HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Assisted dying/assisted suicide, HC 711

Tuesday 27 June 2023

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Watch the meeting

Members present: Steve Brine (Chair); Lucy Allan; Paul Blomfield; Chris Green; Mrs Paulette Hamilton; Rachael Maskell; James Morris.

Questions 181 - 236

Witnesses

I: Dr Georg Bosshard, Practising geriatrician and nursing home physician, Reader for Clinical Ethics, University of Zürich; Professor Samia Hurst-Majno, Professor of Biomedical Ethics, University of Geneva and member of the Swiss National Advisory Commission on Biomedical Ethics; and Dr Yvonne Gilli, President, Swiss Medical Association.

II: Silvan Luley, Dignitas, To live with dignity – To die with dignity; and Bernhard Sutter, Director, EXIT (Deutsche Schweiz).

Examination of witnesses

Witnesses: Dr Bosshard, Professor Hurst-Majno and Dr Gilli.

Q181 **Chair:** Good morning. This is the Palace of Westminster in London, and this is the Health and Social Care Committee. We are joined by a series of guests, who I will introduce in just a minute, for our latest public evidence session in our assisted dying/assisted suicide inquiry. This is our fourth oral evidence session for the inquiry.

Today we are hearing from witnesses from Switzerland, who are all virtual for obvious reasons. The first panel comprises some Swiss academics doing research in the field and a representative from the Swiss Medical Association. The second panel is made up of two of the providers, including Dignitas, which British people will of course be very familiar with.

Let’s introduce our first panel, which will be for 45 minutes or so, and then we will move on to our second panel. Joining us now, we have Dr Georg Bosshard, a practising geriatrician and nursing home physician and reader for clinical ethics at the University of Zürich; Professor Samia Hurst-Majno, professor of biomedical ethics at the University of Geneva Medical School and a member of the Swiss National Advisory Commission on Biomedical Ethics; and Dr Yvonne Gilli, president of the Swiss Medical Association.

Thank you very much. We have tested your lines, so, as long as the connection stays, we can hear you, as can all the people who are interested in this. As you would imagine, there is significant interest in this inquiry here in the UK and, indeed, around the world. We have spoken to many other jurisdictions, and we have visited the United States. In our last session we heard from the Netherlands, among others.

Dr Gilli, how would you summarise the current approach in Switzerland to the issue? Where do you think the public are at the moment on the issue?

Dr Gilli: Basically, anyone in Switzerland is allowed to help someone else to commit suicide. The restriction imposed by the Swiss criminal court, in paragraph 115, is that it must not be done for selfish motives. Euthanasia is illegal and regulated in paragraph 114 under the chapter of homicide, even at the request of the victim. We think that there is very good acceptance in society, as well as among doctors, for the actual solution, particularly without having very specific legislation on assisted suicide.

It is very much appreciated that we have medical ethical guidelines on the management of dying and death, and there included is assisted suicide, but within a broad context around the management of dying and death. Doctors follow those guidelines in Switzerland. It is not legally binding, but it is an ethical code. Almost every doctor in Switzerland is a member of the Swiss Medical Association and therefore is obliged to follow those guidelines.

Q182 **Chair:** Thank you for that. Professor Hurst-Majno, you have done some work on staff attitudes towards assisted suicide in hospital settings in Switzerland. Could you outline for us what you found? Pretty universal support would be a good summary.

Professor Hurst-Majno: That is right. We conducted a study in the university hospitals of Geneva and Lausanne. It should be mentioned that this is a very precise setting. It is not a general study of attitudes of physicians in Switzerland. It is about the specific question of assisted suicide entering the walls of the hospital and being conducted within the hospital by hospital staff.

We were surprised to find quite a high degree of support among different healthcare professionals. We have no idea whether these results can be generalised to other parts of the country. Switzerland is pretty complicated, with 26 different cantons and different language regions. The study has not been replicated in other areas of the country and results may very well be different there.

In studies by physicians in general, not specifically about entering hospital but about the Swiss current system on assisted dying, support is pretty high. That has been studied before. As a matter of fact, it led to the most recent revision of the Swiss Academy of Medical Science guidelines, which have already been mentioned.

Q183 **Chair:** If it was changed to allow physician-administered, what do you think would be the outcome?

Professor Hurst-Majno: Perhaps I should say a word on terminology. We make a very explicit distinction in Switzerland between suicide assistance and physician-administered, which we would call active euthanasia. We tend not to use the term "assisted dying", which I understand is more frequent in the UK, because it blurs the lines between what is legal and illegal in Switzerland. We tend to keep these things very distinct.

We have never had a lot of support for physician-administered dying—active euthanasia—and perhaps one of the reasons is that the Swiss model seems to be predicated in part on a model of resistance to the medicalisation of death. This is one of the aspects that tends to get underestimated when our system is viewed from abroad. We are the only country in the world that allows non-physician assisted suicide. Every other country that allows it has made physician participation a requirement.

Our system might seem a little exotic viewed from the outside. Part of this is resistance to the medicalisation of death, not just by society, but by medicine itself. There has been very strong resistance within the medical profession towards stronger medicalisation of assisted dying. Many people who use assisted dying choose to die at home. It is in this context that, for a very long time, hospitals have actually banned the practice outright on their premises. The study we conducted in Geneva and Lausanne has to be understood in the context of a move towards less resistance on the part of hospitals and legislation in certain cantons to limit the possibility for hospitals to ban assisted suicide on their premises.

I do not think that there is societal, medical or political support for the legalisation of euthanasia in Switzerland today. My colleagues might differ on this, but I see nodding. There have been attempts to change the legislation and allow active euthanasia in Switzerland. These attempts have all currently failed, and I really do not see support for it. The study we conducted was not about physician-administered dying. It was about the possibility for hospital collaborators—people employed by a public hospital—to do the prescribing of a lethal drug which the patient would then ingest themselves, remaining clearly within the confines of suicide assistance, which is legal.

Q184 **Chair:** Dr Bosshard, let’s bring you in. You were neither shaking nor nodding your head during that. What is your view on the discussion so far? In the law as it stands, is the country at ease with itself on that law?

Dr Bosshard: I basically agree with what Dr Gilli and Professor Hurst-Majno have said so far. In terms of acceptance among physicians, I can add some numbers. A large opinion poll of medical doctors carried out by the Swiss Academy of Medical Sciences in 2018—the Brauer study—showed that 75% of all doctors thought that assisted suicide should be legal in Switzerland, and 50% of all doctors said that they would be willing, under certain circumstances, to assist in the suicide of a patient.

As Professor Hurst-Majno said, it is basically about assisted suicide. It is not about euthanasia. It is not about a doctor administering a lethal substance. We have to say that our model of assisted suicide goes quite far technically, in that patients are not only allowed to digest a lethal substance, but the right to die societies are also allowed to use IV drips. The crucial thing that will be considered assisted suicide is that the patient or the person wanting to die has to open the IV drip herself or himself. It is quite a forward-going model and, in the end, it is technically a bit close to euthanasia. In terms of terminology, it is assisted suicide.

Q185 **Chair:** We understand that. Are the high figures that you were quoting on the grounds of compassion and alleviation of suffering? What do you think lies behind the psyche on that, as somebody who is a reader in clinical ethics? What do you think the psyche is?

Dr Bosshard: I would put it another way. We have carried out studies on medical end of life decisions. We can show that in modern medical systems it is an exception that the patient dies completely naturally, meaning that there is no decision at all preceding death.

In modern medical systems, it is commonly the case that there are decisions before the patient dies. Normally, of course, the decision is not about assisted suicide; there are decisions not to carry on life-sustaining treatment or maybe not to start a new life-sustaining treatment, and probably to use sedatives in high doses for terminal sedation. In that context, it seems logical to me that assisted suicide is allowed. It would be consistent. I have to say that in clinical practice I have one or two cases every year in my nursing home of assisted suicide. They are not much more difficult than, for example, cases of terminal sedation or other difficult cases of dying. We have to see medical end of life decisions as a whole. Assisted suicide is not so completely different and not so particularly different as many people would put it.

Q186 **Chair:** Finally, Professor Hurst-Majno, where is the debate around end of life decisions and minors—under-18s?

Professor Hurst-Majno: That is a very interesting question. The Swiss legal system does not forbid it. In the Swiss legal system, the criminal code article says nothing about the age. The law on medical products says that physicians must respect the rules of the art when they are prescribing, but that says nothing about age either. The ethical guidelines of the Swiss Academy mention minors, not about assisted suicide but about end of life care in general.

The fact of the matter is that in law it is allowed to assist the suicide of minors, but my understanding is that nobody will touch it. There is no accepted case of suicide assistance in minors. Under Swiss law a minor may make their own decisions as regards medical care, as long as they are capable of decision making. You do not have to be an adult in Switzerland in order to make your own medical decisions. You just have to be capable of decision making, and that can be assessed by medical professionals.

Suicide assistance has a particular status. It is not part of medical care in an ordinary sense. It is not something that people have right of access to. It is something which people have a liberty right to. In the case that they find someone willing to assist them, and they fulfil the other requirements, the state will not prevent it. That is the structure of this right, but, to my knowledge, no minor has found a person who was willing to assist them in an assisted suicide request.

Q187 **Chair:** You said that nobody wants to touch it. Why do you think that is? Why is it okay to alleviate suffering for an adult, but we would be content to allow children to suffer?

Professor Hurst-Majno: That is a good question.

Chair: That is why I asked it.

Professor Hurst-Majno: It is a question which exists at all the margins of societal support. My guess would be that there is too much uncertainty as to whether there would be societal support for people who dared to go into that terrain, but that is a guess.

Q188 **Chair:** Fascinating. Dr Gilli, do you wish to add anything?

Dr Gilli: No. Age plays a role. It is not an absolute role, but in the legal sense of becoming an adult. For example, with a 16 or 17-year-old things start changing, so if a boy really suffers from unbearable pain or a deadly untreatable illness, there will be cases in Switzerland where assisted suicide will happen, but that does not mean that there will be a legal case about it. In those circumstances everybody would be very careful in following the guidelines and integrating family matters and the whole social situation surrounding the person.

Chair: We have some slight line issues with you, but we have got the gist.

Dr Gilli: And—*[Inaudible]*—agree.

Chair: We have some slight connection issues with you, but we got the majority of it. I will hand over to colleagues now. If you wish to come back on a point, use your physical hand. We cannot do the body language that we can when you are in the room, but colleagues are keeping an eye out for that. If you want to come back in on something, we will try to make sure that it is an easy-flowing conversation. On that point, I bring in my colleague Paul Blomfield, who is here with us in London.

Q189 **Paul Blomfield:** Thank you very much, Chair. I thank you all for joining us this morning. We are conscious that Switzerland is the jurisdiction in which assisted death has been available for longer than anywhere else in the world. We are keen to learn from your experience.

Could I start by following up a comment you made, Professor Hurst-Majno? You talked about resistance to the medicalisation of death. I understand the line you were drawing between patient-administered drugs and physician-administered drugs, but would you agree that in all circumstances there is a role for medical professionals in the process in Switzerland?

Professor Hurst-Majno: I completely agree. What I was trying to describe is what I perceive to be the logic behind some of the things that might appear inconsistent from the outside in our Swiss system. Suicide assistance has been legal in Switzerland for much longer than what we would recognise as modern medicine being in existence. It has been legal for longer than the period during which most of the requests have been due to terminal and incurable disease.

The examples that our predecessors had in mind when they made this legal at the end of the 19th century, and then, when it came into effect, in the 20th century, mostly did not have anything to do with illness. Medicine is a latecomer to the scene, which is highly unusual. This means that the image that seems to be at work when people express their wishes and the limits is a system where it is an individual, a citizen, a sincere person who is concerned and who meets someone who has a severe situation of distress and wants to die, and is convinced by the distress of that other person.

In practice, of course, doctors have a part in many steps in the process. A doctor must prescribe the lethal drug, or it cannot be had. A doctor must assess decision-making capacity, which is a legal requirement under the criminal code. A doctor must assess the clinical situation and existing alternatives in order for societal support for the practice to exist. Once the person has died, since it is an instance of unnatural death, there is the visit of a forensic physician and the possibility of an inquiry at that stage. Doctors are there at every step.

The image of assisted suicide is still the image of someone who is a volunteer—not a professional—coming to the home of someone who wants to die, and that person dies at home with family members around them. Although assisted suicide has made headway in hospitals—so in a medicalised setting for death—that is not the image that people seem to have in mind.

Of course, in the case of physician-administered, in the case of euthanasia, you have to depart from that image. You have to imagine death in the hospital setting with the white, the chrome, the IV drips and the lab coats. That seems to be insufficiently compatible with Swiss images around assisted dying to garner support for active euthanasia, despite the fact that there have been movements advocating it for decades.

Q190 **Paul Blomfield:** Thank you very much; that was very clear. Could I follow up another point that you made? You talked about attempts to extend legislation having failed. This is of particular interest to our inquiry because there is a concern, which we are exploring, that, once a jurisdiction chooses to make assisted death available, it is a slippery slope and will inevitably lead to a widening of the scope of such legislation. You are saying that that has not been the case in Switzerland over 80 years.

Professor Hurst-Majno: Arguments around fears of a slippery slope assume that there is a destination where we do not want to arrive, otherwise it is not a slippery slope, and that we will inevitably get there. There have not been legislative changes in Switzerland despite attempts to open more, and also attempts to close more. There have been both kinds of attempts. There have been attempts to introduce further oversight of right to die societies. Those have also failed.

Each time, we had a very lively debate followed by the conclusion that we were satisfied with the status quo. This does not mean that there has not been a broadening of criteria. In practice, assisted suicide is not only limited by law in Switzerland; it is limited by a certain perception of the acceptability of practices that might be unusual. The law allows so much that there is a fear of doing everything that the law would allow. There is no support in society for quite that much.

The criteria used by right to die societies have indeed expanded over the years. They have expanded from requiring that there should be a terminal disease to requiring that there should be an incurable disease, and requiring that there should be incurable suffering, which may be due to just one disease or several. After all, if it is the suffering that is the primary concern, the fact that it is due to one disease or more than one might not be so material to the argument.

This has largely been followed with some delay by the medical profession. There has been resistance and delay on the part of physicians who are at the frontline and are also aware of some of the risks. Largely, there has been an expansion of criteria to some degree, but it was not in the legal parts of the framework, hence the absence of changes in legislation.

Q191 **Paul Blomfield:** Thank you very much indeed. Dr Bosshard, you were talking earlier about the attitudes of your colleagues and physicians across Switzerland. Can we reflect on the views of the Swiss population as a whole and how far you feel there is support for the existing settlement in Switzerland from your patients, as a geriatrician?

Dr Bosshard: They all know that in Switzerland, and in most westernised countries, there is a very high degree of agreement to any form of assisted dying, even in countries where the legislation is very conservative. When it comes to the general public, they are basically in favour. When it comes to my patients, they are very different. The good thing is that if you do not want to have any discussion on assisted suicide, which is the majority of patients, it is no issue at all. The few patients who have an interest in it have that possibility.

It is a very different issue if you are young and you agree, in an opinion poll, that assisted suicide should be allowed, or if you are terminally ill or something like that. Whether you go to assisted suicide or not, that is okay. The fact that you are in favour of assisted suicide does not mean that you, as a person, will choose that way. It is just to have freedom in society for that way of dying. That is an important issue, and we should have a variety of possibilities for having a good death. People are so different. We should have a healthcare system and a society that can meet all the needs of these very different people and the variety of wishes of people.

Q192 **Paul Blomfield:** You are right that all the polling suggests that there is strong public support for the option of assisted dying both in jurisdictions that have the option and in those, like the UK, that do not. How would your patients feel if things changed in Switzerland and the blanket ban or criminalisation that we have in the UK was applied in Switzerland?

Dr Bosshard: Your question is what would happen in Switzerland if we removed assisted dying.

Q193 **Paul Blomfield:** What would be the view of your patients if you were in our position?

Dr Bosshard: Nobody is really thinking about that because it is absolutely not an issue. I think there would be a revolution. What do you think, Samia? It is absolutely unthinkable. It is very important for Swiss people to have that freedom at the end of life. The right to die society EXIT has more than 100,000 members. It is a public rights issue at the forefront. It is really important for Swiss people to have that right.

Q194 **Paul Blomfield:** Professor Hurst-Majno, do you want to come in on this?

Professor Hurst-Majno: I absolutely agree. It is a small minority of people who make use of the possibility and die that way, but a much greater number of people value the reassurance that comes with the possibility. People treat it almost like a form of insurance. If the possibility was removed I think there would be a public outcry, and from patients too.

Q195 **Paul Blomfield:** It is an interesting point you make that the numbers of those who choose that option remain very small.

Professor Hurst-Majno: Yes.

Q196 **Lucy Allan:** Good morning, panel. Because the Swiss model is self-administered, it raises questions around safety and regulation. I would like you to talk a little bit more about exactly that, and how well regulated the Swiss model is. To what extent do all three of you feel that this is a safe practice that is not being abused, and that self-administration does not create additional risk?

Dr Bosshard: One issue is over-regulation and another issue is under-regulation. You should have something in between. We have quite a good model for that. I think it is safe. We have more than 1,000 cases every year. If the model was not well regulated, sooner or later, there would be cases becoming public where something was wrong. That is almost never the case. The matter of regulation is not so bad. Of course, we could have more regulation, but more regulation is also problematic. For example, in Switzerland, you do not see a psychiatrist if you want to have assisted suicide unless you are mentally ill or dementia is an issue. If dementia is not an issue and there is no mental illness, you do not have to see a psychiatrist. I think that is good. I do not think that a patient with cancer should have to see a psychiatrist before he gets assisted suicide.

In practice, we often have a system of two doctors seeing the patient. The members of the right to die societies also have an important role in assessing decisional capacity. It is a mixed responsibility between the doctors who make the prescription and the volunteers from the right to die societies. I think that is enough for most cases. When I talk to people in some other legislations, where they start with assisted suicide, in my opinion under-regulation is not often the problem but over-regulation is.

Q197 **Lucy Allan:** That is interesting. Dr Gilli, you have your hand up.

Dr Gilli: I just want to add something. Aside from the medical and ethical guidelines, the prescription of a drug for suicide must be reported to the cantonal authorities within 30 days. Death after assisted suicide must also be reported to the competent authorities as an extraordinary death. It is subject to a corresponding examination by the cantonal medical officer or the forensic medicine department.

That does not happen in every case because most cases are sufficiently judgeable by the medical—*[Inaudible]*—ethical guidelines in the situation. The authorities play a role and that increases safety for patients and their relatives.

Q198 **Lucy Allan:** Despite self-administration being the model, doctors are involved at every stage and that makes it safe. Is that your view?

Dr Gilli: Doctors, and the official administrations of the cantons. There are also doctors involved there, but they do not have any relation to the actual case.

Q199 **Lucy Allan:** Professor Hurst-Majno.

Professor Hurst-Majno: Self-administration is actually one of the safeguards. It means that it is the patient herself who must make the final call and who can change her mind at any time. The practice of right to die societies is also largely to do that with accompaniment. In the US the model is often to leave the patient with the prescription, and then they go home and can do what they will with it. This is not the regular Swiss practice. The potion is brought to the patient's home by the volunteer, and the person watches them drink it, basically. This prevents things like using it to kill someone else, which would not be easy in any case. The fact that the patient herself can change her mind until the last minute is a safeguard. The fact that the practice is accompanied is also a safeguard.

Q200 **Rachael Maskell:** Professor Hurst-Majno, I would like to ask you a little bit about vulnerable people and the safeguards around coercion. How do you ensure that people, both from Switzerland and from across the world, have safeguards in place so that there isn't coercion into your processes?

Professor Hurst-Majno: As I said, the fact that there must be a decision on capacity and that the person can change her mind until the end is part of the safeguard. You are right that it is only part of the safeguard. Vulnerability is the increased risk of being wronged, as Dr Bosshard said. There can be a risk of over-protection and a risk of under-protection. Lack of access can also be a vulnerability. We have had cases like that come to the attention of the courts in our country.

Of course, pressure to go into assisted suicide can exist. It is all the more concerning that these pressures are not necessarily intentional. They are not necessarily explicit. There can be societal biases that send implicit messages that someone is no longer wanted or is no longer a "useful" member of society. Part of the protection is having access to the alternatives. It is having access to the sorts of alternatives to assisted dying that the person would want. That means having a good social system in place and having good access to healthcare in place. That is an inherent part of the protection against the risks for vulnerable persons of being edged or pushed towards suicide assistance.

In the absence of such a system, what to do with suicide assistance is probably the hardest question of all. If there is a situation where people do not have access to the alternatives, we should not live under the illusion that simply banning suicide assistance in their case will resolve their problem. It cannot be the only solution that is proposed as protection for vulnerable individuals. The protections we have are the involvement of physicians in many steps; access to healthcare; and access to social alternatives for vulnerable individuals, which is important; and discussions about alternatives, which are a very important part of the Swiss Academy medical ethical guidelines on requests for death and assisted dying. It is also about having such discussions, in the case of non-resident foreigners, by the right to die societies that accept those cases. Because many of these pressures are implicit and unconscious, I do not think there can ever be a guarantee that they will never have an effect, but the protections that are in place do a good job of limiting the risk.

Q201 **Rachael Maskell:** I want to follow up on something that was said previously—that there is no need for a psychiatrist to carry out an assessment. If that is the case, how can you be secure in the decision that is made?

Professor Hurst-Majno: A psychiatrist is required in cases where there is a psychiatric diagnosis and where there is doubt as to whether a mental illness may affect decision-making capacity. Basically, we count on our primary care practitioners being able to screen for things like depression and mental disorders, and refer appropriately as they would if the request was not assisted dying, but was a more ordinary request for help with medicine. What we do not do is have a requirement for psychiatric evaluation in every single case, even in the absence of red flags and symptoms that something might be awry.

Q202 **Rachael Maskell:** Dr Gilli, I want to press the point further. You are obviously providing this service both for nationals and people travelling from overseas. How do you assess somebody who is travelling to Switzerland, to Dignitas? How would you provide the safeguards and ensure that medical ethics were upheld through the process?

Dr Gilli: Thank you for the question. Patients who receive treatment in Switzerland are subject to the same framework conditions as residents in Switzerland. The guidelines for accompaniment are just as binding for them as the notification of extraordinary deaths to the authorities. We recommend making sure that the doctor in charge is a member of the Swiss Medical Association and thus has the obligation to follow the guidelines, so that it is all a binding part of the professional code of conduct. That is an additional safeguard for patients from abroad, the violation of which can be sanctioned not only by the authorities but by the professionals.

It is important for patients to know that the guidelines are available in English, and are public and accessible on the internet. There is only a short time that gives us the possibility to follow the guidelines and assess the situation, so I guess there is a certain additional risk for patients coming from abroad for assisted suicide in Switzerland.

Professor Hurst-Majno: Right to die societies are not subjected to accreditation and professional criteria. That is accepted in Switzerland. I know that because there have been attempts to subject them to such things and they have failed. It is a situation where we trust them to do their work well without putting in place the administrative requirement that would demand that they do their work well. It is one of the paradoxes of the Swiss situation. So far, they look like they have deserved this trust, and so they continue to have it, but there are no training requirements imposed on such societies. That is an important point.

Q203 **Rachael Maskell:** No training requirements either?

Professor Hurst-Majno: No, not from the state, not from the law. The societies themselves may, and in fact do, have training requirements for their members, but it is on their own initiative.

Q204 **Rachael Maskell:** It is self-regulatory in that sense.

Professor Hurst-Majno: Exactly. It is a self-regulatory system.

Rachael Maskell: Chair, it would be really helpful to have those guidelines and to look through them.

Chair: It really would, yes.

Q205 **Rachael Maskell:** I have a further question for Dr Bosshard. Obviously, palliative care is comparatively a new area of medicine in Switzerland. How are you finding that that is given true credence by the societies that oversee assisted dying?

Dr Bosshard: We all agree that to have good palliative care is absolutely crucial. It is much more important than to have legislation for assisted dying. It is important that we do not see palliative care and assisted suicide as completely opposed. They are not together, but they are also not opposed. We should make good palliative care, but it is not the task of palliative care to prevent euthanasia or assisted suicide. That is a very important issue. In Switzerland, most palliative care physicians are not against assisted suicide. It is not their business. There is no close collaboration, but there is a kind of acceptance. In that way it works quite well.

Chair: If you could provide that afterwards in writing to the team, we would be grateful as we are pulling together our evidence. The last question for this panel is from Paulette Hamilton.

Q206 **Mrs Hamilton:** Good morning. I will address my first question to Dr Yvonne Gilli. It follows from what Rachael just talked about. What are your views on organisations from Switzerland like Dignitas accepting foreign nationals into the country for assisted dying reasons?

Dr Gilli: I completely agree with what Samia Hurst-Majno said. In the Swiss population there is a certain ambivalence concerning these organisations, especially when it comes to the fact that the people need a flat and some rooms where other citizens live. It is a confrontation if somebody comes to die beside my flat. I think that is just an expression of ambivalence towards living and dying in general.

The other side is that from a medical association view it is very important that we are sure that the professionals act professionally and that we have qualified doctors and an in-depth assessment of the patient who comes to Switzerland to die, and that the medical ethical guidelines are applied. There are safeguards, as we mentioned before. It has to be reported to the authorities as an extraordinary death. In the case that there are relatives of the patient who are doubtful about the whole situation, they can apply to the court. The authorities have to assess the situation. In fact, in Switzerland, up to now with self-regulation there are no serious doubts that the circumstances are within the legal framework and medical ethical guidelines of Switzerland. There are court cases and punishments by the courts in Switzerland, but they are rare.

Q207 **Mrs Hamilton:** Professor Hurst-Majno, over to you.

Professor Hurst-Majno: There is no movement, to my knowledge, in Switzerland to ban the acceptance of non-resident foreigners from coming to Switzerland for suicide assistance. Given the model that I described before—the idea that most people want to die where they have lived and to have their dying time be the continuation of their life and the wish for people to die at home, which is part of the motor behind the support for assisted suicide in Switzerland—I would not think that most people think that having to leave their country and go somewhere far away where a different language is spoken is the ideal option. It is even farther than the local hospital, where most Swiss do not want to go to die. There is ambivalent support. It is not like there is enthusiasm for this practice. There is also the troubling proximity that Dr Gilli described. Beyond that, I would not think people are cheering this on. They would probably much rather that those people could remain at home.

Q208 **Mrs Hamilton:** If people choose not to go through organisations like Dignitas, how is it thought of in Switzerland to go through a doctor instead of those organisations? Is that ever done?

Professor Hurst-Majno: Yes, it is. It is not forbidden for doctors to assist suicide. As we mentioned, they are involved in all the steps even if it is not always visible. Some physicians receive suicide assistance requests, and some of them accept to go through with them.

Those cases usually fly under the radar. There are no official statistics of suicide assistance cases overall in Switzerland, at least not regular ones. There are studies that are conducted, but they are sometimes few and far between. We also know that it can be a difficulty for patients to know which physicians will accept and which will refuse. There was at least one case in front of our courts where a patient complained of exactly that—the lack of knowledge of who might accept. People always said, "I refuse but try your luck elsewhere." She was exhausted by that.

It is possible to contact a physician. In theory, it is also possible for a non-resident foreigner to contact a Swiss physician directly rather than Dignitas, but every Swiss physician—every Swiss person actually—has a complete right to say no, even to someone who would fulfil legal requirements, because suicide assistance is a liberty right and not an entitlement. I expect that that would frequently be the case if non-resident foreigners, rather than going through tried routes, attempted to contact physicians directly.

There is also the issue of place. Hospitals, even when they accept suicide assistance, will now not accept explicit referrals for that purpose. There has to be a place for the person who dies. Someone who has no residence in Switzerland might have difficulty finding such a place in the absence of a dedicated space, which Dignitas has, for example.

Q209 **Mrs Hamilton:** My final question is around the language barriers. Someone coming into the country does not have to go through an organisation like Dignitas; they can pick the consultant, GP or doctor they want to go to. You talked earlier about frameworks. Do you have a framework for foreigners coming into the country who want to take part in assisted suicide? Is there a framework for them, or can they fall through the net?

Professor Hurst-Majno: My expectation is that they will not find an individual physician willing to assist them. The refusal does not even have to come with justifications because it is a liberty right. It is not a usual case of conscientious objection, where you must refer to a colleague. There is no right to access suicide assistance in Switzerland. Period. If a physician does not want to enter into a difficult situation, which these would be, they are likely to refuse. I have no knowledge of an individual physician accepting such a case.

Mrs Hamilton: I am done unless anybody else wants to add to that. That has answered my questions. Thank you.

Chair: Do other colleagues wish to ask our first panel of guests any follow-up questions? Thank you so much for joining us. We will suspend the sitting because we have to bring other people on to the technology.

Dr Bosshard, Professor Hurst-Majno and Dr Gilli, thank you so much for your evidence. Thanks for joining us. We will produce our work later in the year. I know that you will follow it with interest. Thank you so much.

Examination of witnesses

Witnesses: Silvan Luley and Bernhard Sutter.

Chair: Welcome back. This is still the Health and Social Care Committee with our inquiry into assisted suicide/assisted dying. We are live here in London talking to guests on our second panel, and I shall introduce them. We have Silvan Luley from Dignitas, and Bernard Sutter, who is a director at EXIT (Deutsche Schweiz). Many people will be aware of your organisations, gentlemen. We have a cross-party group of colleagues here in London on the Committee who will ask you a series of questions. We are very grateful for your time. We start with my colleague, James Morris.

Q210 **James Morris:** Mr Luley, in Dignitas's evidence to our inquiry, the first sentence says, "Contrary to a widely-held opinion, people suffering from mental health problems normally have sufficient capacity of discernment to decide whether they would like to continue living or end their life." The paragraph concludes, "There are no rational reasons to patronise these people through paternalism." Can you explain what you mean by that?

Silvan Luley: The Swiss Federal Supreme Court, in a judgment in 2006, which was followed by a judgment by the European Court of Human Rights in 2011, made it clear that a person who is able to make up their mind and act accordingly has the freedom and the right to decide on the time and manner of their own end of life. The so-called right to die, or more precisely the right to choose, is a basic human right all over Europe. As far as I know, the United Kingdom has signed the European Convention on Human Rights too.

That case concerned a person who was suffering from a psychiatric illness. The Swiss Federal Supreme Court, in that judgment in 2006, made it clear that people with a psychiatric illness have the right to decide on the time and manner of their own end of life, just as much as people who have a somatic physical illness, terminal or not.

Q211 **James Morris:** What is your evidence for the part of the sentence that asserts that people suffering from mental health problems "normally have sufficient capacity"?

Silvan Luley: If you speak to experts in the field—psychiatrists or psychologists—you will see that it is a widely held misconception, and maybe even a prejudice, that people who have some sort of mental illness are not competent. The law in Switzerland, and, by the way, in the United Kingdom, clearly says that everybody is assumed to have capacity unless there are certain signs that let you assume that they do not. Nobody needs to prove that they are competent; it is the other way round. There was a question in the earlier panel with Professor Hurst-Majno, Dr Gilli and Dr Bosshard about whether people should in all cases see a psychiatrist or not. It was not mentioned that the legal basis is that everybody is assumed to be competent. This base, of course extends to people with a psychiatric illness too.

The starting point is that people are competent. People have the right to decide about their end of life. From there on, it is a matter of investigating the individual request and whether that wish to have an end to one's own life, based on whatever motivation it may be, was a motivation that comes from some delusion or severe depression that would legally impair capacity. Then, of course, the proof of being competent tilts to the other side and the person wishing to end their life needs to see a psychiatrist and have an assessment. In that assessment, it is established whether the person has the competence to make a decision on their own end of life.

Q212 **James Morris:** To be clear on the process, if somebody was to approach you to say, "I want to consider going down the assisted dying route. I have been suffering from severe depression most of my life and I want to end my life," how would you handle that person? What is the process you go through to handle that person?

Silvan Luley: The very first approach is to take that wish to die seriously. It is one of the biggest mistakes to treat people as inferior or not take them seriously when they express a wish to die. It is also a reason why we, at Dignitas, have connected dying with suicide attempt prevention for 25 years. The approach is the same. You have a human being who is suffering. They reach out for help. They wish to have a solution for their problem, and the solution is to look together at what can be done in the individual situation.

The Swiss Federal Supreme Court clearly outlined that, in the case of a request for assisted dying of a person who has an underlying psychiatric illness, the person needs to see a psychiatrist who assesses whether the wish to have an end to life is rooted in some psychiatric illness that can be treated or is a problem that can be solved and the person would be better off afterwards, or whether that wish to die is based on long-standing suffering where the person has tried treatments and been in and out of psychiatric hospitals but their quality of life has been low for many years, and they have well reflected on that.

There are two different types of psychiatric illness that need to be distinguished. To get to the bottom of that, it takes psychiatrists and special medical doctors to assess whether it is possible to go towards treatment or whether it is a case of a well-thought-out wish to have an end to their life. If it is a well thought-out wish to die, which has been stable for many years, only then and only a psychiatrist in such a case can give what they call a green light, which is writing the prescription for the lethal medication.

Q213 **James Morris:** Mr Sutter, what is your perspective on the checks and balances around people presenting with a mental health reason for wishing to go down the route of assisted suicide?

Bernhard Sutter: You have to understand that these are very rare cases. We are talking about 1% of the people who die with our organisation, EXIT. You also have to understand that we are a members' society. When people join us, their average age is 47. The average age of people dying with us is 79.6, almost 80. You basically have 30 years of information, counselling, being in touch and so on. That is a lot of time. In the cases that you are talking about, of people who have a diagnosis of mental illness, as I said, under the law and safeguards, it will not be easy in Switzerland to terminate your life by yourself.

I do not have much to add to what Mr Luley said. It is clearly up to the assessment of the pre-treating doctors and the psychiatrists who have to do the assessment to find whether the person can get this help or not. As I said, there is a lot of counselling in these cases. Over the years, even with our members, in the end it rarely leads to assisted dying.

Q214 **Chair:** I said at the start, in introducing you, that many British people will be familiar with your two organisations. I suppose some will. Many British people will be familiar with Dignitas, the reason being that, although it is not illegal to provide your services to foreign citizens and non-residents of Switzerland, of course Dignitas does provide the service to non-Swiss residents, while EXIT requires people to be Swiss permanent residents or nationals. Mr Sutter, why do you not choose to do that?

Bernhard Sutter: We are a not-for-profit organisation. We have limited capacities. We would like to be here for our members who have been members for a long time, so we think we do not have capacity to help people from the US, the UK, Japan and so on. We are here for the Swiss people.

Q215 **Chair:** Mr Luley, why do you choose a different model?

Silvan Luley: Dignitas, To live with dignity - To die with dignity, which is the correct name, is a non-profit organisation, just like EXIT. It is also a human rights organisation. As I mentioned before, it has been acknowledged, not only by the European Court of Human Rights but by courts in Germany, Italy and Austria, that to decide on the time and manner of one's own life is a human right and a human freedom. Our organisation was founded 25 years ago by a human rights attorney-at-law, with a group of other attorneys, and people who thought that a human right extends to everyone, and it would be unlawful and unjustifiable discrimination against people from outside Switzerland not to allow them access to what we call the last human right.

I have one small thing to add. In the earlier panel with Professor Hurst-Majno and Dr Gilli, there was discussion about accepting people from abroad. In the canton of Zürich 10 years ago two people had initiatives. One of those initiatives aimed to prohibit access for people from abroad to Switzerland for assisted dying. That initiative was rejected by 78% of the voters. It is a clear sign from the public that helping or supporting people from abroad is accepted.

It is true, and I agree with Professor Hurst-Majno and others, that there is some ambivalence about it. This is, of course, the reason why we at Dignitas say that our aim is to become unnecessary. If the UK made a law that allows people to have access to the last human right, the best thing would be to come as close to the Swiss model as possible and then no one from the UK would ever have to come to Dignitas in Switzerland. Over the past 20 years, 540 people have done so. Your country was one of the first in the world, 80 years ago, to have a discussion on legalisation. People in the UK would be happy to have the same choice and the same last human right as they have in Switzerland. Dignitas will then disappear, certainly for people from the UK. Nobody will come here any more.

Q216 **Chair:** Do you think that people in the UK would be happy to have the same last human right as people in Switzerland?

Silvan Luley: Maybe "happy" is a euphemistic word, but I have followed polls back to the 1970s and, as far as I can see, there has in all that time been strong support from the public and a strong wish by the public to have the choice. As was discussed earlier, people wish to have the choice. Just as much as they have choice in life, they would like to have choices at the end of life. We seem to forget sometimes that dying and death are a part of life, just as much as birth and joy. It all belongs together. People would like to have choice towards the end of their life too. It is not that they would make use of it, but having the choice is the essence. That choice will reduce suffering. It will reduce the number of suicide attempts, especially among the elderly and ill people and so forth.

Q217 **Chair:** Thank you for clarifying that. I think it is worth saying on the record that there is no such thing as public opinion. There is only published opinion, as one of our former Prime Ministers once said. Of course, polls are a snapshot of opinion. There are many people who do not agree with your view, sir. Of course, it is a matter for the British Parliament to decide on that, as the courts here have been very clear.

I want to ask you about money. You say on your website that Dignitas is a not-for-profit organisation and that any accounting surplus in your services is put back into expansion of them and into suicide prevention. That is interesting to me. Could you tell me a bit about that, please?

Silvan Luley: There are two misconceptions in the UK, which are mainly carried by the tabloids and other uninformed people. One is that Dignitas is a clinic. The clinic label is an invention by the tabloids which regularly misleads people to think that we are some hospice or place where you can check in and get treatment. It is not the case.

The second misconception is that it will cost £10,000 or £11,000 to access Dignitas. That is also not true. We are non-profit and our articles of association clearly state that people who do not have funds can request a reduction or an exemption. Whether you are a millionaire or a beggar does not matter. Everybody gets the same service. That is in line with Swiss law. As the earlier panel discussed, article 115 of the Swiss criminal code says that you are not allowed to provide assistance in suicide out of selfish motives. Selfish motives can be asking for too much money above a certain level, which is above covering the costs of the services.

Q218 **Chair:** We will come back to that cost point in a minute. What does the suicide prevention investment look like?

Silvan Luley: We treat all people reaching out to us on the same base of respect and we listen to their wish to die, no matter what their wish to die is. This is about cracking the taboo on suicide. We discuss it with them when they bring up methods to end one's own life—do-it-yourself methods—and we inform them of the risks involved. We refer them to helplines like the Samaritans in the UK, and others.

Assisted dying and, above all, suicide attempt prevention are very closely connected. Even though there is not much research yet, it is known that people who have access to professional help to end their suffering and who are treated in a respectful and open-minded, taboo-free way are much less at risk of going out and jumping from a high building, or going in front of a train. The crucial thing is to catch people before they make a do-it-yourself suicide attempt, which in most cases will fail. It is 10, 20 or 50 times more likely to fail. That is the connection to the suicide attempt prevention work.

Q219 **Chair:** Finally, going back to costs, you said that there are misconceptions because of misreporting in the British tabloids, which I find extremely hard to believe—that was irony. Your website sets out four major costs. Unless I am missing something, preparation is £3,500; doctor consultation is about £880; costs associated on the day are about £2,200; and, if included, the funeral and administrative arrangements that come with that are about £2,200. My maths puts that at just under £10,000. Where do I have that wrong?

Silvan Luley: I don't know about British pounds because what we have published is in Swiss francs only.

Q220 **Chair:** I have just done the conversion, that is all.

Silvan Luley: In Swiss francs it is published, and those are the costs. The membership fees are to cover costs, depending on what service a person requests. The question is whether they can pay or not. If they cannot, they will ask for a reduction or an exemption and, if necessary, it is done for free.

Q221 **Chair:** How does that work? Is there some sort of hardship fund that you then put your surplus into to help people?

Silvan Luley: You will also find that on our website. We indeed established two funds where people can donate. One fund is to make it possible for people who are not well-off to get access to our services. The other fund is for our international and political work to advance the last human right. With those funds, and of course with the membership fees and the little bits of donation we get every year, we are able to make it possible to grant reduction and exemption for everyone.

Of course, people have to make a request when they ask for a reduction. They have to hand in evidence of their financial situation and it is assessed here. If it is a reasonable request from a person, such as elderly people who live off a small pension, they may not have £2,000 or £9,000, let alone the money to travel to Switzerland and to stay here for the procedure. In those cases, we waive the cost; they do not have to pay us.

Chair: Finally—I keep saying "finally," but I find you curious and interesting so I am asking you more things. When we visited the US in Oregon, which was the first state to allow this, there is no universal access to medically assisted dying. If you cannot afford it, you are effectively shut out of it. Obviously here, in England, we have a national health service. You are a campaigning organisation, as you said, campaigning for the last human right. What are your reflections on how a change in the law would be paid for here? In our country, the health service has never had more money, but it has a massive waiting list. It has massive demand on it and a workforce challenge. What are your reflections on how a publicly funded health system like ours could face that challenge?

Silvan Luley: Being a guest here and a foreigner—not being a British person—it would be almost arrogant of me to make suggestions as to how you solve these challenges in your country.

There is one thing I will say. Here, in Switzerland, as was discussed in the earlier panel about organisations like EXIT and Dignitas, To live with dignity – To die with dignity, if the work we do was implemented in the healthcare system, those organisations would not exist. They only exist because the medical and political establishment in Switzerland, towards the end of the 1970s and the beginning of the 1980s, did not want to take care of the public wish to have choice over end of life. That is why the organisations popped up.

In Britain, if you implemented it in the healthcare system, it would be simply a part of normal health provision among palliative care and hospice care. That is what we of Dignitas think it should be. It should be all put together and not separated. Dr Bosshard made it quite clear that palliative care and assisted dying should not be divided. If you bring that all together and implement it so that people have access and can discuss with their doctor all the options there are, even by law, towards end of life, that would probably be a good approach.

How are you going to fund that? Personally, I think saying that you do not have the money to provide good public health that is—I am missing the words. If Brits do not get proper public healthcare—it is not a question of assisted dying, yes or no—you have a serious problem in your country which you should definitely solve as soon as you can.

Chair: Very good. Thank you very much for that. I am going to hand over to colleagues now.

Q222 **Rachael Maskell:** Thank you. I want to follow through on the issue of funding as a starting place, and explore why the fees are so different between the two societies, with EXIT having substantially lower fees, in the light of what you were saying, which is that you cannot provide assisted suicide out of selfish motives. My question is first to EXIT and then to Dignitas as to why Dignitas fees are so far in excess of those of EXIT.

Bernhard Sutter: You have to understand the finance model of my organisation. EXIT simply works like insurance. That means we have members who pay a yearly fee, which is 45 Swiss francs. That is comparable to the prime for an insurance. If you have paid the fee, the prime, the services are free. It means that the majority of members never have to call upon us. They do not need so many services. They get information from time to time, and we help them with their living will and so on. The money pays for the unfortunate few who have to actually go down the path of assisted dying. How we work is an insurance model.

Of course, the thought behind it was that we do not want to sell death. We want to be free for those who want to go down that path, and it is paid for by the solidarity of all the other members. It works very well. It has been working like that for 40 years.

Q223 **Rachael Maskell:** I will put my question to Dignitas. Why is it so much more?

Silvan Luley: My colleague Bernard Sutter of EXIT made a good point. One of the main factors is that EXIT (Deutsche Schweiz) is a much larger organisation than Dignitas. I think there are around 150,000 or 160,000 members.

Bernhard Sutter: Yes, 160,000.

Silvan Luley: There you go. They pay for membership or lifelong membership. At Dignitas we only have around 12,000 members worldwide, of which around 4,000 are members of our German partner organisation.

If we had the same membership base, we could have the same model as EXIT. To extend that, if health insurance in Switzerland paid for our services and for what we do, people would not need to pay anything at all. We only have to ask for money because the medical establishment and the healthcare system in Switzerland is not doing the work that we do. If they did, nobody would turn to an organisation like ours and we would not have to ask for money.

If the state subsidised our organisation and gave us money for the service that we provide—a current thing in Switzerland is that the state does not under or over-regulate, as Dr Bosshard pointed out earlier—and they gave provision of things to the private sector, it would consequently mean that the state gave us the money to provide that service, but it is not the case; that is why we have to ask for money. We would be happy to do the services around assisted dying, just like all the other work that we do in the field of palliative care, suicide attempt prevention and advanced healthcare planning, and to provide it all for free. I would be happy to do that, but I need money to pay our staff. If you want to have professional working people and train them, as we do, you cannot work only with volunteers. You need to pay these people.

Q224 **Rachael Maskell:** I want to go back to the issue of palliative care. I was interested in your comments on that. It is still a relatively new field of medicine in Switzerland compared with here in the UK. When we were taking evidence in our last session, we heard how having assisted dying as part of your options changes the conversation. How has greater prominence of palliative care changed the conversation around assisted dying?

Silvan Luley: Would you like to start with Bernhard Sutter or with me?

Q225 **Rachael Maskell:** I am happy to start with you and then we will go to Mr Sutter.

Silvan Luley: One of the misconceptions is to dig a divide between palliative care and assisted dying. It is one of the biggest errors in the system, so to say. Palliative care and assisted dying go hand in hand. Most of the patients turning to us are already in palliative care. We also co-work with palliative care experts.

To give you an example, we are co-working with a palliative care team in Germany. I know the palliative care expert there personally. I went there some time ago to talk and have discussions with them. They told me openly that they have several patients in their practice who are members of Dignitas. They talk openly about those patients' wish to die; they take care of that wish and provide excellent palliative care. Some of the patients say, "Thank you. I have both options." Some then die by palliative care—continuous deep sedation, in hospice care—while at the same time having requested an assisted death with Dignitas. It also happens the other way around. They are being treated perfectly with palliative care and are stabilised on a level that allows them to travel to Dignitas at the very end. This co-working is the way it should work, if that answers your question.

Q226 **Rachael Maskell:** Thank you. Mr Sutter.

Bernhard Sutter: EXIT counsels all the alternatives that there are, of course. Palliative care is a big alternative. We have been working with palliative organisations quite tightly for 25 years. I am happy to live in a small country that has a very highly developed medical system and where, basically, anybody who wants access to palliative care can have it.

As Mr Luley said, we see many people who are actually in palliative care. They are just trying to find out about their options. Some also talk to EXIT because they are a member, and in the end we never hear from them again, meaning that palliative care worked perfectly well for them. You have to know that about 98% of Swiss people die other than by assisted dying. It is a very small minority who choose this path in the end.

Personally, I feel that we have very good palliative specialists in Switzerland. We have a relatively good network of palliative care. That is just my personal impression, of course, from everyday work.

Q227 **Rachael Maskell:** May I ask one brief question about recordkeeping and how that is undertaken? When we were in Oregon, we were struck by the records that the state department maintained about how people die and complications around that, as well as the time. In the evidence that we have received, it states that most people die within 30 minutes and fall asleep within two to five, but it can be longer. How is that information actually recorded? How is it analysed? What methodology is used? How are complications recorded? I put the question first to EXIT and then to Dignitas.

Bernhard Sutter: Keep in mind that, in every case where a person dies of their own free will with assisted dying, the police are called. The police come immediately afterwards. Every case is looked into by the police, the coroner and the state district attorney. All these cases are kept on record in different facilities: the district attorney, the coroner's office and so on. We have relatively tight control. In that respect, we have good data.

You mentioned complications, meaning that somebody could take more than 30 minutes to die. Those are very rare with EXIT. That is due to our 40 years of experience of when and how to apply medication with different diagnoses. For example, with certain illnesses of the inner systems and so on, you certainly cannot take it orally. You have to go on IV. If it is hard to find for the IV and so on, it is the other way around. This helps us to keep complications down to an extremely low level.

Q228 **Rachael Maskell:** We heard that nausea, seizures and so on occur. Do you recognise that?

Bernhard Sutter: I don't think that I understood the question. Are you saying that there are complications other than the process being longer?

Q229 **Rachael Maskell:** On top of time length, we heard reports of people experiencing seizure and nausea in the period after taking medication.

Bernhard Sutter: I am not a doctor—I am the director here—so I do not think that I can get into that too much. Of course there are cases when someone feels nausea. That is also to do with their underlying illness, for example. The people who die with us are not committing suicide in that way. They are dying within a few days. They have terminal cancer, with all that that brings with it. These people are not in great shape, so of course there are other things that can come, but the medication, sodium pentobarbital, which has been used for 30 years, has been proven to be very effective and very complication-free, in the case of EXIT. I can talk only about EXIT. Of course, there are other organisations in Switzerland, but I am talking about EXIT.

Q230 **Rachael Maskell:** Does Dignitas have anything to add?

Silvan Luley: Most of what Mr Sutter said I can only confirm. I would like to ask you who provided those reports of alleged nausea and seizures. Who says that? If the medication is pentobarbital, nausea is an issue. You can check that. That is why, before ingesting pentobarbital, you have to ingest an anti-emetic. You have to use stomach-soothing medication, which is what we do.

Seizure is not an issue because pentobarbital is an anaesthetic. If you have ever had full anaesthesia due to having surgery, it is exactly the same effect. The medication has been around for 100 years and has been used as an anaesthetic and sleeping medication in most cases, so seizure is not an issue.

The important part, which is what we do, together with the Swiss medical doctors co-operating with us, is to assess each individual request for assisted dying and look at the medical situation. For example, if someone has a certain type of stomach cancer or intestinal issues, you need to know what to do. That would be a case where you would not do an oral ingestion but would do an intravenous ingestion, for example. All this expert know-how has been accumulated by EXIT for 40 years, by us for 25 years, and by the medical doctors co-operating with us and working on this issue. When we assess cases and look at the situation, we know what to do. That is why there have been no difficulties with it.

Dignitas has conducted over 3,600 assisted deaths in our 25 years. There has been not one case that did not work, in the sense of the person not reaching the goal in a dignified way. People drink the medication or take it intravenously, fall unconscious within three or four minutes, and die after 30 or 45 minutes, on average.

I have one more thing to add. Mr Sutter has already said it. It is something that Dr Gilli, in the earlier panel, forgot to mention. She said that not every case is investigated. That is incorrect. As Mr Sutter correctly said, we have to report each case to the authorities. For you, it would be the Crown Prosecution Service—the CPS. Here in Switzerland, we have the public prosecution system, which investigates each case in co-operation with the medical authorities and so on. They check each case. It is their obligation. They have been doing that and would be doing that if we as an organisation trespassed against the legal framework here in Switzerland.

It has been insinuated that the organisations build their own law framework. That is also a misconception. It is the legal framework that tells us what we as organisations—EXIT and Dignitas—can or cannot do. Because we all work with pentobarbital, it is medical doctors who decide whether they will or will not grant access to assisted dying.

Q231 **Paul Blomfield:** I would like to explore an issue that came up in the earlier panel: the relationship between the state—the Government—and the practice of assisted dying. There was a bit of surprise on our Committee when we were told that there are no specified training requirements, for example, for those who are involved in supporting people with an assisted death. Can you explain to us how the practice works and what reassurances you are able to give?

Bernhard Sutter: The main point that you have to keep in mind is that a lot of people think of the Swiss system as a non-medical system, but that is not actually true. We depend hugely on the pre-treating doctors, the hospital reports and the physicians—the prescribing doctor, the psychiatrists who do assessments and so on. If you need an IV, you have a medically trained nurse who helps you with that. The whole system only works because there are mainly medically trained staff. It would not work otherwise. That you have to know. It is already a huge safeguard.

When people say that there are no training requirements from the Government, it is meant simply about the people in our organisation who do the human kind of work; those who visit the patient, talk to the patient's family members and, as we put it, accompany the patients in the process. There are no requirements for that but, again, we have 40 years of experience. We only take professionals for this accompaniment. That means that we hire nurses, psychologists and social workers. We have the requirement that they must be at least 40 years of age, because there has to be some life experience, and that they cannot do it for financial reasons. They have to be able to finance their life in a different way. Many of them, for example, are married and have a husband or wife who earns money.

Then they go through our internal training of one year, which we have shaped and formed over the past 40 years. I am proud to say, as a director, that it has been working. Again, every case is looked into by the authorities. Every accompanying person is also looked into in that inquiry. I am proud to say that I think that our internal training for these accompanying people really works.

Q232 **Paul Blomfield:** Mr Luley, would you like to add to that?

Silvan Luley: I echo what my dear colleague Bernhard Sutter said. It is the same approach at Dignitas.

It would take up too much of your valuable time to explain historically why Switzerland has this model. One thing that is essential historically is that our state is based on progressive liberal thinking and freedom of choice. That is the very basis. In the past 100 or 150 years, the Parliament and Government were made up mainly of progressive liberal forces. That was the time when codifications like the civil code and criminal code were established. The approach is to have as little state as possible and as much freedom as possible. If something functions by itself, the state needs only to govern it, which is what the state is doing, as we outlined earlier. It sees no need to intervene and do work that the public can do themselves. That is the very background to why it is the way that it is.

I am not saying that that would work in other countries that have a different historical or political background, but the basis here is that citizens have all freedoms unless it hurts or disturbs another person, and the state intervenes only if there are excesses or problems. Other countries have approaches where everything is forbidden unless we—the state, the king or whoever—allow it to be enjoyed by the public. Those are very different approaches. The Swiss approach is based on freedom of choice.

On several occasions, the Swiss Government have said that the organisations are working correctly and that we provide a good and professional service. That is the reason why, as was discussed in the earlier panel, the Government and Parliament have repeatedly decided not to do extra legislation unless it is necessary. We do not need a specific law, beyond what the legal framework already is in Switzerland, if it is not necessary, because it works well.

Q233 **Paul Blomfield:** Mr Sutter, can I explore a little more the role of palliative care? It is argued that good palliative care removes the requirement for people to choose an assisted death. In the UK, international studies suggest that we have some of the best palliative care in the world. We think that it should be better, but, nevertheless, studies suggest that we lead the world in that area. Why do you think that so many Britons therefore still choose to come to Switzerland to seek an assisted death?

Bernhard Sutter: I do not have any evidence for this. I can just tell you what I have received from our patients. For the huge majority, the way you die nowadays, in hospital, with or without palliative care, is the right way. For most people, I guess, it is the right way.

There are basically two cases where it might not be the right way. Some patients do not want to die sedated. They want to be able consciously to say goodbye, for example. They want to gather their family around them at one point, to spend one last day looking at pictures, talking to one another, having a meal together and so on, and then say goodbye, take the medication and fall asleep. For them, for some reason—of course, I do not know what their motivation is—it seems that palliative care may not be the right thing.

Then there are a very few cases, as I hear from our patients, where palliation sometimes does not work fully. We have to realise that it is very few cases. Very few cases take assisted dying. Assisted dying takes a lot of energy. You have to go through whole processes at the end of your life, when you are already really weak and are about to die. You have to do all of that, you have to talk to other people and you have to have courage. You have to administer the medication yourself. That is not as easy as just being in a hospital and slowly passing away.

We do not have to be afraid that assisted dying is in competition with palliative care. I really do not think that it is. I think that there are a few patients who want to have another choice. That is what it is all about. In my country, we take the patient seriously. We listen to them. It is they who decide whether or not they want to have treatment. It is they who have the choice. It is not the doctor, it is not the reverend and it is not the politician who tells them; it is the patient themselves. I would say that very few people take assisted dying.

Q234 **Paul Blomfield:** Mr Luley, you were nodding in consent. Can I explore one issue a little further? It is the question of self-administration, which we talked a lot about with the earlier panel, and concerns about medicalisation of death. In your experience, does self-administration and resistance to moving towards physician-assisted death cause any difficulties, or is it restricting, for people with terminal conditions?

Silvan Luley: I will fill in very briefly on what my dear colleague Bernhard Sutter said. I have been working in this field for almost 20 years and have spoken to thousands of patients, including some from the UK. People always say the same thing. They say, "I have gone through life upright, self-determinedly, and made my choices. I want to go out of life self-determinedly, on my own choice."

That is to make the point that people wish to have a choice. Assisted dying is not for, against or in competition with palliative care; it is complementary. I stress that point. Most people turning to us are already making use of palliative care. The Brits I speak to are all very thankful for understanding doctors who give them the maximum treatment so that they can stay at home for as long as they can. They are thankful for palliative care in the UK and so on. They simply say, "It is excellent. We are very thankful for that, but I want to have my choice. The way I have led my life is the way I want to go out of life." That is the crucial point. It is about choice.

The second question was about self-administration. I will not take up too much of your time. That would be a long philosophical, ethical and, of course, legal discussion. Where is the line between a person drinking the lethal medication and a doctor administering it? It is a very thin line. It is really a legal thing where you say, "As long as the person acts in a way that brings about their own death, we are in the field of suicide assistance—professional assistance for suicide and physician-supported assisted suicide." As soon as the doctor administers the medication, which is possible in Canada, the Netherlands, Belgium, several Australian states and so on, we are in the field of what is legally called voluntary euthanasia.

There is a good reason why there is the collective term "assisted dying". At the end, it does not really matter whether the patient says, "I want it," and drinks it himself or herself, or whether the patient says, "I want this," and the doctor applies it. Here in Switzerland, this has grown historically, and it is all about self-determination but also self-responsibility. That means that if you want something in life you do not just say to your state, "Please help me. Solve my problems." It is the other way around; the state expects you to solve your own problems, to get active and to act yourself. That philosophical approach also extends to assisted dying, in the sense that if you want self-determination at the end of life, to the point of ending your own life, you do it yourself—with professional support, yes, but you are expected to take responsibility for that and act accordingly.

Q235 **Paul Blomfield:** I have one last question. A lot of our inquiry has focused on the question of safeguards for people making this choice. I want to reflect on how that works for British citizens coming to Dignitas. What advice do you give them on obtaining copies of medical records or reports from doctors in the UK so that you are clear on the circumstances leading to their choice?

Silvan Luley: To my knowledge, the Data Protection Act in UK law gives every person the right to have access to their medical records, so that is not an issue. People get their medical records when they ask for them. They get doctors' reports and do not need to make a secret about what it is for. They do not need to give a reason why they want to have a copy of their medical record. We do not need to give any special advice on how they should do that because, by law, they get that and do not have to justify what they need it for. It is their right.

Q236 **Paul Blomfield:** Arguably, a doctor providing medical records in order to assist somebody in taking their life, with your support, is getting themselves into difficulties with UK law. Are you aware of any circumstances in which people have struggled to get their medical records from their doctors in order for them to come to Dignitas?

Silvan Luley: To my knowledge, there is no legal basis in the UK for saying that a doctor violates any law if he or she provides medical reports to a patient whether or not the patient mentions what they are using it for. I think that the British Medical Association and the royal college have taken a neutral position. It would be interesting to see a doctor try to reject handing over medical reports just on the grounds of the person saying, "I am using that to go to Dignitas," given that it is a basic human right. We would need to do a legal case on that to test the law in the UK.

There are no problems. People get their medical reports. What is interesting for you to know is that, behind closed doors, many UK medical doctors are pro-assisted dying. They just do not say it in public out of fear of the repercussions, but our patients get their medical reports. Sometimes there is resistance at first. Sometimes a doctor who has never been confronted with such a wish might react very cautiously and say, "I don't want to get involved in that"—quite understandably. Even Swiss doctors would not say up front, "Oh yes, no problem. Here it is." They would ask first, "What do you want that for? What is your aim? Ah, it is for assisted dying. Let's discuss your wish for assisted dying and whether there are other possibilities, like palliative care." It starts a discussion.

If, as Dignitas and I very much hope, and I think EXIT and the public in the UK hope, you legalise assisted dying, it will definitely improve conversations between patients and doctors. It will lift a lot of fear of things happening in the grey shade, or behind closed doors, as I put it. It will make that transparent, public and clear. It will also make it possible to do research work, because data can be collected. Doctors will feel safe and people will feel safe. That is one approach to doing it.

It is happening anyway. It has been happening for years and years, without giving safety to doctors and patients. That is the legal situation in the UK. The Commission on Assisted Dying made this point over 10 years ago when it said: "The current legal status of assisted suicide is inadequate and incoherent" in the UK. The commission visited Dignitas in 2011. It is about time to change that, so that people feel safe, doctors feel safe and then things will improve considerably.

Chair: We have to leave it there. Thank you very much, Mr Sutter and Mr Luley, from EXIT and Dignitas in Switzerland, for joining us. That is the end of today's session.