctor to say that they had spoken to this patient an hour earlier and they wanted to bring forward their assisted dying date. I had to bring it to the attention of the assisted dying doctor that a psychiatrist had seen the patient that morning and they were delirious and did not have capacity. The assisted dying doctor had not made that clinical diagnosis. That is just an interesting observation.

In relation to some patients, it was mentioned that patients were gasping and therefore not able to breathe, and therefore assisted dying was a relief of their suffering. There are other examples. I was looking after a patient with quite severe shortness of breath last year. I looked after her for about a week. She was very frail and was very short of breath. I went off the ward for a week and returned. Before I returned, I got an email from one of the nurses saying that the patient had expressed a wish that life was over and that this was difficult. The nurse engaged on the topic of assisted dying. The nurse was telling me in the email to let me know before I returned to the ward that that was now in train. They were exploring that.

I returned to the patient, whom I had previously known. Clearly, she was short of breath. I added a very low dose of midazolam. For any clinician who is in the audience or on the panel, it was 5 milligrams in a little syringe driver, which is a little pump. I talked to the patient about the mention of assisted dying and about trying to relieve her shortness of breath. She lived for another 10 days. She never brought up the topic of assisted dying or wanting to die again. Her shortness of breath was relieved by a very small change in her medication. That did require me then to engage with her son and talk about the original exploration of assisted dying and the importance of her symptom relief. That was a beautiful example for me of the input of palliative care, not at a highly specialised level—just good palliative care can make a difference—and how the assisted dying topic can be brought up, I would suggest, at times inappropriately.

To take another example, we talked about vulnerable groups. My colleagues in palliative care told me yesterday that in their hospice there is a Pasifika population. There is quite a large number in the area in which I work. They have a great fear of coming to the hospice. They have expressed their increased fear in relation to what could happen to their relative in the hospice in relation to medication because of the assisted dying. I do not want to identify that group as a vulnerable group, but that is a cultural group who have a fear already, a great sense of community and looking after someone until they die. Their hesitation to engage with palliative care has increased, according to my colleague, since the introduction of this legislation.

I work as a clinician every single day. In my view, one person who inappropriately receives assisted dying who is vulnerable, under coercion, lacks capacity, or where an error is made, in my view, is one person too many.

The Chair: Professor Donnelly, I am very sorry. We have to move on.

Baroness Finlay of Llandaff: Can I just get my question in, though, to Simon O'Connor very briefly? There was talk of money. I understand that there is only one hospice in New Zealand that actually provides assisted dying on the premises. The others have not. Because it is so reliant on voluntary funds, what has happened to its voluntary funding? What has

happened to its statutory funding? Has there been a change compared to the other hospices?

Simon O'Connor: By the way, I cannot speak on behalf of hospices per se, but I have done research into it quite a bit. Long and short, all bar one hospices do not see any compatibility between assisted suicide, euthanasia and palliative care. One does allow practice on the premises. Soon afterwards it saw, actually, a notable decline in its fundraising; it dropped substantially. People were not prepared to fund. It has recovered in the last year a little bit but not back to its original state.

The other interesting point—granted, we are relying on the statements of Ministers—is that that particular hospice gets over 80% of its funding from the Crown compared to 50% from others. Long and short, it has an impact. Donors in support of hospices are not supportive of said hospice allowing assisted suicide on its premises.

The Chair: Dr Young, you were shaking your head. Is there something you disagreed with there?

Dr Jessica Young: Absolutely, yes. I know for a fact that, after they said that they[1] would allow assisted dying on site and took a principled approach to participating in assisted dying because they saw the community, who provide 50% of their funding, as a community stakeholder and after the national public spoke that they would like this law as part of our referendum, their fundraising actually went up. Simon is incorrect there.

Simon O'Connor: I am very happy to furnish the financials for the Lords to look over. I feel quite confident.

The Chair: We note there is a disagreement. I am going to move on to a different question.

Q177 **Lord Markham:** Yes, this one is to Dr Young and Dr Snelling. I am really trying to build on some of the points that Baroness Hayter was making. We have heard lots of concerns in the evidence about minority groups, disabled groups and people suffering from domestic abuse, the concern being that they would be adversely impacted by an assisted dying Bill in the UK. Obviously, I am very aware that you have these same groups in New Zealand. I am wondering what the research and data says about whether these groups have been adversely impacted in New Zealand in both your own research and the three-year review that was conducted.

Dr Jessica Young: I can confidently say that there are no examples in our research of vulnerable groups being put at any additional risk once the law has been introduced. Data from Canada, Oregon, Washington, Switzerland, Belgium and the Netherlands indicate that objective measures of vulnerability, such as low income or education, or institutionalisation, are actually associated with a lower likelihood of receiving assisted dying. It is quite the opposite effect.

[1] Dr Young subsequently clarified that this statement referred to Tōtara Hospice.

Again, I think this is this dissuasion issue. This is the issue of people being assumed to be vulnerable when in fact they have their own unique access issues. People are not being believed that they know their own mind to seek assisted dying and it is being assumed that they do not have capacity when they in fact do have capacity.

Lord Markham: Similarly, there is a concern here that assisted dying would have a negative impact on palliative care in the UK. I am sure the same concerns were expressed in New Zealand. Again, I am very interested to hear the evidence in New Zealand, please. Dr Young or Dr Snelling, you did the research.

Dr Jessica Young: I am very happy to speak to that issue. Palliative care has not diminished in the face of assisted dying legislation. We have evidence to suggest quite the opposite. People are more willing to talk about death and dying, which obviously aligns with the hospice mandate for everyone to approach the end of life openly. There is substantial evidence by courts, expert panels and non-partisan parliamentary committees that demonstrates that the concerns proposed about palliative care are unfounded. There is Carter v Canada, the Victorian report, the Western Australian Government report, Canada's inquiries and other inquiries.

The concerns about palliative care being undermined are more about the palliative care professionals who cannot sit with their own discomfort about assisted dying. Where this works in unison with palliative care, patients are grateful; families feel supported by the hospice services and assisted dying providers; and healthcare professionals who are not assisted dying providers feel that they can talk openly with their colleagues, so that they can all work together to achieve what the patient wants, whether that is an assisted death or a natural death, if that is the appropriate course.

Lord Markham: Just to be clear—there were some gasps here—that is based on the research you have done on the people you have been speaking to across the services.

Dr Jessica Young: That is correct.

Q178 **Baroness Smith of Newnham:** If I have understood correctly, of the four evidence givers in this session, Dr Snelling was a nurse, but you no longer practice. You have experience as a nurse. Professor Donnelly is currently a clinical practitioner.

Dr Jeanne Snelling: Yes.

Professor Sinéad Donnelly: Yes.

Baroness Smith of Newnham: I would like to ask Dr Snelling whether she feels there are any particular ethical questions that might face somebody in the nursing profession dealing with assisted dying or assisted suicide, and then allow Professor Donnelly to continue her answers to the questions to my colleague Baroness Finlay earlier,

particularly responding perhaps to the suggestions that we have heard that palliative care is not being diminished. That clearly flies in the face of some of the evidence we have heard.

Dr Jeanne Snelling: The experiences of nurses is really diverse. They reflect the general population having different views towards assisted dying. Some of them can feel quite conflicted and uncomfortable. Some of our research, for example, in the aged care sector involved a manager who was well aware of the concerns of some caregivers and worked with them to explore the issues and managed any patients who were accessing assisted dying in such a way that those caregivers did not have to be involved in the actual provision of care. Over time, she witnessed that people became more comfortable with assisted dying and, even though they did not want to be involved with the actual provision of it, they still wanted to provide patient-centred care to these residents who were their patients.

We do have evidence from nursing groups about what they need to feel supported when assisted dying is implemented. It is really important that they get a chance to talk about how they feel, how they will be supported and what procedures and policies will apply, but they do need to have a voice as well in terms of what those policies and procedures look like. Did that answer the question, Baroness?

Baroness Smith of Newnham: Well, it was an answer to the question. I could probe a bit further, but the Lord Chairman will probably not want me to do that at this stage. Maybe we can turn to Professor Donnelly and, if there is time to come back later, we will.

Professor Sinéad Donnelly: I am a clinician, as you have said. The research that we did was with palliative care nurses and doctors in four hospitals, about 25 nurses and 11 palliative care doctors. What concerns did they have? For example, there is no funded bereavement service in New Zealand. The examples they gave were of the support that they needed to do in the follow-up to the patient receiving assisted dying with the families. That has been an added dimension to the work because a different type of bereavement support is required.

I gave you an example of the distressed relative phoning an hour before the assisted dying and needing support from the palliative care nurse. We should realise that bereavement support is not officially funded in New Zealand. That is extra work for the palliative care services.

More recently, I was the chair of the hospital palliative care network nationally in New Zealand. I heard of situations in hospitals where oncology services were impacted by the assisted dying process. For example, there was a patient within a hospital whose family wanted them to stay in the hospital for their assisted dying. They were on an oncology ward. That caused distress to some of the oncology nurses and oncology doctors to the extent that the whole process—there had been several occasions—led to a medical oncologist going out on sick leave just because of the interaction of having a patient receiving assisted dying on

the public medical oncology ward amid the patients who were receiving treatment for their cancer. As a result, that doctor went out on sick leave for a few weeks, increasing the burden on the rest of the oncology services, which are already under duress in New Zealand as in many other countries.

Those are some examples. I am happy to give more.

Q179 **Lord Goddard of Stockport:** I have two questions, one for Jessica and one for Simon, if I could. I will be as quick as I can. Could you envisage New Zealand or any other jurisdiction that you have experienced and studied repealing assisted dying legislation? If not, what do you think we can learn from that?

Dr Jessica Young: Can I imagine our Act being repealed?

Lord Goddard of Stockport: Yes.

Dr Jessica Young: No. The public spoke very loudly that this is a law that they want. It went through a parliamentary process. That was then subject to a referendum and 65% of the public said they would support this. That is a very clear message to Parliament that they do not want this repealed. I think you can take comfort from your public polling: 75% of patients, on the basis of choice, autonomy and freedom, want this. The medical views are shifting. Increasingly, jurisdictions around the world are passing these laws and no one has repealed their laws.

Lord Goddard of Stockport: Simon, just very quickly, did you say that the Bill has been expanded in New Zealand already? Is that what you said in an earlier answer?

Simon O'Connor: No, there are pushes to expand it. There are very small changes, which I would argue as a former parliamentarian were driven by the bureaucracy and not in the law. A good example of that is organ donation. New Zealand now has created policies about taking organs from euthanised patients. Again, that was not specified in the law. The civil servants have decided to pick up that ball and run with it.

To emphasise, there are calls for expansion, which I said are inevitable. In fact, as you have heard from the other witnesses this morning, we are replete with calls to expand it, to change it or to remove safeguards and so forth, but it has not expanded formally yet.

Lord Goddard of Stockport: That is clear. Thank you.

Q180 **Baroness Scotland of Asthal:** Professor Donnelly, I will come to you first. You have explored and given us many examples of where patients have—I will not say "been coerced"—been persuaded to consider assisted dying. Does that cause you concern? Do the examples you gave us cause you real concern?

Professor Sinéad Donnelly: Yes, of course they do. I work in medicine and I have for so many years. The word "vulnerability" has been used and it has been suggested that we should not say that people are

vulnerable, but, from my experience of all the years, people who have advanced cancer or who are facing their dying are vulnerable.

The subtle things can make a big difference. Coercion is not a big example of, "I want you to go and have assisted dying" or, "I will remove your money". It is simple things like—this is a true example—a sister saying, "Why don't you consider assisted dying?" The patient had never considered it. On reflection, he was devastated that his sister suggested that, but then he proceeded to do it. It is very subtle, but we all know human nature. We all know the way we interact with each other and the way we are influenced. Coercion happens on a very subtle level. That is a great concern to me.

Baroness Scotland of Asthal: We have been told that a number of patients request assisted dying because they feel they are a burden or are lonely. Is that the sort of issue that you have been concerned about as well?

Professor Sinéad Donnelly: I spoke, as I said, to another palliative care physician yesterday, and that is exactly what she said. Even at the moment she had a patient under her care and the patient expressly said that that was the reason. Their family had come from overseas to accompany them as they were deteriorating in the hospice. They had yet some time to live. They were somewhat stable. They said they felt a burden to the family because they have come all this way, so they were exploring assisted dying.

In the Oregon data, which was quoted, they collect the reasons that people are requesting assisted dying. Feeling a burden is high on the list in that state in the United States.

Baroness Scotland of Asthal: Does it also concern you that New Zealand has fallen from being ranked third to 12th when it comes to palliative care?

Professor Sinéad Donnelly: Yes, it is severely underfunded. From palliative care's perspective, it appears to us that it does not have the support that the assisted dying legislation has. As has been said, the assisted dying service is fully funded. That is completely counter to the 50% funding from the state for palliative care in New Zealand.

New Zealand palliative care depends too much on op shops, swap shops, charity shops for its funding. That is a serious concern. That is part of the reason palliative care is falling behind in the OECD rankings.

Baroness Scotland of Asthal: In relation to Mr O'Connor, you said that you have the data; you have the financials. Would you be able to send those to us to demonstrate that what you are telling us is accurate in terms of the way in which finance has been adversely affected as a result of the law that you assisted to bring into place?

Simon O'Connor: Yes, easy. I have the email of your clerk, so I am happy to send that through and you can interrogate the numbers yourself. It is pretty straightforward.[2]

Baroness Scotland of Asthal: You said that once we bring this in—I am paraphrasing you—there will be no stopping it. It is going to be expanding. There are those who want it and those who do not. Those who want it to expand will obviously be pleased. Those who are fearful of it need to be sure that they are right to be fearful of the expansion because it is coming.

Simon O'Connor: Absolutely, it will come. Without taking away from the exceptionalness of the United Kingdom, it will be no different from any other jurisdiction in the world. As I say, even just listening to the witnesses this morning, everything really is moving from a health issue to a justice issue.

What I mean by that is that it always starts as a discussion about very serious health conditions, particularly the major neurological ones, but very swiftly the conversation moves into matters of justice, equity and access. You have heard also that we need to get rid of safeguards because they are deemed as too onerous and so forth.

Again, it is an inevitability. In New Zealand, there is a call to get rid of the six-month protection and to allow doctors, in their position of power, to seed the ideas of assisted suicide. Here in New Zealand too, if I might, they are also looking again—the witnesses have hinted at this—to remove conscience rights from doctors. The great irony, if I might finish on this point, is that autonomy is put forward as one of the key reasons to have assisted suicide, and yet there are calls here in New Zealand to have the strong coercive arm of the state appear and force doctors, nurses and hospices to participate in some way. Those are some of the proposals that have been put forward.

I just want to come back to that word I keep using. It is inevitable, as it has been or will be in New Zealand and across other jurisdictions, that it will expand.

The Chair: I am going to have to leave it there. I think we have trespassed enough on your time. It is a comfort to us, because it has been dark here for some time, to see that the sun has actually risen in New Zealand. Thank you very much indeed for spending so much time with us. We are extremely grateful for your evidence. It has been taken down and transcribed. Copies will be sent to you by email to check. If you do spot any errors, please let us know, and we will see that they are corrected.

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[2] Simon O'Connor subsequently drew attention to reports from Tōtara Hospice – 2025 report Final-Impact-Report-Online-Pages.pdf (page 47) and 2024 report https://hospice.co.nz/wp-content/uploads/2025/04/TOTARA-HOSPICE-IMPACT-REPORT-2024.pdf (page 34)

With that, I am not sure whether the Bishop can say something suitable. No? We will leave it in English. Thank you very much indeed. A good day to you all.