

I am a palliative medicine physician trained and worked in Ireland, USA and Scotland, now working in Aotearoa New Zealand. My views today are informed by my extensive experience the ability of palliative care to satisfactorily address people's physical and existential needs and fears at the end of life without ending their lives prematurely.

My starting point is that assisted dying is not part of medicine. Assisted dying sets up a conflict within medicine and for palliative care in particular. We cannot expect doctors to be advocates for life and direct providers of immediate death – whether offering the option of a premature death, or acceding to a patient's request for such, doctors' involvement in the decision sends an existential message that the patient's life is no longer worth living even if, doctors see themselves as a neutral party.

In NZ 1,800 doctors signed an open letter that doctors should not be included in the practice of assisted dying citing that “*crossing the line to intentionally assist a person to die would fundamentally weaken the doctor-patient relationship which is based on trust and respect.*

In New Zealand, where legislation mirrored on Canadian law has been in effect exactly 2 years, it is far too early to derive lessons. This is particularly so based on the limited data being gathered despite our protracted discussions with the Ministry of Health advising them to collect data similar to Oregon or Canada.

I now refer to the observations made by palliative medicine physicians in our study of the impact of assisted dying on palliative care practice. Patients are being granted euthanasia on the basis of their request, and the fact that they are likely to die within six months. But, the feedback from doctors is: *there was no attempt as far as I could see from the documentation, to explore why. And no sign in those notes of intractable suffering.*

The practice of palliative care has deteriorated with less engagement on the tough subject of suffering and its meaning for individual patients which is core work of palliative care. All of this means that true choice for patients and those who work in palliative care has been reduced. Patients with delirium deemed lacking in capacity by an experienced palliative medicine doctor are undergoing euthanasia. Many have proceeded with assisted dying on the basis of feeling a burden.

There is the example of the man who lived alone, whose sister suggested euthanasia for him *he felt completely devastated in the fact that she thought that that might be an option.*

*he has proceeded with it but that rift between him and his sister, was palpable,*

Assisted dying is being chosen by those who live alone:

*“A man recently had a cancer diagnosis and lived alone and didn’t have anyone to care for him. An external family member initially said ‘We’ll do everything we can to support you’. After a week put her hands up and said ‘We can’t support you’,*

Rather than go to rest home, he chose assisted dying. Coercion is subtle and happening everyday. There are inadequate funds to provide a good palliative care service but assisted dying takes huge resources in time and energy from palliative care. There are concerns about the grief of children and teenagers of parent or grandparents who choose Assisted dying. Paediatricians have serious concerns about 18 year olds choosing Assisted dying when it is known that an 18year old may have adequate cognitive development but not emotional development..

I have referred to the negative impact on palliative care. Many are seeking assisted dying because they feel a burden. People are requesting and receiving assisted dying without objective signs suffering. People whose capacity to consent is questionable are receiving assisted dying. The vulnerable are being exploited and the standard of palliative care services has diminished.