

### Written evidence submitted by Dr Alison Payne (ADY0127)

1. To what extent do people in England and Wales have access to good palliative care? a) How can palliative care be improved, and would such improvements negate some of the arguments for assisted dying/assisted suicide?

I think people in the UK generally have access to good palliative care although it is variable due to shortage of community nurses. For many people, the quality of life experienced towards the end of a terminal illness is not what they want, they fear loss of control, poor pain control, loss of dignity and worry about the distress this will cause both for themselves and others. Much of their suffering is existential, regardless of religious or cultural beliefs.

1. What can be learnt from the evidence in countries where assisted dying/assisted suicide is legal?

I was a GP in the UK from 1988 – 1994 and then 2007 – 2020. I have been deeply involved in providing end of life care for my patients over the years including when many of them were my own age, dying of AIDS. From 1995 – 2007 and from 2021 to present I live and work in NZ, and provided palliative care then and now. I am now also an Attending Medical Practitioner for Assisted Dying as it is a choice I have always believed in; when it became legal I entered the training.

Observing how AD operates in NZ, my experience is that when I meet an applicant for AD for the first time, they are anxious but immensely relieved that I am there to explain the process. The biggest fear has been that I will declare them ineligible (the criteria are very strict). Family members often struggle with their loved one's choice but recognise that this is what the person wants, and come to honour and respect it. Some are involved, some aren't, but it is the choice of the person concerned. We discuss the fact that the person is going to die anyway; this is their way to keep control in an uncontrollable situation. I have not yet seen evidence of coercion – more often the family are reluctant for it to happen.

The assisted death is a hugely peaceful event. The person is in charge and has had the chance to do and say all that they want and to set the scene as they wish. They are not experiencing the ignominy of 'terminal sedation' that can go on for days or even weeks; they are conscious and in control until the end, and they die quickly without distress – which means those in attendance are not left with horrible memories of their loved one's final hours. Frequently I hear laughter coming from the room while people have their last time together. The relief on the faces of those left behind is obvious, as well as their grief.

2. What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?

Very similar to those of abortion. Conscientious objection is of course permitted, but it is imperative that clinicians direct the person to where they CAN get the help they request. Here in NZ some clinicians refuse to engage, thus denying the patient their legal right to be assessed and causing needless stress as they navigate their way to the AD service. Other considerations are around the privacy and safety of the practitioner. I am immensely proud of what I do and consider it a great privilege to help someone with their last wish, however I am unable to speak out until AD is more common practice.

3. What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying/assisted suicide services?

Age over 18y. Mental capacity to understand what AD involves; ability to make the choice of method (oral vs IV); in an irreversible state of physical decline, suffering such that the person's suffering cannot be relieved in an acceptable way. A clear understanding of their prognosis and how their illness may progress. Supporting evidence of this from clinicians who care for the individual. The existence of an Advance Decision stating the person's views on quality of life / end of life care is helpful to indicate the person has long held views. Has been offered palliative care..

4. What protections could be put in place to protect people from coercion and how effective would these be?

Attending Practitioner (AP) questions the person and their family at every step on this issue. AP discusses with the person's usual clinical carers and others eg home carers, family members etc. Remember this person is going to die anyway within 6m – this is one of the criteria.

5. What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying/assisted suicide services?

See the NZ Ministry of Health website where there are several documents for people to read. I print them out and take them with me when I do my first visit, as well as emailing them to the person or a family member.

6. What capabilities would a person need to be able to consent to assisted dying /assisted suicide?

Mental capacity to understand AD and what it involves, that it is irreversible but they can opt out at any time along the process. Can appoint a proxy to sign the forms for them (must be someone who won't benefit financially from their death). Not suffering from treatable depression or other mental illness.

7. What should the Government's role be in relation to the debate?

Listen to the views of their constituents. As a GP in the UK many patients expressed a desire to me to have a choice over AD (many people don't use it once they know they have the option). My own MP conscientiously objected which disappointed me as I am certain the majority of his constituents supported choice. NO ONE is forced into this in my experience. Disabled people are treated in the same way as anyone else as the qualification criteria do not include disability.

Organise an appropriately worded referendum - as NZ did.

Set up a robust system with a clear funding stream.

Ensure the Medical Colleges accept the decision of the referendum. My own college the RCGP remains against, despite the majority of members surveyed either supporting AD choice or abstaining. Shared decision making is the mantra of good medical care; doctors must not bury their heads in the sand over what their patients want near the end of their lives.

Ensure that hospitals, hospices, care facilities etc are made aware of AD and patient's choices.

Provide information for the public and ensure that they are aware that this is like abortion, it is a choice that no one needs or is forced to make. Remind them that opting out is possible at any stage. Remind them that it runs ALONGSIDE good palliative care, it isn't an either / or.

NZ provides comprehensive information to the public, to health care professionals and to care proviers; the UK Govt could seek advice and information from the Ministry of Health and Registrar for AD in NZ:

[Assisted Dying Service | Ministry of Health NZ](#)

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