

Written evidence submitted by Dr Ryan Spielvogel, MD, MS (ADY0039)

I write to you today to urge you and your colleagues to **pass legislation authorizing assisted death in the United Kingdom**. As a practicing physician in California where assisted death is legal, I have seen up close the universally positive impact having assisted death as an option has had on my patients and my physician colleagues. Personally and professionally, my journey from open-minded ambivalence to avid support was gradual but always steadily unidirectional.

As I compose this letter, some specific formative experiences come to mind. The law authorizing assisted death (what has come to be called “medical aid in dying” in the United States) went into effect in June of 2016 in California. The following week, I received my first consult. For the first time in my career as a physician, I was about to help a man die. I remember sitting at my desk not knowing what to feel. But like many experiences before this, I decided the only way for me to sort out my feelings on the topic was to try it and reflect afterwards.

In the room, Percival* sat across from me, waiting for me to speak. There was no formal training on how to do this yet and awkward moments passed. I somehow fumbled my way through our first visit, but he didn’t seem to mind. I was most struck by how clear he was in his reasoning and how firm he was in his resolve. Unlike most of my patients, Percival had no illusions about what lay ahead. His disease was consuming him—sapping his strength and robbing him of any pleasure in life. Moreover, there was no way for him to ever get that back. “I want to end it before I get so weak that I become a vegetable,” I remember him saying.

In the weeks that followed, Percival fulfilled the rest of the legal requirements. Throughout the process, I held it together better than I expected until the time came for him to leave my office for the last time. I shook his hand and opened my mouth, but the words failed me. “Good to see you,” didn’t feel right. “See you later” was an outright lie. I had never been faced with this before. I was knowingly sending a patient to his death. I settled on, “It’s been a pleasure.” He nodded his acknowledgement and left.

I prescribed him the aid-in-dying drug that day, and he took it the next. A few days later, I called his daughter to check in on how everything went. I’ll never forget what she said. “We got to have a memorial for Dad while he was still alive. Then he took the medication surrounded by friends and family. He went to sleep and passed away peacefully. It was beautiful.” My eyes welled up, not expecting how far the gift had expanded beyond the patient.

I thought long and hard about Percival and death in the weeks that followed. It was once said that nothing in life is certain except for death and taxes, yet most people seem surprised when death comes

knocking at the door. This unexpected quality that our culture has ascribed to death along with our erroneous assumption that we can somehow prevent it if we just try harder is what Dame Cicely Saunders—the mother of modern hospice—once referred to as our “death-denying society.”

But then here was Percival—a man who accepted the inevitability of his death and met it head on. He took control of his suffering and exercised his autonomy in a way that was heretofore unthinkable in California. As a result, his death was not at all traumatic for himself or his family—it was a celebration.

The power in his action was transformative. It was a statement that death does not need to be something that happens to you on its terms. It gave him the agency to write for himself that last sentence in his book of life. Through this, **I came to recognize assisted death for what it is—an invaluable form of restorative justice.**

In the years that have followed my experience with Percival, I have overseen many deaths from medical aid in dying—either directly or through the medical residents in the program where I am faculty. I am now the senior medical director for aid in dying services for my large healthcare institution that includes 5,000 physicians and 60,000 employees and covers the care of 3 million patients. I can say unequivocally that **having this option available has had an enormously positive effect on patients and physicians alike.**

The way our law has been written and implemented, safeguards exist on all sides. Only patients who can demonstrate their capacity to make sound medical decisions can access aid in dying. This helps prevent coercion, and in the 25 years that aid in dying has been legal in jurisdictions in the United States, **there has never been a single substantiated claim of coercion.** In our law, two physicians must independently assess a patient and determine that the patient is eligible (terminal prognosis plus mental capacity). This serves not only as a potential check-and-balance for such a consequential determination but also offers the primary physician a valuable second perspective on cases and the complexities therein.

And most importantly, participation is optional—for patients, physicians, and staff. **Physicians and staff who have objections to the practice of assisted death for any reason are allowed to opt out** of providing this service—without fear of censure, discipline, or retribution. For the physicians who do not want to participate, they simply don’t have to. However, I hear time and time again from the physicians who *do* participate how rewarding this work is. Far from being distressed, **participating physicians often describe offering this service to their patients as one of the most meaningful and fulfilling acts they can facilitate as a doctor.**

As the medical director, I personally train all physicians in our system on the process of assisted death when they are considering offering this service (usually in the context of a specific patient of theirs asking for it). Without exception, the physicians are anxious at the start—just like I was. After their respective patients' deaths, I always check back in with the doctors and I hear things like “paradigm shift” or “this was an inspiration” or “it is a privilege that we can offer this to our patients.” Those are direct quotations.

What about patients who object? Patients who have objections to the practice simply do not have to pursue the option—same as all options in life. However, for patients approaching the end who want to exercise their autonomy and gain some control over their own dying process, assisted death offers them empowerment at a time that many feel powerless and disenfranchised. As I noted in an editorial for our local medical society (Spielvogel, 2022), the option of assisted death allows patients like Percival to bypass much of the suffering they know is ahead and skip to a more humane ending consistent with their values. Patients choosing assisted death are *not* choosing between life and death. Their time is up either way; it's just a question of how much suffering they want to endure. In six years and the many cases in which I have participated, **I have yet to meet a patient who wants to die. They would gladly relinquish the opportunity for more suffering-free time with their loved ones, but that's a choice they don't have.**

There will always be physicians who oppose this practice. At issue is that bedrock of medicine: do no harm. But what constitutes harm? For the imminently dying patient who has no quality of life left and is ready to move on, continuing to live may constitute harm to them. Forcing our patients to endure suffering because it is the natural order of things is not new to our profession. James Young Simpson famously experienced a backlash when he first used chloroform for effective labor analgesia in the 1800s because suffering was felt to be a necessary part of a woman's delivery. Quite clearly, it has since become common practice to ease labor pain with various medications. The insistence that all must suffer their lot when their end is near is similarly antiquated.

Ana* was a patient of mine a few years ago who was dying from metastatic colon cancer. Spinal metastases made every movement agony and took away her last pleasurable activity: going out and tending her garden. She sought my assistance to help her end her suffering, but her family stonewalled us at every turn. Due to their deeply held religious beliefs, they felt strongly that going through with this act would damn her immortal soul. So under false pretenses, the family sent her to a religiously-affiliated skilled nursing facility that would not allow her to ingest the aid in dying drug on the premises. Then they quickly sold her house so that she would have nowhere to go. Once she and I figured out

what was going on, it was too late. Ana was beyond distraught at the duplicity, but she was at their mercy.

I spent a whole month exploring options for her while she wasted away in bed suffering exactly the kind of agonizing existence she wanted to avoid. I did eventually find a skilled nursing facility that was willing to take her on a charitable basis and allow her to ingest once she got there, but Ana died before the transfer could happen. Ana had made her choice and her family had denied her that.

Every time I see a patient for assisted death I think of Percival, Ana and others like them. Some make it out on their terms; some do not. I try to think about my own mortality, too. If I were facing a slow, steady decline and had intractable suffering resistant to other efforts to palliate, would I choose this option for myself? I honestly don't know, but the fact that I would have the choice makes all the difference.

Over and over again I see how having responsible and effective assisted death as an option in our society enriches it and improves the quality of life for those still here. It provides reassurance to those facing terminal illness—always giving them the final say. And it relieves the existential angst faced by many physicians as they watch their patients dwindle and suffer through the dying process. For the most part, when I now see my patients endure suffering at the end of life, I know it's their choice. Respecting our patients' choices is at the heart of being a good physician and is the highest achievement in fulfilling our oaths.

As such, I hope that you and your colleagues find it in your hearts to author and pass legislation that will bring this humane option to the citizens of the United Kingdom. Thank you for your time and consideration. I am happy to answer any and all questions you might have and am available to provide oral evidence if needed.

Spielvogel, R. Apr 2022. Letting go: A physician's tale of medical aid in dying. *Sierra Sacramento Valley Medicine*.

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