



House of Commons
Health and Social Care
Committee

**Assisted Dying/
Assisted Suicide**

Second Report of Session 2023–24

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 20 February 2024*

HC 321

Published on 29 February 2024
by authority of the House of Commons

Health and Social Care Committee

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Committee staff

The current staff of the Committee are Maria Amrin (Committee Operations Manager), Alice Baxter (Committee Specialist), Dr Lucy Durham (Clinical Fellow), Sandy Gill (Committee Operations Officer), Libby McEnhill (Senior Committee Specialist), Sumayyah Mian (Clinical Fellow), Dr Stephen Naulls (Clinical Fellow), Anne Peacock (Media and Communications Manager), Fergus Reid (Clerk), Yohanna Sallberg (Second Clerk), Emma Stevenson (Committee Specialist), Katherine Woolf (Parliamentary Academic Fellow), and Catherine Wynn (Committee Specialist).

Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is hscocom@parliament.uk.

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Introduction

1. The response to the launch of this inquiry and the continued engagement from people interested in it has emphasised to us just how important and, for understandable reasons, emotive a subject this is. In total, we received over 68, 000 responses to our online form, and over 380 pieces of written evidence. We are grateful to everyone who contributed to our online form, submitted written evidence or participated in one of our roundtable events. We are particularly grateful to those who shared very difficult personal stories. We understand how hard it must be to relive those times and emotions and we would like to emphasise how helpful it was to draw upon those lived experience accounts in our deliberation.

2. We want to begin by setting out the parameters of our inquiry and the terminology we have used. The terminology used in this debate is in itself contested and, as the Parliamentary Office of Science and Technology noted in their briefing paper on the subject, there is no consensus on which terminology to use when debating the issue of whether people should be legally permitted to seek assistance to end their lives.¹ We have chosen to use the term “assisted dying/assisted suicide” (hereafter abbreviated as AD/AS) when talking about all types of physician-assisted deaths, including self-administration of the lethal drug required to die, as well as physician-administered deaths (often referred to as euthanasia). The choice of terminology is intended to be as inclusive and neutral as possible and is not intended to reflect a specific stance on the issue.

3. The focus of our inquiry, and therefore our report, is the human element, with a specific focus on health and social care (including palliative and end-of-life care²). Health policy is a devolved matter, and our principal focus in this report is England. However, as the law applies to England and Wales, some examples will include data from both, and some of the data we have drawn upon relates to the whole of the UK.

4. We asked for submissions to focus on the following terms of reference:

- To what extent do people in England and Wales have access to good palliative care?
- How can palliative care be improved, and would such improvements negate some of the arguments for assisted dying/assisted suicide?
- What can be learnt from the evidence in countries where assisted dying/assisted suicide is legal?
- What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?
- What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying/assisted suicide services?
- What protections could be put in place to protect people from coercion and how effective would these be?

1 POST Brief 47, [Assisted Dying](#) (September 2022)

2 See chapter 4 for a definition of palliative and end-of-life care and further detail.

- 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?
- What capabilities would a person need to be able to consent to assisted dying/assisted suicide?
- What should the Government's role be in relation to the debate?

5. In the context of this particular debate we will not provide a definite answer to all these questions; instead we have sought to present a balanced overview of what the evidence we have received has suggested, as well to draw upon research and information available in the public domain. Although Select Committees usually make recommendations to Government, in respect of AD/AS, the Government has made it clear that it will not take any steps towards legalising AD/AS but instead that this would be Parliament's role, should Members wish to do so.

6. Since the House's last opportunity for a substantive division on the issue of Assisted Dying/Assisted Suicide in 2015, there have been relevant developments in medical science and jurisprudence, including court cases challenging the UK's current legal framework and foreign jurisdictions where changes are being considered or implemented. It therefore seemed important to gather the most up-to-date information and views on the topic to inform Parliament and the wider public.

7. In chapter 1 we look at cases brought before the courts, challenging the current law in England and Wales. We then go on to examine recent debates and bill proposals in the UK Parliament and in other legislatures in the UK and beyond, and explore views on what the Government's role should, or could, be in the debate. As the focus of our inquiry was on health rather than the law relating to this subject, we were grateful to our colleagues on the Joint Committee on Human Rights for exploring some of the legal and human rights aspects during their evidence session on 24 May 2023.³ Chapter 1 also considers the subject of UK citizens who access AD/AS abroad and notes public opinion polling on law change.

8. Chapter 2 focuses on international jurisdictions where AD/AS is currently legal. Observing trends and research emerging from these jurisdictions and exploring the way in which the legal frameworks have been developed, is key to understanding the issue. In chapter 2 we present the evidence we have received on the international experience of AD/AS and we sought to summarise this information in a series of tables, and a map. As part of our work looking at international experiences, we also travelled to Oregon to hear from stakeholders and representatives from the Oregon Health Authority.

9. Health and care professionals are involved in some aspect of delivering AD/AS in all jurisdictions where AD/AS is legal and where there is a formal system in place for its delivery. In chapter 3 we therefore summarise evidence and research on the experience of health and care professionals internationally, as well as the views of representative bodies here in the UK. We also held roundtable discussions with health and care professionals in England.

3 Oral evidence taken before the Joint Committee on Human Rights on 24 May 2023, [HC 1195](#)

10. In chapter 4 we look at the evidence about the care provided to people who are managing a long-term, and sometimes terminal, conditions, and the role that palliative and end-of-life care play. We sought to understand whether it was possible for palliative and end-of-life care to improve to a point at which suffering can be eliminated altogether. As part of this process, we heard from experts in palliative care, and we visited Royal Trinity Hospice in South London to speak to staff providing care there.

11. Our aim for this report is for it to serve as a basis for discussion and debate in future Parliaments. We have therefore endeavoured to bring together a comprehensive and up-to-date body of evidence relating to this difficult, sensitive, and yet, crucial subject. The debate on AD/AS is not new, and our report is not intended to provide a resolution to it, but we do hope that it will be a significant and useful resource for future Parliamentarians.

12. Throughout our inquiry, a common theme across the evidence was the pursuit of the very best end of life care, and what many witnesses called “a good death”, where the person dying was cared for with compassion and high-quality care and provided with as much agency and choice as possible. However, there is spectrum of views on how to best achieve this.

1 Assisted Dying/Assisted Suicide

Parliament, the current law and the Government's role in the debate

The current law

13. Different laws regulate 'assisted dying' and 'assisted suicide' in different parts of the UK (although nowhere in the UK are these specific terms used in legislation). Our primary focus in this inquiry has been on England and Wales. In England and Wales, suicide or attempted suicide are not criminal offences.⁴ However under section 2(1) of the Suicide Act 1961 it is an offence for a person to act in a way which is "capable of encouraging or assisting the suicide or attempted suicide of another person," and to act in a way which was "intended to encourage or assist suicide or an attempt at suicide."⁵

14. There have been several court cases and legal challenges relating to people wanting to access AD/AS in England (and in other parts of the UK) due to living with a terminal or life-limiting illness, or serious injury. Such cases include the challenges made by Diane Pretty in 2002, Debbie Purdy in 2009, Tony Nicklinson in 2014 and Paul Lamb in 2014.⁶ Cases have tended to centre around concerns that if an individual assists another person with ending their life, that individual would likely be investigated and prosecuted for their involvement, and have tended to argue that this is incompatible with the rights of the person who wants to end their life, under the European Convention on Human Rights (ECHR). Our inquiry has not focused primarily on the law relating to AD/AS, nor have we considered the detailed arguments underpinning these legal challenges. This is because our focus must primarily be on the health-related aspects. Our colleagues on the Joint Committee on Human Rights held an evidence session on 23 May 2023 on the legal dimension.⁷ It is of course also open to the Justice Select Committee to conduct further inquiries into the topic should it wish to do so.

15. When the Supreme Court examined the issue in relation to the cases brought by Tony Nicklinson, Paul Lamb and AM⁸ in 2014, it decided (by a majority of seven to two) against making a declaration regarding whether the current law on AD/AS was compatible with the right to a private life under Article 8 of the European Convention on Human Rights. The Supreme Court took the view that Parliament was the most appropriate forum for considering changes to the law on this issue.⁹

UK citizens accessing AD/AS in Switzerland

16. Some of the written evidence we received argued that although the law in England and Wales is clear, subsequent Crown Prosecution Service (CPS) guidance and statements made by the Government and the courts have left many feeling confused and frustrated. In part, this is because, whilst it is widely recognised that some UK citizens travel abroad to die, and often need help from loved ones to do so, there is no certainty that those assisting someone in this way will not face criminal investigation or charges.

4 POST Brief 47, [Assisted Suicide](#) (September 2022)

5 [Suicide Act 1961](#), section 2

6 House of Commons Library, [The law on assisted suicide](#) (July 2022)

7 Oral evidence taken before the Joint Committee on Human Rights on 24 May 2023, [HC 1195](#)

8 AM is the anonymised name of the claimant

9 House of Commons Library, [The law on assisted suicide](#) (July 2022)

17. A UK citizen who wants to pursue AD/AS would have to travel abroad. Reports from organisations such as Dignity in Dying suggests that UK citizens who pursue AD/AS tend to travel to Switzerland.¹⁰ Most of these people go to Dignitas (full name Dignitas—to live with Dignity, to Die with Dignity).¹¹ There is, however, no centrally collected data by the UK Government; only the data released by organisations such as Dignitas or Life Circle.¹² Table 2 below shows the number of UK citizens who accessed AD/AS at Dignitas from 2015 to 2022.¹³ There is no sure way of knowing how many UK citizens choose to end their life abroad through AD/AS, where they do so, or in which circumstances.

Table 1: The number of UK citizens accessing AD/AS at Dignitas from 2015 to 2022.

	2015	2016	2017	2018	2019	2020	2021	2022
Number of AD/AS deaths at Dignitas (UK citizens)	37	47	34	24	42	18	23	33

Source: Dignitas, [Accompanied Suicides per Year and Country of Residence 1998–2022](#)

18. In Switzerland, AD/AS does not take place in hospitals or other healthcare settings, nor is it restricted to residents and/or citizens,¹⁴ as it is in many of the other jurisdictions we have looked at as part of the inquiry. Instead, the Swiss system for AD/AS relies on external “right-to-die” organisations to facilitate the assessment and implementation of the AD/AS.¹⁵ These organisations are characterised as “membership organisations” or “societies”, and someone wanting to pursue AD/AS has to apply, be granted membership, and then pay a membership fee.¹⁶ When we heard evidence from Dignitas and Exit, they stated that both organisations are run not-for-profit.¹⁷ Several written submissions criticised the availability of AD/AS for non-Swiss residents and citizens in Switzerland. Some argue that this constitutes “suicide tourism”, which, in a book on the topic, the author Daniel Sperling defines as:

[...] whereby people travel to countries or states to take advantage of permissive laws on assisted suicide that do not exist in their home countries or states.¹⁸

19. The table below presents figures from Dignitas showing the number of deaths which have taken place there between 1998–2022. The five countries included in the table are those with the highest percentage of people accessing AD/AS at Dignitas. UK citizens have, since 1998, made up almost 15% of all AD/AS deaths at Dignitas.

10 Dignity in Dying (ADY0418)

11 Dignitas, [‘Accompanied Suicides per Year and Country of Residence 1998–2022’](#), accessed 5 June 2023

12 Life Circle, [‘About Us’](#), accessed 28 September 2023

13 Dignitas, [‘Accompanied Suicides per Year and Country of Residence 1998–2022’](#), accessed 5 June 2023

14 POST Brief 47, [Assisted Dying](#) (September 2022)

15 Gamondi et al, “Attitudes of university hospital staff towards in-house assisted suicide”. PLOS ONE, vol 17 (2022)

16 Dignitas, [‘Brochure of Dignitas’](#), accessed 7 December 2023; EXIT (Deutsche Schweiz), [‘Our Society’](#), accessed 7 December 2023

17 [Q214](#); [Q215](#)

18 Sperling, D. *Suicide Tourism - Understanding the legal philosophical and socio-political dimensions*. Oxford University Press (2019)

Table 2: AD/AS deaths at Dignitas between 1998–2022

Country	Total number of AD/AS deaths at Dignitas between 1998–2022	Total percentage of AD/AS deaths at Dignitas between 1998–2022
Germany	1449	39.53%
UK	531	14.48%
France	499	13.61%
Switzerland	226	6.16%
Italy	207	5.65%

Source: Dignitas, [Accompanied Suicides per Year and Country of Residence 1998–2022](#)

20. There is no official data published on Life Circle’s website, but according to a Dignity in Dying press release in 2020, Dignity in Dying had been told by Life Circle in correspondence that 11 UK citizens had died at their organisation in 2019 (down from 19 in 2018).¹⁹

21. We also heard evidence around the involvement of doctors in enabling someone to access AD/AS in Switzerland. According to the Dignitas web page, the person pursuing AD/AS would need to have “one or more up-to-date medical reports” which has to include “substantial information on the case history, diagnosis, and—if possible—actual and suggested treatment/measures as well as prognosis”. This medical report should, according to the website, not be more than three to four months old.²⁰ However, doctors may feel prevented from providing such medical reports if the person requesting it makes it clear why they are requesting it. According to the BMA guidance document titled ‘Responding to patient requests for assisted dying: guidance for doctors’:

The law does not provide a clear definition of which actions might constitute assisting or encouraging suicide. We recommend that doctors do not: [...] write medical reports specifically to facilitate assisted suicide abroad.²¹

22. One of the participants during our roundtable told us:

But if they [doctors] know that you’re going to Dignitas, all of that vanishes immediately. Doctors will not engage with you because of fear of being subjected to legal charges that they are assisting you, assisting a suicide, assisting a death. Hospice workers will tell you privately, “We really support what you’re doing”, but likewise, they cannot officially sit down with you and counsel you through it. So it’s the loneliness and the fact that officialdom makes fugitives of you.²²

23. However, the ‘Guidance for the Investigation Committee and case examiners when considering allegations about a doctor’s involvement in encouraging or assisting suicide’, from the GMC states that:

19 Dignity in Dying Press release, [‘One Brit Travels to Switzerland for an assisted death every week, new figures reveals’](#), 29 January 2020

20 Dignitas, [‘Brochure of Dignitas’](#), accessed 6 December 2023

21 BMA, [Responding to patient requests for assisted dying: guidance for doctors](#) (June 2019)

22 Roundtable transcript

Some actions related to a person's decision to, or ability to, commit suicide are lawful, or will be too distant from the encouragement or assistance to raise a question about a doctor's fitness to practise. These includes but is not limited to: [...] providing access to a patient's records where a subject access request has been made in accordance with the terms of the Data Protection Act 1998.²³

24. During our first evidence session, Lord Falconer who has led, and supported, several attempts to change UK law on AD/AS, commented:

Where we have got with the law now is such a mess. We allow people to go to Switzerland. We allow people to be helped to go to Switzerland. We investigate their loved ones when they come back, which is a hellish experience. The law is such a mess. I don't think I have met anybody who does not think that. The law itself recognises that. I think it is time for a change.²⁴

25. During the Covid-19 pandemic, the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (made under the Coronavirus Act 2020) restricted people's movements, and made various activities outside a person's home illegal, including travel abroad.²⁵ However, in response to an urgent question asked by the Rt Hon Andrew Mitchell MP regarding whether the restrictions on movement would stop someone from travelling to access AD/AS, the Rt Hon Matt Hancock MP, then Secretary of State for Health and Social Care, stated:

[...] it is legal to travel abroad for the purpose of assisted dying where it is allowed in that jurisdiction. The new coronavirus regulations, which come into force today, place restrictions on leaving the home without a reasonable excuse; travelling abroad for the purpose of assisted dying is a reasonable excuse, so anyone doing so would not be breaking the law. These coronavirus regulations do not change the existing legal position on assisted dying.²⁶

26. The CPS has previously issued guidance for prosecutors in respect of prosecuting cases of encouraging or assisting suicide. The guidance was first issued in February 2010 and was then updated in October 2014. The guidance in October 2014 was issued as a result of the decision of the Appellate Committee of the House of Lords in *R (on the application of Purdy) v Director of Public Prosecutions*, which required the DPP "to clarify what his position is as to the factors that he regards as relevant for and against prosecution" (paragraph 55) in cases of encouraging and assisting suicide. Debbie Purdy, a woman who lived with MS, pursued the case because she argued that it was a breach of her human rights not to know whether her husband would be prosecuted if he accompanied her to Dignitas.²⁷

23 GMC, [Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide](#) (January 2013)

24 [Q1](#) [Lord Falconer]

25 The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 ([SI 2020/350](#))

26 HC Deb, Thursday 5 November 2020, [col 475](#)

27 The Guardian, ['Debbie Purdy wins 'significant legal victory' on assisted suicide'](#), 30 July 2009

27. The DPP guidance sets out:

1. Prosecutors must apply the Full Code Test as set out in the Code for Crown Prosecutors in cases of encouraging or assisting suicide.

The Full Code Test has two stages:

(i) the evidential stage; and

(ii) the public interest stage.

The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.

2. The DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met.²⁸

28. The then DPP, now the Leader of the Opposition, Rt Hon Sir Keir Starmer MP, wrote in the Times that he was “unlikely to prosecute those motivated by compassion who help a relative or close friend” with a “clear, settled and informed” wish to die.²⁹ At the time the guidelines were revised, the BBC reported that Lord Carlile, the then chairman of the campaign group Care Not Killing which is opposed to AD/AS, had stated that the revised guidelines “greatly reduce the risk of undermining existing law.”³⁰

29. From 1 April 2009 to 31 March 2023, 182 cases were referred to the CPS by the police that were recorded as assisted suicide. Of these 182 cases, 125 were not proceeded with by the CPS and 35 cases were withdrawn by the police.³¹

30. Anne-Marie Irwin, a solicitor who acted for Noel Conway in his application for a judicial review seeking a declaration that section 2(1) of the Suicide Act 1961 was incompatible with his right to a private and family life under the Human Rights Act 1961, provided written evidence to us. She argued that despite the DPP’s updated guidance on prosecuting a person who has assisted someone in a situation like this, the outcome of a police investigation is impossible to predict. She stated:

They [the loved ones who has assisted someone to end their life at Dignitas] have reported living in fear of prosecution and/or undergoing the intense stress of an investigation, include police questioning and a lengthy wait for a prosecution decision, when they are grieving their loved one.³²

31. On 5 October 2023 the CPS released updated homicide and prosecution guidance, which the CPS website states to include “amendments to relevant public interest factors on mercy killing and suicide pacts in the context of mercy killings.” However, the

28 Crown Prosecution Service, [Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide](#) (February 2010)

29 The Times, ‘DPP must clarify policy on assisted suicide’, 31 July 2009

30 BBC, ‘Motivation key over assisted death prosecutions’, 25 February 2010

31 Crown Prosecution Service, ‘Latest Assisted Suicide Figures’, 18 April 2023

32 Anne-Marie Irwin ([ADY0309](#))

announcements sets out that this does not “touch on ‘assisted dying’, or other similar scenarios which are treated separately in law”. The announcement for the updated guidance lists six public interest factors “tending against prosecution”:

1. The victim had reached a voluntary, clear, settled and informed decision that they wished for their life to end. The must have the freedom and capacity to make such a decision. This decision must have been made sufficiently close in time to their death and independently reached by the victim and not influenced by pressure, control or coercion by the suspect or anyone else. This requires thorough scrutiny and critical examination of the suspect’s account, on its own and when placed in the context of the evidence as a whole. Prosecutors should consider what access the victim had to health care professionals including discussions about treatment and support options;
2. The suspect was motivated by compassion alone and only in circumstances where the preceding factor is present;
3. The victim was physically unable to undertake the act to end their own life;
4. The actions of the suspect may be characterised as reluctant, in the face of significant emotional pressure due to the victim’s wish for their life to end. Prosecutors should consider whether this is capable of independent verification by others;
5. The suspect made a genuine attempt to take their own life at the same time;
6. The suspect reported the death to the police and fully assisted them in their enquiries into the circumstances and their part in it.³³

32. We heard several accounts during our roundtables from people who have a lived experience of a loved one pursuing AD/AS. One of the participants who, together with their sister had travelled to Dignitas for their mother to have an AD/AS, told us about the legal repercussions when they returned:

I was interviewed under caution by the police for two hours and then investigated for two years. That was only resolved when the CPS [Crown Prosecution Service] finally said that they were not going to proceed with a prosecution because it wasn’t in the public interest to do so. But, in the meantime, they had looked at my bank account, they had taken witness statements from people that we loved, who loved my mum, they had taken equipment from me. My reputation, I felt, was in serious jeopardy. It drove my sister almost to the brink of suicide. She’s very vulnerable. It was incredibly stressful to be involved with the police, and it cost us thousands and thousands of pounds in legal fees to defend ourselves.³⁴

33 CPS, “[CPS publishes updated homicide prosecution guidance](#)”, 5 October 2023

34 Roundtable transcript

33. In their written evidence submission, Professor Bronwyn Parry and Dr Sally Eales summarise the outcomes from their qualitative study (which was subsequently used by pro-AD/AS campaign group Dignity in Dying to inform three reports). The submission concludes that:

The logistics of planning an assisted death abroad left people feeling isolated due to a lack of support, and many needed help from others to navigate the process—something that is illegal. However, the majority of people we interviewed were willing to break the law to help their loved one achieve a pain free death. There was a clear sense that the State and healthcare system were abandoning people by failing to help them achieve this end.³⁵

34. The campaign group Dignity in Dying (who are in favour of legalising AD/AS for those with a terminal illness) produced a report titled ‘The True Cost - How the UK outsources death to Dignitas’. In the report, they set out that by their calculations it costs anywhere between £6,500 to over £15,000 for a non-Swiss resident to access AD/AS in Switzerland.³⁶ When we asked Silvan Luby, a representative and staff member at Dignitas about the cost of accessing AS/AS at Dignitas, he told us:

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.³⁷

35. As the individual seeking AD/AS has to be well enough to travel to Switzerland, many decide to do so much earlier than needed, in fear that they will not be fit to travel if they wait. We received many submissions which argued that the current law effectively permitting (by not preventing) people to travel abroad to pursue AD/AS resulted in many terminally ill people choosing to go through with AD/AS much earlier than they would if AD/AS were available in the UK, out of concern of not being able to go once their condition has progressed.³⁸ Dignity in Dying stated:

Travelling to Switzerland for an assisted death is only an option for people who have the funds and physical strength to make the journey and it often results in people dying much sooner than they would choose to if assisted dying were legal in this country. While many cases never come to the attention of the authorities, loved ones are at risk of prosecution for providing any form of help. The process of a criminal investigation can be hugely distressing to all involved.³⁹

36. Similarly, one the participants at our roundtable told us:

[...] people are travelling well before they would because you’ve got to deal with the 600-mile journey to another country. You’ve got to deal with all this paperwork. You’ve got a limited number of appointments to be able to secure an assisted death from Dignitas. My mum went as soon as she possibly could on the basis that a three-month delay to another appointment

35 Professor Bronwyn Parry and Dr Sally Eales ([ADY0479](#))

36 Dignity in Dying, [The True Cost - How the UK outsources death to Dignitas](#) (November 2017)

37 [Q220](#)

38 For example: Reverend Canon Valerie Plumb ([ADY0030](#)), Revd Canon Rosie Harper ([ADY0066](#)), Religious Alliance for Dignity in Dying ([ADY0241](#)), Professor Emily Jackson ([ADY0290](#)), Caroline Lucas MP ([ADY0356](#))

39 Dignity in Dying ([ADY0418](#))

at Dignitas might actually mean she could never make it at all, because she'd become immobile because her disease was unpredictable. So she left sooner than she otherwise would have. We're shortening people's lives because they're choosing to go out early. And that's an intolerable current state, in my view.⁴⁰

37. Another roundtable participant who had accompanied their mother to Dignitas told the Committee:

[...] as soon as she [the mother] found out that she had motor neurone disease, she immediately said, "I want to go to Dignitas". Three months after the diagnosis, she was accepted, and we went there, myself and my sister with my mother so that she could have an assisted death, and I was really fearful about being arrested on the way back. Three of us went out. Two of us came back. But also, it was just her choice, and it wasn't ever something I'd thought about. Prior to that I don't think she had either, but I think when you're suddenly terminally ill and it's all looking very, very bleak, you soon pick a side.⁴¹

38. **A view put forward by some who have provided evidence to us was that the current state of the law is unclear.**

39. **During our inquiry we have heard statements from people who have been involved in assisting a loved one to pursue AD/AS abroad.**

40. **We also heard about the documentation which has had to be secured as part of the application, including a medical report for the person applying. We note that the General Medical Council's guidance for Investigation Committees assessing a doctor's fitness to practice following an allegation of a doctor's encouragement or assistance in suicide, sets out that that providing access to a patient's records where the request is made in accordance with the Data Protection Act 1998, should be considered lawful or too distant from being considered encouragement or assistance. However, the BMA's guidance recommend that doctors should not write medical reports specifically to facilitate assisted suicide abroad. Although it is not illegal to provide medical reports in this circumstance, it does not seem to be entirely clear to doctors what they are allowed to do. We would welcome revised guidance from the GMC and the BMA enabling doctors to assist their patients.**

The Government's position on AD/AS

41. The Government have retained a neutral stance on the issue of whether to bring in legislation to allow AD/AS. In their evidence, they stated:

The Government's position remains that any change to the law in relation to assisted dying is a matter for Parliament to decide and an issue of conscience for individual Parliamentarians rather than one for Government policy.⁴²

40 Roundtable transcript

41 Roundtable transcript

42 Department for Health and Social Care ([ADY0398](#))

42. When the Minister of State for Social Care appeared before us on 4 July 2023, she restated this:

I recall back in 2015, shortly after I had been elected, that we debated a private Member's Bill about assisted dying. There was a substantial debate at the time. I remember the day very well. We know that at the time Parliament voted very clearly against assisted dying at that point. What I can do is reiterate the Government position, which is that should the will of Parliament change, the Government will not stand in its way, but Parliament needs to take that step.⁴³

43. The most recent debate in the House of Commons on AD/AS took place in Westminster Hall on 4 July 2022 during a general debate⁴⁴ on e-petition 604383, a petition which called for the Government to “bring forward legislation to allow assisted dying for adults who are terminally ill and have mental capacity.” The e-petition called for AD/AS to be allowed “subject to strict upfront safeguards, assessed by two doctors independently, and self-administered by the dying person.” This petition reached 155,803 signatures.⁴⁵ Some 38 Members contributed to the three-hour long debate. At the end of the debate James Cartlidge MP, then Parliamentary Under Secretary at the Ministry of Justice, concluded:

I think that colleagues on both sides are calling for a national conversation and, if not an inquiry, then certainly an investigation by the Health and Social Care Committee, for example. Obviously, if any of those steps go forward, the Government will do their best to assist, within the constraints of their neutral position, which I take very seriously. The matter was recently debated at length in the House of Lords. It is for hon. and right hon. Members, if they wish, to bring forward private Members' Bills or debates in the usual way, such as through the Backbench Business Committee.⁴⁶

44. The alternative to legislation introduced by a government minister is a Private Member's Bill (PMB). Information about what a PMB is and the process for these in Parliament can be found in the below information box.

43 [Q296](#) [Helen Whatley]

44 A general debate considers neutrally worded motions that usually begin with “That this House has considered...”. These debates allow discussion on a subject without committing the House to an opinion or course of action. General debate motions cannot be amended, and if considered in Westminster Hall, can't be voted on for or against ([MPs Guide to Procedure](#) (2024))

45 UK Government and Parliament Petitions, [E-petition 604383: 'Legalise assisted dying for terminally ill, mentally competent adults'](#) (Closed 30 June 2022)

46 HC Deb, 4 July 2022, [col 266WH](#) [Westminster Hall]

Box 1: Information about Private Members Bills (PMBs)

A PMB is a Bill introduced by a Member of Parliament who is on the “backbenches”. A “backbench” MP refers to a Member who does not hold a Ministerial or Shadow Ministerial post. PMBs which become law tend to be brought in through the “PMB Ballot” at the start of each Parliamentary session (these bills are often called ballot bills). This is because ballot bills benefit from being introduced to the House early in the session, therefore making it more likely that they will have the time necessary to be considered and agreed in the House of Commons, passed and sent to the House of Lords for the same process before the parliamentary session finishes. Some 20 ballot bills are introduced in the House of Commons at the start of each parliamentary session and the first seven are given precedence for debate during the first few “PMB Fridays”, which are Friday sittings of the House of Commons when PMBs have precedence over other business. The House of Commons Standing Order 14(8) stipulates that there should be 13 PMB Fridays per session. In the House of Lords PMB debate days are not limited, and there is no allocated time by which a debate on PMBs must conclude.

Sources: House of Commons Library, [Private Members' Bills](#) (April 2016); House of Lords Library Note, [Private Member's Bills in the House of Lords](#) (May 2016).

45. Lord Forsyth expressed concerns about the Government’s position that legalisation of AD/AS would have to be instigated by a Private Member’s Bill. He suggested that attempts to table multiple amendments and to “filibuster” debate (when one or several Members talk for so long that the time for the debate runs out) have prevented the progress of Private Member’s Bills on this topic in the House of Lords, and that without a change in the Government’s approach to the issue, there would continue to be unsuccessful attempts to bring forward Private Member’s Bills in successive Parliaments. He also suggested that the Government’s position “de facto” supports the law in its existing form.⁴⁷ Baroness Young argued that substantive parliamentary time is needed to discuss the matter and called on the Government to grant time for “a full and proper debate”.⁴⁸ Similarly in their evidence, Lord Etherton, Lord Brown of Eaton-under-Heywood and Lord Pannick stated:

[...] it is virtually impossible for a private member’s bill on a subject as complex as this to get the time in Parliament that would be needed for them to become law. Indeed, two attempts to progress the assisted dying debate in the House of Lords in the last decade have attracted majority support in the Lords but fallen due to lack of time.⁴⁹

47 Lord Michael Forsyth ([ADY0297](#))

48 Baroness Barbara Young ([ADY0310](#))

49 Lord Etherton, Lord Brown of Eaton-under-Heywood and Lord Pannick ([ADY0311](#))

46. Karin Smyth MP and Rt Hon Kit Malthouse MP, co-chairs of the All-Party Parliamentary Group Choice at the End of Life, argued in their written evidence:

[...] there must also be a role for Government in facilitating the debate on assisted dying. That is not to suggest that the Government must necessarily abandon its position of neutrality, but it could maintain its position and still ensure that Parliament can thoroughly debate the issue.⁵⁰

47. Sarah Green MP stated in her written evidence:

The Government needs to dedicate time, as it has done in the past with regards to other issues of conscience, to debating seriously and on the basis of robust evidence, the issue of assisted dying. In doing so, it must necessarily recognise that the status quo is unsafe and is failing dying people and their families.⁵¹

48. In their written evidence, the campaign groups Care Not Killing and Our Duty of Care, who are against legalising AD/AS, stated:

No-one can pretend that Parliament has not considered these questions at length and in detail in recent years—through bills, committees, questions and other debates—and this should remain a question for Parliamentarians. The September 2015 Commons debate showcased Parliamentary deliberation well [...]⁵²

49. Similarly, many of those who responded to our online form and who agree with the current law (in other words agree with AD/AS being illegal) in England and Wales stated that the law on AD/AS has already been considered multiple times and more parliamentary consideration of the issue was characterised as being “fruitless” or was deemed to be “unnecessary” by some respondents.⁵³

50. In evidence to us, several organisations and campaign groups also referred to public opinion polling undertaken on AD/AS. We recognise the challenges inherent in the objective interrogation and assessment of public attitudes to very complex and multi-faceted issues such as AD/AS. An outline of the evidence we received on polls conducted in the last 10 years is annexed to this Report.⁵⁴ In its evidence, the National Centre for Social Research (the largest independent and not-for-profit social research organization in the UK) wrote that its British Social Attitudes surveys had regularly included questions on attitudes to AD/AS, and that these:

[...] found consistent support for the proposition that doctors should be allowed by law to end the life of a patient with a painful incurable disease, if the patient requests it. The proportion of respondents saying this ‘definitely’ or ‘probably should be allowed’ has been relatively stable over time. Support rose from 77% in 1983 to 82% in 2005, but it then fell back to 77% in 2016.⁵⁵

50 Karin Smyth MP and Rt Hon Kit Malthouse MP, Co-Chairs, The All-Party Parliamentary Group on Choice at the End of Life ([ADY0487](#))

51 Sarah Green MP ([ADY0319](#))

52 Care Not Killing (CNK Alliance Ltd) and Our Duty of Care ([ADY0343](#))

53 Annex 1

54 Annex 3

55 National Centre for Social Research ([ADY0262](#))

51. Several Private Member's Bills have been introduced on this issue over recent years. None of these attempts has come close to becoming law, as none of the bills has made progress past the Committee stage which is one of the initial stages of bill consideration in both Houses. There have also been attempts to amend Government Bills to include provisions around introducing legislation on AD/AS. Some of the attempts to change the law include:

- Lord Joffe's Patient (Assisted Dying) Bill introduced in Session 2002–03. It had its second reading in June 2003.⁵⁶
- Lord Joffe's Assisted Dying for the Terminally Ill Bill introduced in Session 2003–04. A Select Committee was appointed to look at aspects of the Bill.⁵⁷ The Bill lapsed when the 2003–04 session ended and was reintroduced in the 2004–05 session and the Select Committee reappointed. In 2005, the Assisted Dying for the Terminally Ill Bill Committee reported and made a series of recommendations for future debates on the topic. The Committee argued that a distinction needed to be drawn between 'assisted suicide' and 'voluntary euthanasia', and the different considerations which apply to each of them. The Committee also pointed to the challenges that existed from a clinical practice perspective: namely, allowing doctors the opportunity for conscientious objection, the difficulty in providing an accurate prognosis to determine somebody as 'terminally ill', and the assessment of mental capacity.⁵⁸
- In 2009 Lord Falconer introduced an amendment to the Bill which became the Coroners and Justice Act 2009, aimed at removing the threat of prosecution for assisting a terminally ill individual to travel abroad to a place where assisted suicide was lawful if two doctors independently certified that the individual was terminally ill and had the capacity to make the decision to end their life by travelling to the country. The amendment was defeated by 194 votes to 141.⁵⁹
- Lord Falconer introduced Assisted Dying Bills in the 2013–14,⁶⁰ 2014–15,⁶¹ 2015–16,⁶² and 2019–21 sessions.⁶³
- The most recent attempt to change the law was Rob Marris MP's Assisted Dying (No. 2) Bill which was introduced in the Commons in session 2015–16.⁶⁴ It was defeated on division at second reading by 330 votes to 118.⁶⁵
- Lord Hayward introduced an Assisted Dying Bill in session 2016–17. It never had a second reading.⁶⁶

56 [Patient \(Assisted Dying\) Bill \[HL\] \(2003\)](#)

57 [Assisted Dying for the Terminally Ill Bill \[HL\] \(2004\)](#)

58 Select Committee on Assisted Dying for the Terminally Ill Bill Volume I: Report, First Report Session 2004–05, [HL Paper 86-I](#)

59 House of Lords Library Briefing, [Assisted Dying Legislation: North America and England and Wales](#) (March 2017)

60 [Assisted Dying Bill \[HL\] \(2013–14\)](#)

61 [Assisted Dying Bill \[HL\] \(2014–15\)](#)

62 [Assisted Dying Bill \[HL\] \(2015–16\)](#)

63 [Assisted Dying Bill \[HL\] \(2019–21\)](#)

64 [Assisted Dying \(No.2\) Bill \(2015–16\)](#)

65 HC Deb, 11 September 2015, [col 693](#)

66 [Assisted Dying Bill \[HL\] \(2016–17\)](#)

- In the 2021–22 session, Lord Forsyth tabled an amendment to the Health and Care Act during Committee stage. The amendment would have required the Government to introduce a Bill within twelve months that would permit terminally ill, mentally competent adults to end their own lives with medical assistance. The amendment was not moved.⁶⁷
- Baroness Meacher introduced the Assisted Dying Bill in the 2021–22 session. Baroness Meacher’s Bill sought to allow terminally ill, mentally competent adults to have the option to accelerate their deaths with medical assistance. It was based on existing laws in Oregon.⁶⁸ This Bill, received a second reading on 22 October 2021 but did not progress further before the parliamentary session ended.

Debates on bills to legislate AD/AS in other UK jurisdictions and the Crown Dependencies

52. An overview of AD/AS legislation internationally will follow in chapter 2. This section of the report will instead focus on jurisdictions in the UK other than England and Wales and on the Crown Dependencies. AD/AS is currently not legal in any part of the UK or the Crown Dependencies but here we will briefly consider the proposals to move towards legalisation which have been put forward in almost all of these areas, except Northern Ireland. The States of Guernsey has not considered legalising AD/AS since a proposal was put forward⁶⁹ and rejected in 2018.⁷⁰

53. Assisting a suicide in Scotland is not a specific offence, however people who are suspected of doing so could potentially be prosecuted for more general offences including murder, assault or offences under the Misuse of Drugs Act 1971. Unlike in England and Wales, there is no published prosecution policy specifically relating to cases where there is suspicion of assisted suicide in Scotland.⁷¹ There have been several Member’s Bills (equivalent to Private Member’s Bills in the UK Parliament) put forward to legalise AD/AS in some form, in the Scottish Parliament. In September 2021 Liam McArthur MSP proposed the Assisted Dying for Terminally Ill Adults (Scotland) Bill, which sought to “enable competent adults who are terminally ill to be provided at their request with assistance to end their life.”⁷² The consultation stage of the Bill proposal process received over 14,000 responses, which is the largest response for a Member’s Bill since the establishment of the Scottish Parliament in 1999.⁷³ This was an open consultation, run by Liam McArthur’s office, in which both individuals and organisations were welcome to submit evidence. The consultation process is part of the procedure that MSPs must follow

67 [Lord Forsyth of Drumlean’s amendment, After Clause 148 to the Health and Care Act 2022](#)

68 [House of Lords Library Briefing, Assisted Dying Bill \[HL\]](#) (October 2021)

69 [The States of Guernsey, Requête – Assisted Dying](#), P.2018/24

70 [The Guernsey Press, ‘Assisted dying proposal defeated in the States’](#), 18 May 2018

71 [House of Commons Library, The Law on Assisted Suicide](#) (July 2022)

72 [The Scottish Parliament, Proposed Assisted Dying for Terminally Ill Adults \(Scotland\) Bill – Liam McArthur MSP Summary of Consultation Responses](#) (September 2022)

73 [The Scottish Parliament, ‘Assisted Dying for Terminally Ill Adults \(Scotland\) Bill Consultation’](#), accessed 27 September 2023

in order to obtain the right to introduce a Member's Bill.⁷⁴ The consultation summary sets out that a "clear majority" of respondents (76%) were supportive of the proposal, with 2% partially supportive, 21% fully opposed and 0.4% partially opposed.⁷⁵

54. The consultation summary lists the themes showing why respondents were supportive. These were similar to themes we heard, including a wish to prevent "bad deaths" and prolonged suffering, and allowing people autonomy to choose the end of their lives. Concerns raised by respondents who were in principle supportive of the proposal included concern about how to define "terminal illness", and administration of the lethal drug (self-administered or administered by a healthcare professional). Some also argued that a wider group of people should be eligible under the proposal, including people with longer-term degenerative conditions such as neurological conditions and forms of dementia.⁷⁶

55. The consultation document sets out that amongst the people who were opposed to the proposal frequently cited reasons, also similar to what we have heard, included sanctity of life (sometimes based in religious beliefs). A large number of respondents also stated that there would never be enough safeguards to "prevent some people from feeling pressure to end their lives, perhaps through fear of being a burden on family, friends, health care services and/or wider society, or even being coerced for various reasons into deciding to choose an assisted death." Other themes amongst respondents opposing the proposal were concerns around ensuring someone was making the decision out of free will, that the legislation would expand in criteria in the future and the proposal would stigmatise and threaten "some of the more vulnerable people in society, such as young people, older people and people with a disability."⁷⁷

56. The Scottish Assisted Dying for Terminally Ill Adults (Scotland) Bill has received the support required (at least another 18 MSPs supporting it)⁷⁸ for it to have the right to be introduced.⁷⁹ In their evidence to us the Royal College of Physicians of Edinburgh, which "continues to take a position of having no organisational stance on assisted dying" stated:

With regard to the debate around any proposed assisted dying legislation, we understand proposals are likely to continue to come forward through Private Member's Bills (Member's Bills in Scotland) and we would ask the UK Government to encourage a respectful, evidence-based and inclusive debate that ensures the views of the physician community are actively sought and considered. We also consider that it is appropriate for the UK Government to continue to consider and assess how effectively, or otherwise, assisted dying legislation elsewhere in the world is operating.⁸⁰

74 The Scottish Parliament, ['Assisted Dying for Terminally Ill Adults \(Scotland\) Bill Consultation'](#), accessed 27 September 2023

75 The Scottish Parliament, [Proposed Assisted Dying for Terminally Ill Adults \(Scotland\) Bill – Liam McArthur MSP Summary of Consultation Responses](#) (September 2022)

76 The Scottish Parliament, [Proposed Assisted Dying for Terminally Ill Adults \(Scotland\) Bill – Liam McArthur MSP Summary of Consultation Responses](#) (September 2022)

77 The Scottish Parliament, [Proposed Assisted Dying for Terminally Ill Adults \(Scotland\) Bill – Liam McArthur MSP Summary of Consultation Responses](#) (September 2022)

78 The Scottish Parliament, ['Proposed Assisted Dying for Terminally Ill Adults \(Scotland\) Bill'](#), accessed 20 October 2023

79 The Scottish Parliament, ['How a Bill, or proposed Bill, becomes an Act'](#), accessed 27 September 2023

80 Royal College of Physicians of Edinburgh ([ADY0278](#))

57. In Jersey, a petition calling for the States Assembly to amend Jersey law and allow assisted dying was launched in 2018 and received 1861 signatures. The petition was followed by an online public survey, a GP and doctors' survey and a public meeting, all which indicated public support for proposals to legalise AD/AS.⁸¹ In February 2020 Deputy Richard Renouf, the Minister for Health and Social Services in the Government of Jersey, committed to establishing a Citizens' Jury⁸² tasked with considering whether AD/AS should be legalised in Jersey.⁸³ The Citizens' Jury conducted its work between spring 2021 and September 2021. The final report published in September 2021 includes various aspects of the discussions held in the Citizens' Jury, including whether participants thought that AD/AS in Jersey should only be available for Jersey citizens. Some Jury members argued that Jersey would be a closer option for some people (including UK residents) than Switzerland. 81% of jury members voted yes to the question "Should assisted dying only be for Jersey residents", and 19% voted no, and therefore the final recommendation was for AD/AS to extend to Jersey residents only.⁸⁴

58. Other discussions by the Citizens' Jury outlined in the report included whether to extend AD/AS to people who were not diagnosed with a terminal illness, but were experiencing "unbearable suffering". As outlined in the graph and table below, the Citizens' Jury agreed that it should include both groups. The report sets out that:

Jury members talked through considerations around timing of a diagnosis and the possibility of inaccurate diagnosis or medical trials that could have an impact on an individual's condition. The groups discussed the need for people to have a sense of empowerment, choice and control on the whole process and a chance to alleviate unbearable suffering and have peace of mind. Jury members discussed how the decision around which health criteria decisions are based on for permitting assisted dying might impact on making the process fairer and more accessible too.⁸⁵

81 The Jersey's States Assembly, '[Jersey Assisted Dying Citizens' Jury](#)', accessed 27 September 2023

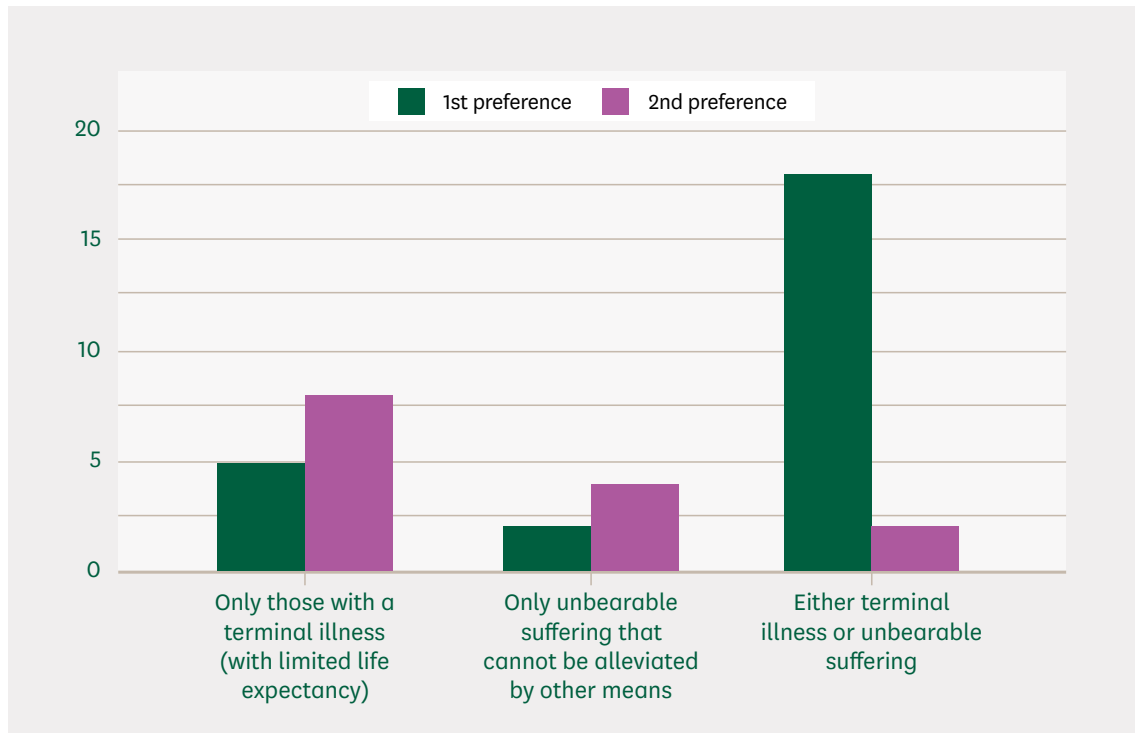
82 More information about the process: Involve Foundation ([ADY0413](#))

83 The Jersey's States Assembly, '[Jersey Assisted Dying Citizens' Jury](#)', accessed 27 September 2023

84 [Final Report from Jersey Assisted Dying Citizens' Jury](#) (September 2021)

85 [Final Report from Jersey Assisted Dying Citizens' Jury](#) (September 2021)

Figure 1: Graph and summary of responses by citizens' assembly members to the question "Who should be eligible for assisted dying related to health?"



Source: [Final Report from Jersey Assisted Dying Citizens' Jury](#) (September 2021)

59. The Citizens' Jury final report concluded that:

78% of Jersey Assisted Dying Citizens' Jury members agreed assisted dying should be permitted in Jersey under the following circumstances:

- where a Jersey resident, aged 18 or over, has a terminal illness or is experiencing unbearable suffering and wishes to end their life;
- subject to stringent safeguards including a pre-approval process; a mandatory period of reflection and consideration; with the direct assistance from doctors or nurses only, as opposed to non-medically qualified staff.⁸⁶

60. The next step for the Jersey States Assembly is to lodge proposals for a debate to confirm proposals for an "assisted dying service" in Jersey and, should the States Assembly approve these proposals, a draft law will be prepared. This, the Jersey States Assembly estimates will take a minimum of 12–18 months. Should the draft law be approved by the States Assembly, there will be an 18-month implementation period before the law comes into effect. The current proposals set out that anyone who has been "ordinarily a resident in Jersey for at least 12 months" will be eligible to access AD/AS.⁸⁷

61. During our first evidence session we heard from Dr Alexandra Mullock, Senior Lecturer in Healthcare Law and Co-Director of the Centre for Social Ethics and Policy, University of Manchester, who assisted the Citizens' Jury process in Jersey. She told us:

⁸⁶ [Final Report from Jersey Assisted Dying Citizens' Jury](#) (September 2021)

⁸⁷ The Government of Jersey, ['Assisted Dying in Jersey'](#), accessed 27 September 2023

I was quite surprised by the outcome of the citizens' jury in Jersey. They had many hours of very balanced evidence from campaigners, religious groups and doctors. They heard evidence about the law in lawful jurisdictions. I was very surprised that they decided they wanted to take quite a permissive, liberal approach, based on the concerns that they had heard. That is not my position. I feel quite worried about what has happened in some places like Canada and the Netherlands.⁸⁸

62. The Tynwald in the Isle of Man has discussed the issues around assisted dying several times.⁸⁹ On 27 June 2023, a Private Member's Bill aimed at legalising AD/AS in the Isle of Man received its first reading in the House of Keys.⁹⁰ The Bill passed its second reading on 31 October 2023,⁹¹ and commenced its Committee stage on 7 November 2023. The Committee is due to report by the end of February 2024.⁹²

63. This Bill was introduced following a public consultation which received 3326 responses, predominantly from Isle of Man residents. This was an open consultation, and the consultation report states that:

The consultation was not an opinion poll or form of referendum on the issue as it is inevitable that people with strong views of all persuasions were more likely to participate.⁹³

64. When asked whether in principle the respondents agreed or disagreed that assisted dying should be permitted for terminally ill adults on the Isle of Man (of which 3316 respondents answered), 1630 respondents (49.01%) agreed, 1650 (49.61%) disagreed and 36 (1.08%) stated that they were not sure. Respondents who agreed cited individual rights, dignity and the need to have autonomy and choices. Respondents who disagreed cited "a range of ethical, religious and moral reasons", as well as fears around initial provisions in the bill being expanded over time. Other respondents who disagreed argued that AD/AS would be unnecessary due to the high-quality palliative care on the Isle of Man, and some expressed concerns about the pressure the provision of AD/AS might put on people who felt like a burden to their families and the possibility of coercion for financial gain.⁹⁴

65. The Bill put forward in the Isle of Man following the consultation seeks to "enable certain adults who are terminally ill to be provided at their request with specified assistance to end their own life; and for connected purposes" and was promoted by Dr Allinson MHK.⁹⁵ This Bill similarly to the proposal in Jersey, sets out that to be eligible to apply the person must have been "ordinarily resident in the Island for not less than one year."⁹⁶

66. During our evidence session on 4 July 2023, the Minister for Social Care was asked about other jurisdictions in the UK possibly moving to legalising AD/AS and what the Government might respond if that happened. The Minister told us:

88 Q80

89 Isle of Man Government, [Assisted Dying – Private Members Bill Consultation](#), accessed 27 September 2023

90 Isle of Man Government, [Assisted Dying – Private Members Bill Consultation](#), accessed 27 September 2023

91 "Proposed Isle of Man assisted dying laws progress to next stage", BBC News, 31 October 2023

92 Tynwald Parliament of the Isle of Man, [House of Keys Committee on the Assisted Dying Bill](#), accessed 22 November 2023

93 Isle of Man Government, [Assisted Dying – Private Members Bill Consultation](#), accessed 27 September 2023

94 Isle of Man Government, [Assisted Dying – Private Members Bill Consultation](#), accessed 27 September 2023

95 Tynwald Parliament of the Isle of Man, 'Bills in Progress', accessed 27 September 2023

96 Tynwald Parliament of the Isle of Man, [Assisted Dying Bill 2023](#)

We observe and watch what is going on in other countries, and clearly, very importantly, within other parts of the United Kingdom. We should watch as those proposals progress in those other areas.⁹⁷

67. When pressed on whether there had been any consideration or discussion about what the possible implications of other jurisdictions adopting a law facilitating AD/AS, the Minister responded:

I have personally not been part of a discussion along those lines. I cannot speak for other discussions that may have happened.⁹⁸

68. *The UK Government must consider how to respond to another jurisdiction in the UK, or the Crown Dependencies, legislating to allow AD/AS, and how it may impact jurisdictions which do not allow it. Following the recommendation by the Jersey Citizens' Assembly, it looks increasingly likely that at least one jurisdiction among the UK and Crown Dependencies will allow AD/AS in the near future and Ministers should be actively involved in discussions on how to approach the divergence in legislation.*

97 [Q294](#)

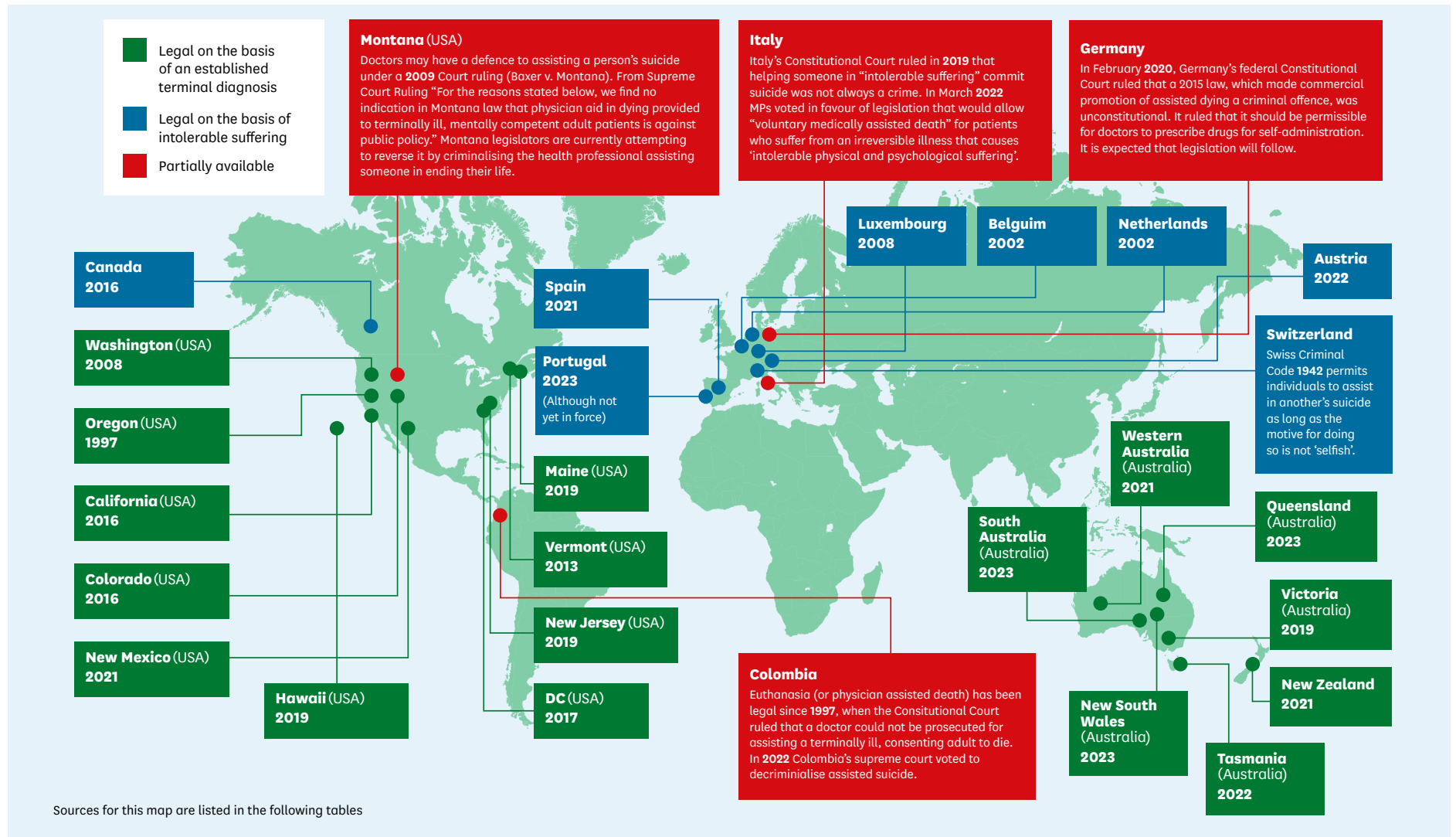
98 [Q295](#)

2 International examples

69. In this chapter we will focus on the international jurisdictions which we have looked at in more detail as part of our inquiry. The map on the next page shows a high-level overview of where AD/AS is legal, or in some cases, not illegal but lacking a formal system with regulated processes such as an established application and approval process, or regulatory oversight of the practice. For the purpose of comparison, we have divided these international jurisdictions into three broad groups;

- i) jurisdictions where it is legal to access AD/AS on the basis of a terminal diagnosis (which usually requires a medical professional to determine that the person has a limited time left to live),
- ii) jurisdictions where it is legal on the basis of a much wider set of eligibility criteria such as intolerable suffering (physical or mental), and
- iii) jurisdictions where AD/AS is not illegal or where there is ongoing case law. We have not looked at these jurisdictions in detail.

Figure 2: Map of jurisdictions where AD/AS is currently legal in some form.⁹⁹



Jurisdiction allowing AD/AS due to a terminal diagnosis

Table 3: Overview of jurisdictions where AD/AS is legal on the basis of a terminal diagnosis

Jurisdiction	New Zealand	Washington (USA)	Oregon (USA)	California (USA)	Colorado (USA)
Legal since (or will become legal as of)	2021	2008	1997	2016	2016
Legislation extends to minors	✗	✗	✗	✗	✗
Citizens/residents requirement	✓	✓	✗	✓	✓
Self-administration of drug	✓	✓	✓	✓	✓
Physician assisted administration of drug	✓	✗	✗	✗	✗

New Zealand: New Zealand Government Ministry of Health, 'Assisted Dying Service', accessed 13 November 2023. Te Whatu Ora Health New Zealand, 'Planning for an assisted death', accessed 13 November 2023.

Washington (USA): Washington State Legislature The Washington Death with Dignity Act (2009). Washington State Department of Health, 'Death with Dignity Act', accessed 13 November 2023.

Oregon (USA): Oregon Health Authority, 'Frequently Asked Questions : Death with Dignity Act', accessed 13 November 2023.

California (USA): California Department of Public Health, California End of Life Option Act 2021 Data Report (July 2023).

Colorado (USA): Colorado Secretary of State, Colorado End of Life Options Act (2016).

Jurisdiction	Western Australia (Aus)	South Australia (Aus)	Tasmania (Aus)	Queensland (Aus)	New South Wales (Aus)	Victoria (Aus)
Legal since (or will become legal as of)	2021	2023	2022	2023	2023	2019
Legislation extends to minors	✗	✗	✗	✗	✗	✗
Citizens/residents requirement	✓	✓	✓	✓	✓	✓
Self-administration of drug	✓	✓	✓	✓	✓	✓
Physician assisted administration of drug	✓	✓	✓	✓	✓	✓

Western Australia (Aus): Government of Western Australia Department of Health, ‘Voluntary Assisted Dying’, accessed 13 November 2023; Government of Western Australia Department of Health, Accessing voluntary assisted dying in Western Australia – Who is eligible? (2021).

South Australia (Aus): Government of South Australia South Australian Legislation, Voluntary Assisted Dying Act 2021; Government of South Australia SA Health, ‘Voluntary assisted dying in South Australia explained’, accessed 7 February 2024.

Tasmania (Aus): Tasmania Legislation, End-of-Life Choices (Voluntary Assisted Dying) Act 2021; Tasmanian Government Department of Health, Voluntary Assisted Dying in Tasmania – Fact Sheet: General Information for the Community (November 2022).

Queensland (Aus): Queensland Government Queensland Health, ‘The eligibility criteria’, accessed 13 November 2023. Queensland Government Queensland Health, ‘Development of the Voluntary Assisted Dying Act’, accessed 13 November 2023; Queensland Government, ‘Administration of the voluntary assisted dying substance’, accessed 7 February 2024.

New South Wales (Aus): New South Wales Government Voluntary Assisted Dying Act 2022 No 17; NSW Government NSW Health, ‘What is voluntary assisted dying and who is eligible?’, Accessed 7 February 2024.

Victoria (Aus): Victoria State Government Department of Health, ‘Voluntary Assisted Dying Overview’, accessed 13 November 2023.

Jurisdiction	New Mexico (USA)	Hawaii (USA)	The District of Columbia (USA)	New Jersey (USA)	Vermont (USA)	Maine (USA)
Legal since (or will become legal as of)	2021	2019	2017	2019	2013	2019
Legislation extends to minors	✗	✗	✗	✗	✗	✗
Citizens/residents requirement	✓	✓	✓	✓	✗	✓
Self-administration of drug	✓	✓	✓	✓	✓	✓
Physician assisted administration of drug	✗	✗	✗	✗	✗	✗

New Mexico (USA): The Legislature of the State of New Mexico, The Elizabeth Whitefield End of Life Options Act (2021); New Mexico Department of Health, 'Elizabeth Whitefield End-of-Life Options Act', accessed 7 February 2024.

Hawaii (USA): The Legislature of the State of Hawaii, Our Care Our Choice Act (2018); State of Hawaii Department of Health, 'Our Care, Our Choice Act (End of Life Care Option)', accessed 7 February 2024.

The District of Columbia (USA): Government of the District of Columbia, 'Death with Dignity Program Frequently Asked Questions', accessed 13 November 2023. Government of the District of Columbia DC Health District of Columbia Death with Dignity Act of 2016.

New Jersey (USA): State of New Jersey Department of Health Medical Aid in Dying for the Terminally Ill Act (2019) State of New Jersey, 'New Jersey Medical Aid in Dying for the Terminally Ill: Frequently Asked Questions', accessed 13 November 2023; State of New Jersey Department of Health, 'Medical Aid in Dying', accessed 7 February 2024.

Vermont (USA): Vermont General Assembly, 'Vermont Medical Aid In Dying Process', accessed 13 November 2023. General Assembly of the State of Vermont, No. 10. An act relating to removing the residency requirement from Vermont's patient choice at end of life laws (2023); Vermont Department of Health, Patient Choice at End of Life Frequently Asked Questions, accessed 7 February 2024.

Maine (USA): Maine Legislature, An Act To Enact the Maine Death with Dignity Act (2019); Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention, 'Death with Dignity Frequently Asked Questions', accessed 7 February 2024.

70. We have identified 17 jurisdictions (states and territories within a country are considered jurisdictions in their own right in this context) where AD/AS is legal on the basis of a person receiving a terminal diagnosis (see figure 6). Minors are not eligible to access AD/AS in any of these jurisdictions. This involves two medical professionals assessing the person and concluding that they are expected to die within a specific time period from an underlying terminal illness. The length of this time period differs, but all jurisdictions in this group have set the limit within 12 months of the AD/AS application being made. In none of these jurisdictions is AD/AS available to children under 18 years of age, and people may not apply on the grounds of mental illness or a disability (as defined in the respective disability acts in each jurisdiction). These jurisdictions require two medical professionals to assess the person applying and agree that they fulfil the eligibility criteria before prescribing, or administering, the lethal drug. A range of other safeguards apply

in different jurisdictions, including the person being required to make repeated requests to access AD/AS, multiple assessments over a period of time, and a “cooling-off period” between application and prescription or administration of the lethal drug.

71. The jurisdictions in this group that we examined in detail were the USA, Australia and New Zealand. These different jurisdictions use different terminology. However, as we have throughout this report, we will continue to use the term AD/AS, and to distinguish between self-administered (following prescription by a physician) and physician-assisted administered AD/AS.

72. In the Australian states New South Wales, Western Australia, Tasmania and in New Zealand, both self-administration and physician-assisted administration are allowed. In South Australia, Queensland and Victoria, physician-administered AD/AS is only permitted in cases where the individual is unable to administer the lethal drug by themselves. The USA only permits AD/AS through self-administration.

Australia

Table 4: Australian states where AD/AS is currently legal and when legislation was passed, and since when legislation has been active.

Jurisdiction	Legislation passed	Legislation active since
Northern Territory (NT)	1995 ^{100*}	1996 (but ceased in 1997) ¹⁰¹
Australian Capital Territory (ACT)	Legislation currently being considered by a parliamentary committee ¹⁰²	Not yet active
Victoria	2017 ¹⁰³	June 2019 ¹⁰⁴
New South Wales (NSW)	2022 ¹⁰⁵	November 2023
South Australia	2021 ¹⁰⁶	January 2023
Tasmania	2021 ¹⁰⁷	October 2022
Queensland	2021 ¹⁰⁸	January 2023
Western Australia	2019 ¹⁰⁹	July 2021

Sources displayed in the footnotes.

*Subsequently overturned by Federal Parliament in 1997, but a public consideration is now underway.¹¹⁰

73. AD/AS is currently legal in all six Australian states, but not in the two territories (although it was previously legal in the Northern Territory).

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- 100 Northern Territory Government, [Rights of the Terminally Ill Act 1995](#) (December 1997)
- 101 Australian Government Federal Register of Legislation, [Euthanasia Laws Act 1997](#) (March 1997)
- 102 ACT Government Justice and Community Safety Directorate, [‘Voluntary assisted dying laws in the ACT’](#), accessed 5 February 2024
- 103 Victorian Legislation, [Voluntary Assisted Dying Act 2017](#) (2017)
- 104 Government of Victoria Department of Health, [‘Voluntary Assisted Dying overview’](#), accessed 2 October 2023
- 105 NSW Government – NSW Health, [‘Voluntary Assisted Dying – An overview’](#), accessed 2 October 2023
- 106 Government of South Australia SA Health, [‘Voluntary Assisted Dying in South Australia’](#), accessed 2 October 2023
- 107 Tasmanian Government Department of Health, [‘Voluntary Assisted Dying’](#), accessed 2 October 2023
- 108 Queensland Government, [Voluntary Assisted Dying Act](#) (last updated March 2023)
- 109 Government of Western Australia Department of Health, [‘Voluntary Assisted Dying’](#), accessed 2 October 2023
- 110 Northern Territory Government, [Voluntary Assisted Dying](#), accessed 5 February 2024

74. Victoria was the first Australian state to introduce AD/AS.¹¹¹ Following an inquiry and recommendation by the Victorian Parliament Legal and Social Issues Committee, the Victorian State Government established a Ministerial Advisory Panel on Voluntary Assisted Dying (VAD) to provide expert legal advice on the practical and clinical implications of introducing a Bill. Professor Brian Owler, a Consultant Neurosurgeon, chaired this Panel. The Voluntary Assisted Dying Bill was introduced into the Parliament of Victoria in September 2017,¹¹² and AD/AS subsequently became available in Victoria in June 2019. Professor Brian Owler told us:

At the time [when legislation was introduced], it was very similar to the sort of debate that has been happening in the UK. There was a lot of controversy. It was hotly debated in the Parliament, right through the night, and was a very big news story. The Bill passed in 2017 and has been in operation for several years. Subsequent to that, every state in Australia has now passed the legislation. I have to say that by the end of that process the act of passing the legislation was not the controversial, high-profile media story that it was at the start. That is because Australians have come to accept voluntary assisted dying as quite an acceptable part of culture. There is no doubt that the two territories that now, thanks to federal legislation, have the ability to look at legislation, will pass very similar laws in the not too distant future.¹¹³

75. The latest annual report on the operation of the Act in Victoria shows that over the year to June 2023, 649 applications were made, and the number of deaths was 306 (an 11% increase compared to the previous year). 76% of all applicants were diagnosed with terminal cancer, and 81% of applicants were currently accessing or had previously accessed palliative care.¹¹⁴

76. South Australia introduced the Voluntary Assisted Dying Act in 2021. The Act has been in operation since January 2023.¹¹⁵ The state's AD/AS system is overseen by its Voluntary Assisted Dying Review Board which produces quarterly reports. The latest report covering the period between 1 July to 30 September 2023, showed that 39 people died through AD/AS, and that 48 had been granted permit to do so.¹¹⁶ The first annual report was published in November 2023, covering the period 31 January to 30 June 2023. In this period, a total of 71 permits were issued to 68 people; 28 people died from self-administration of the substance; 11 died from practitioner-administration of the substance; 6 died without taking the substance.¹¹⁷

77. Tasmania introduced legislation on AD/AS in 2021, and the system has been operational since 2022.¹¹⁸ In his evidence to us, Mr Michael Gaffney MLC, the Member of the Legislative Council who introduced the End-of-Life Choices (Voluntary Assisted

111 Government of Victoria Department of Health, '[Voluntary Assisted Dying overview](#)', accessed 2 October 2023

112 Victorian Legislation, '[Voluntary Assisted Dying Act 2017](#)' (November 2017)

113 [Q85](#)

114 Voluntary Assisted Dying Review Board Victoria, '[Voluntary Assisted Dying Review Board Annual Report \(July 2022 to June 2023\)](#)' (August 2023)

115 Government of South Australia SA Health, '[Voluntary Assisted Dying in South Australia](#)', accessed 2 October 2023

116 Government of South Australia SA Health, '[Voluntary Assisted Dying in South Australia Quarterly Report 1 May to 30 June 2023](#)' (2023)

117 Government of South Australia SA Health, '[Voluntary Assisted Dying Review Board annual reports 2022–23](#)' (November 2023)

118 Tasmanian Government Department of Health, '[Voluntary Assisted Dying](#)', accessed 2 October 2023

Dying) Act 2021 in Tasmania, outlined the process which he had followed in introducing the Bill and argued that ensuring there is adequate community engagement and constructive collaboration with people who disagree is key:

[...] I believe reinforcing that there needs to be a very transparent and open process where people feel as though they are included in the conversation and each opinion is important. Obviously, with this issue there will never be consensus but I believe all Tasmanians felt they could be involved.¹¹⁹

78. The Tasmanian Voluntary Assisted Dying Commission published a report on the first six months of the operation of the Act in July 2023. The report set out that 16 people (of the 28 identified as eligible) died after accessing AD/AS in this period.¹²⁰ In November 2023 they published their first annual report, covering the period between 23 October 2022 and 30 June 2023. In this period 42 people were issued authorisation to access AD/AS and there were 24 AD/AS deaths.¹²¹

79. AD/AS became available for residents of Western Australia in July 2021 following consultation by a parliamentary joint select committee and a Ministerial Expert Panel.¹²² The most recent annual report on the operation of the Act in Western Australia was published in November 2023, and showed that between 30 June 2022 and 30 June 2023 255 people died following administration of an AD/AS lethal substance under the Act. 82.4% of those people chose to have the lethal drug administered by a healthcare professional, and 17.6% of people chose to self-administer.¹²³

80. AD/AS has been available to residents in Queensland since January 2023, following the passing of the Voluntary Assisted Dying Act in September 2021.¹²⁴ The Act was developed over a three-year period involving two Parliamentary committee inquiries and an inquiry by the independent and expert Queensland Law Reform Commission.

81. The first annual report of the Queensland Voluntary Assisted Dying Review board was published in August 2023 and covers the period between 1 January to 30 June 2023. The report states that during this time 245 people died after accessing AD/AS, and that a majority of those accessing AD/AS had a terminal cancer diagnosis (78.2%). 78% of the people who requested AD/AS had, or were currently receiving, palliative care.¹²⁵ The Honourable Dr Steven Miles, who submitted written evidence on behalf of the Queensland Government, told us:

Our experience demonstrated the value and importance of respectfully listening to a range of views, acknowledging concerns and complexities, and ensuring the rights and interests of organisations and individuals who do not wish to participate whilst also ensuring the rights of individuals seeking access to voluntary assisted dying.¹²⁶

119 Michael Gaffney ([ADY0042](#))

120 Tasmania Voluntary Assisted Dying Commission, [Report on the End-of-Life Choices \(Voluntary Assisted Dying\) Act 2021's operation in its first six months](#) (July 2023)

121 Tasmanian Government Department for Health, [Voluntary Assisted Dying Commission Annual Report 2022–23](#) (November 2023)

122 Ministerial Expert Panel on Voluntary Assisted Dying, [Final Report](#) (2019)

123 Voluntary Assisted Dying Board Western Australia, [Annual Report 2021–22](#) (November 2022)

124 Queensland Government – Queensland Health, [‘Implementation of voluntary assisted dying’](#), accessed 2 October 2023

125 Queensland Voluntary Assisted Dying Review Board, [Annual Report 2022–23](#) (August 2023)

126 Queensland Government ([ADY0272](#))

82. The New South Wales (NSW) Voluntary Assisted Dying Act was passed by the Parliament of New South Wales in May 2022. Following an 18-month implementation period, eligible residents of NSW were able to access AD/AS under the Act from November 2023.¹²⁷ As such, there have not yet been any reports on its operation.

83. The Hon Alex Greenwich MP (Member for Sydney at NSW Legislative Assembly) who introduced the Bill in 2021, stated in written evidence:

My strong support for reform arose from listening to constituents with desperately sad situations, looking for help. The stories were heart breaking and highlighted the ludicrousness of refusing to let people experiencing appalling suffering that could not be relieved, whose death was imminent and inevitable, get medical help to end their life peacefully with their family by their side.¹²⁸

New Zealand

84. In New Zealand, AD/AS has been legal since 2021, following the passing of the End-of-Life Choice Act 2019. The Act was introduced as a Member's Bill (similar to a Private Member's Bill in UK Parliament). The Bill stipulated that its provisions would come into effect only after a public referendum. A referendum was held in 2020 and the 'yes' vote was supported by the then Prime Minister and the Leader of the Opposition.¹²⁹ A majority of the population voted to implement the Act. The Ministry of Health must review the Act within three years of it coming into force. According to the Ministry of Health, the review could include "whether any amendments to this Act or other enactment are necessary or desirable". After the first review, the Act must be reviewed every five years.¹³⁰

85. Dr Alison Payne, a British GP who has been practicing in New Zealand since 2020, stated in her written evidence:

Observing how AD operates in NZ, my experience is that when I meet an applicant for AD [AD/AS] 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.¹³¹

86. The Act requires a "Registrar of assisted dying" to report on the operation of AD/AS each year. The first full Annual Report was published in June 2023, and covers the period from 1 April 2022 to 31 March 2023. During this period 328 people accessed AD/

127 NSW Government - NSW Health, '[Voluntary Assisted Dying – An overview](#)', accessed 2 October 2023

128 Mr Alex Greenwich ([ADY0229](#))

129 "[New Zealand votes to legalise euthanasia in referendum](#)", The Guardian, 30 October 2020

130 New Zealand Ministry of Health, '[Overview - The End of Life Choice Act 2019](#)', accessed 2 October 2023

131 Dr Alison Payne ([ADY0127](#))

AS, and the majority of these people (306) chose to have the lethal drug administered by a healthcare professional (either through a tube or injection), and 22 people chose to self-administer.¹³²

87. When he appeared before us, Professor Roderick MacLeod (former Senior Consultant and Senior Medical Specialist in Palliative Care active in both Australia and New Zealand) criticised the type of data collected in New Zealand:

Some colleagues and I have written to the Ministry to ask for more data to be collected, because we do not know exactly what is going on with the process in New Zealand. There are certain checks and balances that have to be considered and there is a review committee, but as far as I can find out the review committee is something of a tick-box exercise. We have asked that we have more information about the nature of the requests for assisted dying and about the process that is gone through. Part of the difficulty we have here is that if we look at other jurisdictions—Australia is a good example—their intention is to collect a lot of data so that they can make comparisons between states and between their legislation and that of other jurisdictions. In New Zealand, the information we are collecting at the moment is pretty slim.¹³³

United States of America

Table 5: US jurisdictions where AD/AS is currently legal and when it has been legal since.

US Jurisdiction	Legal since
Oregon	1997–Death With Dignity Act ¹³⁴
Washington state	2009–Death with Dignity Act ¹³⁵
Vermont	2013–Patient Choice at End of Life Act ¹³⁶
California	2015–End of life Options Act ¹³⁷
Colorado	2016–End-of-life Options Act ¹³⁸
Maine	2019–Death with Dignity Act ¹³⁹
District of Columbia	2017–Death with Dignity Act ¹⁴⁰
New Jersey	2019–Medical Aid in Dying for the Terminally Ill Act ¹⁴¹
Hawaii	2019–Our Care, Our Choice Act ¹⁴²
New Mexico	2021–End-of-Life Options Act ¹⁴³

Sources are displayed in the footnotes.

132 New Zealand Ministry of Health, [Assisted Dying Service – Ngā Ratonga Mate Whakaahuru](#) (July 2023)

133 Q89

134 Oregon Health Authority, [Oregon's Death with Dignity Act](#), accessed 30 April 2023

135 Washington State Department of Health, ['Frequently Asked Questions About Death With Dignity'](#), accessed 28 April 2023

136 Vermont General Assembly, [The Vermont Statutes Online – Title 18: Health, Chapter 113: Patient Choice at the End of Life](#), accessed 10 October 2023

137 California Department of Public Health, [End of Life Option Act](#), accessed 28 April 2023

138 Colorado Department of Public Health & Environment, [Medical Aid in Dying](#), accessed 28 April 2023

139 Maine Legislature, [Maine Death with Dignity Act 2019](#), accessed 10 October 2023

140 DC Health, [Death with Dignity Act of 2016](#), accessed 28 April 2023

141 State of New Jersey Department of Health, [Medical Aid in Dying](#), accessed 28 April 2023

142 Hawaii Department of Health, [Our Care, Our Choice Act \(End Of Life Care Option\)](#), accessed 28 April 2023

143 The Legislature of the state of New Mexico, [End of Life Options Act](#) (2021)

88. The first US state to introduce legislation on AD/AS was Oregon. The Oregon Death with Dignity Act 1994 (DWDA, enacted in 1997) permits doctors to prescribe lethal drugs for self-administration. The process to pass the legislation in Oregon started via a citizens' initiative.¹⁴⁴ The National Conference of State Legislatures, an organisation providing resources to all state legislators and their staff, defines such initiatives as follows:

Citizen initiatives and popular referenda are two forms of direct democracy. The **citizen initiative** process enables citizens to bypass their state legislature by placing proposed statutes and, in some states, constitutional amendments on the ballot. Twenty-four states have citizen initiative processes. The **popular referendum** process allows voters to approve or repeal an act of the legislature. Twenty-three states have popular referendum processes.¹⁴⁵

89. Of the nine US jurisdictions which subsequently introduced their own legislation, two did so through a similar vote/citizen initiative (Washington and Colorado). The Acts in these nine jurisdictions also follow the Oregon example in what they allow and in regard to eligibility criteria. None of the US jurisdictions allow physician-assisted administration, and the individual requesting AD/AS must have a terminal diagnosis, with a life expectancy of 6 months or less, and be over 18 years old and mentally capable.¹⁴⁶ Capability is most often identified along the lines of what is set out in Oregon statute, as "that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available."¹⁴⁷

90. In almost all of these US jurisdictions the individual must also be a resident;¹⁴⁸ the exception is Vermont (since early May 2023)¹⁴⁹ and Oregon. Following a 2021 lawsuit claiming that the residency criteria of the Oregon Death with Dignity Act violated the United States Constitution, the State of Oregon agreed not to enforce the residency

144 Oregon Health Authority, ['Death With Dignity Act – Frequently Asked Questions'](#), accessed 2 October 2023

145 National Conference of State Legislatures, ['Initiative and Referendum Processes'](#), accessed 10 October 2023

146 Sources: Washington State Department of Health, ['Frequently Asked Questions About Death With Dignity'](#), accessed 28 April 2023; California Department of Public Health, [End of Life Option Act](#), accessed 28 April 2023; Colorado Department of Public Health & Environment, [Medical Aid in Dying](#), accessed 28 April 2023; Maine Department of Health and Human Services, [Death with Dignity Frequently Asked Questions](#), accessed 28 April 2023; DC Health, [Death with Dignity Act of 2016](#), accessed 28 April 2023; State of New Jersey Department of Health, [Medical Aid in Dying](#), accessed 28 April 2023; Hawaii Department of Health, [Our Care, Our Choice Act \(End Of Life Care Option\)](#), accessed 28 April 2023; The Legislature of the state of New Mexico, [End of Life Options Act \(2021\)](#)

147 Oregon Health Authority, [Oregon Revised Statute: Oregon's Death with Dignity Act](#), accessed 30 April 2023

148 Sources: Washington State Department of Health, ['Frequently Asked Questions About Death With Dignity'](#), accessed 28 April 2023; California Department of Public Health, [End of Life Option Act](#), accessed 28 April 2023; Colorado Department of Public Health & Environment, [Medical Aid in Dying](#), accessed 28 April 2023; Maine Department of Health and Human Services, [Death with Dignity Frequently Asked Questions](#), accessed 28 April 2023; DC Health, [Death with Dignity Act of 2016](#), accessed 28 April 2023; State of New Jersey Department of Health, [Medical Aid in Dying](#), accessed 28 April 2023; Hawaii Department of Health, [Our Care, Our Choice Act \(End Of Life Care Option\)](#), accessed 28 April 2023; The Legislature of the state of New Mexico, [End of Life Options Act \(2021\)](#)

149 The New York Times, ['Vermont Removes Residency Requirement for Medically Assisted Deaths'](#), accessed 2 May 2023

requirement in several cases. In 2023 a Bill was introduced in the Oregon State legislature to remove all text in the Act relating to the residency requirement.¹⁵⁰ The Bill passed in July 2023.¹⁵¹

91. When we visited Oregon, we were told by Oregon Health Authority that there had been no reports of misuse of the Death With Dignity Act since it was introduced in 1997. According to the pro-AD/AS advocacy group Death with Dignity, the Oregon Act “works exactly as intended and exactly for whom it was intended, without fail.”¹⁵² However, we were concerned to learn that in Oregon it is not mandatory for the prescribing physician to submit a post-death form, therefore the data is incomplete. Instead, the Oregon Health Authority website sets out only that the attending physician “should” submit the completed documentation within 10 calendar days of a patient’s “ingestion of DWDA [AD/AS] medication or death from any other cause, whichever comes first.”¹⁵³

92. The reports published by the various state authorities in relation to AD/AS differ in the amount of detail they provide about the people accessing it. None of these include any reports of misuse of the Act. Most reports include details about the underlying illness, age, sex, ethnicity and insurance cover of the individuals. Some reports also include place of death (in the individual’s home, in a hospice etc.) and educational attainment level. There is no standardised data collection method across the different US jurisdictions.¹⁵⁴

93. We heard that there is no standardised method for collecting prescriptions for the lethal drugs which have not been used, nor was there consistent data on how many prescriptions were handed back in the cases where they were not used.

150 Oregon Public Health Division Centre for Health Statistics, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

151 The Oregonian - Your Government, ‘[House Bill 2279](#)’, accessed 3 October 2023

152 Death with Dignity, ‘[About us](#)’, accessed 28 April 2023

153 Oregon Health Authority, ‘[Provider Reporting Forms and Instructions](#)’, accessed 10 October 2023

154 Oregon Health Authority, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023); Washington State Department of Health, [2021 Death with Dignity Act Report](#) (July 2022); California Department of Public Health, [California End Of Life Option Act 2022 Data Report](#) (July 2023); Colorado Department of Public Health & Environment, [Colorado End-Of-Life Options Act-Year Six: 2022 Data Summary, with 2017–2022 Trends And Totals](#), 2023; Vermont Department of Health, [Report Concerning Patient Choice at the End of Life](#) (January 2022); Maine Department of Health and Human Services, [Patient-Directed Care 2022 Annual Report](#) (2023). DC Health, [District of Columbia Death with Dignity Act 2021 Data Summary](#) (2021); State of New Jersey Department of Health, [New Jersey Medical Aid in Dying for the Terminally Ill Act 2022 Data Summary](#), (2022); Hawaii Department of Health, [Report To The Thirty-Second Legislature State Of Hawaii](#) (July 2022)

Note: No report was located for the State of New Mexico

Jurisdictions allowing AD/AS due to intolerable suffering

Table 6: Overview of jurisdictions where AD/AS is legal on the basis of “intolerable suffering”

Jurisdiction	Canada	Portugal	Spain	Luxembourg
Legal since (or will become legal as of)	2016	2023	2021	2009
Legal on the basis of an established terminal diagnosis	✓	✓	Not established	✓
Legal on the basis of ‘unbearable suffering’	✓	✓	✓	✓
Legal on the basis of a mental illness diagnosis	Proposal to be considered by March 2027	✗	✓	✗
Legislation extends to minors	✗	✗	✗	✗
Citizens/residents requirement	Must be eligible for province/territory/federal government funded health services	✓	Not established	✗
Self-administration of drug	✓	✓	✓	✓
Physician assisted administration of drug	✓	✓	✓	✓

Canada: Government of Canada Gouvernement du Canada. ‘Medical assistance in dying: Overview’, accessed 13 November 2023; Health Canada, ‘The Government of Canada introduces legislation to delay Medical Assistance in Dying expansion by 3 years’, 1 February 2024.

Portugal: “Portuguese parliament legalises euthanasia after long battle”. The Guardian, 12 May 2023.

Spain: “Spain passes law allowing euthanasia”, BBC News, 18 March 2021. Library of Congress, ‘Spain: Bill on Euthanasia and Assisted Suicide Approved by Congress of Deputies’, 9 February 2021.

Luxembourg: Le Gouvernement du Grand-Duché de Luxembourg. ‘Information on requesting euthanasia or assisted suicide’, accessed 13 November 2013; Ministry of Health (Ministère de la Santé) and Ministry of Social Security (Ministère de la Sécurité sociale), Euthanasia and assisted suicide, Law of 16 March 2009, 25 questions, 25 answers. (June 2010).

Jurisdiction	Belgium	The Netherlands	Switzerland	Austria
Legal since (or will become legal as of)	2002	2002	1942	2022
Legal on the basis of an established terminal diagnosis	✓	✓	✓	Not established
Legal on the basis of 'unbearable suffering'	✓	✓	✓	✓
Legal on the basis of a mental illness diagnosis	✓	✓	✓	✗
Legislation extends to minors	✓	✓	✓	✗
Citizens/residents requirement	✗	✗	✗	✓
Self-administration of drug	✓	✓	✓	✓
Physician assisted administration of drug	✓	✓	✗	✗

Belgium; E. Vermeersch "The Belgian Law on Euthanasia The Historical and Ethical Background". *Acta Chirurgica Belgica*, vol. 102 (2002); pp. 394-397. Constitutional Court, Judgment no. 153/2015 of 29 October 2015. "Northern French seeking euthanasia find legal option in Belgium", *Le Monde*, 13 December 2022; 'The Belgian Act on Euthanasia of May, 28th 2002', *European Journal of Health Law*, vol 10 (2003) pp. 329-335.

The Netherlands; Government of the Netherlands. 'Euthanasia' accessed 13 September 2023. Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, accessed 13 September 2023.

Switzerland; Assisted Dying POSTbrief 47 Parliamentary Office for science and Technology, September 2022. Q188 [Dr Yvonne Gilli]; Q186 [Hurst-Manjo] and Hachtel et. Al., 'Practical issues of Medical Experts in Assessing Persons with Mental Illness Asking for Assisted Dying in Switzerland', *Frontiers in Psychiatry* vol. 13 (2002).

Austria; Bundesministerium Justiz, 'Sterbehilfe', accessed 13 November 2023. "Austrian government proposes law to legalize assisted suicide", *CNN*, 23 October 2021. "New law allowing assisted suicide takes effect in Austria", *BBC News*, 1 January 2022; *Bundesgesetzblatt Für Die Republik Österreich*, Bundesgesetz, Bundesgesetz, mit dem ein Sterbeverfügungsgesetz erlassen wird sowie das Suchtmittelgesetz und das Strafgesetzbuch geändert werden, 31 December 2021.

94. We have identified 9 jurisdictions in the group where AD/AS is legal on the basis of intolerable suffering. We have included Austria in this group, although it arguably has a more restrictive definition for "intolerable suffering". The Austrian legislation (introduced in January 2022) requires the applicant to have a terminal diagnosis or to be able to show proof of serious and permanent long-term illness,¹⁵⁵ but not in every case prove that there is a "time specific" diagnosis for when death will occur.

95. We looked at three of these jurisdictions in more detail during our inquiry: the Netherlands, Belgium and Canada. Again, the terminology is different in each jurisdiction, but we have stuck to our terminology of AD/AS.

155 Bundesministerium Justiz, 'Sterbehilfe', accessed 3 October 2023

The Netherlands

96. In 1971, a Dutch physician administered a lethal dose of morphine to her 78-year-old mother who was deaf and partly paralysed, and who had repeatedly asked her daughter to end her life. The physician, Dr Postma, reported her act to the authorities, which led to the case being tried in the courts. The verdict outlined that a medical doctor could not be blamed for shortening a patient's life if they had observed certain due care criteria, if the patient had an incurable illness or was experiencing unbearable suffering, and had themselves requested it. The court gave Dr Postma a suspended custodial sentence. Some consider this the start of the move towards legalising AD/AS in the Netherlands.¹⁵⁶

97. Following further similar cases, the Dutch Health Council recommended establishing a State Commission, in 1982. The State Commission's 1985 report recommended amending the Dutch criminal code so that "the intentional termination of another person's life at the latter's request would not be an offense if carried out by a doctor on a patient who is 'in an untenable situation with no prospect of improvement'". In 1990, the Ministry of Justice, together with the Royal Dutch Medical Association, agreed a formal notification procedure. Physicians who had complied with the criteria for due care for euthanasia would not be prosecuted.¹⁵⁷ In 1998, a national reporting procedure was developed through establishing multi-disciplinary review committees, consisting of a lawyer, a physician, and an ethicist.¹⁵⁸

98. In 2001 the Dutch Parliament agreed the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which makes both self-administered and physician-assisted administered AD/AS legal. The Act stipulates that the physician assisting the person must be sure that the "patient's suffering was lasting and unbearable" and provides for children between 12 and 18 being able to access AD/AS in certain circumstances. The Dutch law on AD/AS also allows for someone over 16 years old who has previously expressed their will to pursue AD/AS in writing but has since lost capacity due to illness, to pursue it.¹⁵⁹ Following an AD/AS death, the participating healthcare professional must report the death to the municipal coroner who informs regional review committees, who assess compliance with law. Cases where there are any issues around non-compliance with the law are referred to the public prosecutor.¹⁶⁰

99. The Dutch Regional Euthanasia Review Committee receives notifications from participating healthcare professionals and publishes an annual report. The most recent report stated that the Regional Euthanasia Review Committee received 8,720 such notifications in 2022, which is an increase of 13.7% compared to 2021 (7,666 notifications). In the foreword to the report, Jeroen Recourt, the coordinating chair of the Review Committee stated:

100. This upward trend, in both the absolute and relative numbers, has been visible for a number of years. Since no academic research has been conducted into the causes of this

156 E. Vermeersch, "The Belgian Law on Euthanasia The Historical and Ethical Background", *Acta Chirurgica Belgica*. (2002) vol 102, pp 394–397

157 Rietjens et al, ["Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?"](#) *Journal of Bioethical Inquiry*, vol. 6 (2009) pp 271–283

158 Rietjens et al, ["Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?"](#) *Journal of Bioethical Inquiry*, vol. 6 (2009) pp 271–283

159 [Termination of Life on Request and Assisted Suicide \(Review Procedures\) Act 2002](#), accessed 26 May 2023

160 POST Brief 47, [Assisted Dying](#) (September 2022)

increase, it is impossible to make any substantiated predictions about how the number of euthanasia cases will develop in the Netherlands. However, there are no indications that this trend will change in the coming years.¹⁶¹

101. The most common reason for requesting AD/AS was cancer (57.8%) followed by neurological disorders (7.0%), cardiovascular disease (4.1%), pulmonary disease (3.2%) or a combination of conditions (16.4%). In 2022, in 115 notified cases (1.3%) the patient's suffering was stated to be largely caused by one or more psychiatric disorders, the same number as in 2021.¹⁶² One of the cases set out in the 2021 official Dutch report was as follows:

The patient, a woman in her seventies, had suffered from severe, recurring depression for 25 years. She also suffered from post-traumatic stress disorder (PTSD) and had liver problems. The patient had attempted suicide several times. She was mentally and physically exhausted due to her depression, and incapable of doing anything anymore. There were no periods of improvement. About one month before her death, the patient asked her general practitioner (GP) for euthanasia. Before her death, the patient was visited by an independent psychiatrist and an independent physician.¹⁶³

Belgium

102. The debate on AD/AS in Belgium, influenced by the Netherlands, reached the Belgian Parliament in the mid-90s when several bills were proposed in the senate. In 1996 the Belgian Advisory Committee on Bioethics was founded to advise the government and parliament on bioethical problems, and in 1997 they published an Opinion on AD/AS. The Opinion expressed the various concerns of the Committee members but concluded that "it should be possible to reach a practical solution to the problem of euthanasia."¹⁶⁴ Following several years of debate, a bill was drafted and considered. Unlike in the Netherlands, no major medical association supported the legislation.¹⁶⁵ The Act came into force in 2002 and applies only to physician-administered AD/AS, not to the supply of a lethal drug for self-administration, although this is not prohibited either and the Federal Control and Evaluation Commission has accepted that cases of supply of the lethal drug for self-administration fall under the law.¹⁶⁶

103. The 2002 Act applied to all legally competent and conscious adults and emancipated minors (minor with legal independence from their parents or legal guardians).¹⁶⁷ In 2014, the law was amended to remove age restrictions. The amendment means that parental

161 Ministerie van Volksgezondheid, Welzijn en Sport, [Regional Euthanasia Review Committees. Annual report 2022](#) (2023)

162 Ministerie van Volksgezondheid, Welzijn en Sport, [Regional Euthanasia Review Committees. Annual report 2022](#) (2023)

163 Ministerie van Volksgezondheid, Welzijn en Sport, [Regional Euthanasia Review Committees. Annual report 2021](#), (2023)

164 The Belgian Advisory Committee on Bioethics, [Opinion no. 1 of 12 May 1997 concerning the advisability of a legal regulation on euthanasia](#) (1997)

165 E. Vermeersch. "The Belgian Law on Euthanasia The Historical and Ethical Background", *Acta Chirurgica Belgica*. (2002) Vol 102, pp 394–397

166 BMA, [Physician-assisted dying legislation around the world](#) (August 2021)

167 Constitutional Court of Belgium, [Judgement no. 153/2015 of 29 October 2015](#)

consent is required for applicants under 18 years. Minors must possess “capacity of discernment” (regardless of their age) and fulfil several other due care criteria. These include that suffering must be physical and death must be expected in the short term.¹⁶⁸

104. The Belgian Federal Commission for the Control and Evaluation of Euthanasia monitors cases and publishes a biennial report.¹⁶⁹ Following an AD/AS death the participating healthcare professional reports the death to the Federal Control and Evaluation Commission, which assesses compliance with the law. Cases which do not comply with the law can be referred to the public prosecutor.¹⁷⁰ In 2021, 2,700 cases of AD/AS were reported, and of these, cancer was the most common reason (62.8%), followed by neurological disorders (7.9%), cardiovascular disease (3.7%), pulmonary disease (2.4%) or a combination of conditions (17.7%). In 0.9% of cases, the reason for the request was psychiatric disorders.¹⁷¹

Switzerland

105. It is not illegal to provide or access AD/AS in Switzerland. Under Article 115 of the Swiss Criminal Code, it is only a crime if done for “selfish” reasons:

Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.¹⁷²

106. As there is no regulation governing AD/AS in Switzerland, there are no legally outlined residence or citizen requirements or eligibility criteria. The cost associated with AD/AS is entirely funded by the person accessing it, and AD/AS is not available through the state. Doctors can prescribe lethal drugs for self-administration, but all forms of euthanasia (physician-assisted administration) are against the law. According to Swiss case law, the person requesting AD/AS must have decision-making capacity.¹⁷³ Swiss doctors must act in accordance with the Federal Act on Narcotics and Psychotropic Substances and with the Federal Act on Medicinal Products and Medical Devices. These laws require that doctors know the health status of a person requesting AD/AS.¹⁷⁴ The Swiss Academy of Medical Sciences’ revised “Management of dying and death” guidelines were published in 2018. Doctors involved in delivering AD/AS, as prescribers of the lethal drug, are expected to follow the guidelines, but they are not legally obliged to do so.¹⁷⁵

107. Almost all cases of AD/AS in Switzerland take place within frameworks set up by non-profit groups¹⁷⁶ such as Dignitas¹⁷⁷ and Exit¹⁷⁸, from whom we heard oral evidence. These groups operate as “membership” organisations, and anyone seeking to access AD/

168 POST Brief 47, [Assisted Dying](#) (September 2022)

169 Health, Food Chain Safety, Environment, [‘Federal Commission for the Control and Evaluation of Euthanasia’](#), accessed 26 May 2023

170 House of Commons Library Brief, [The Law on Assisted Dying](#) (July 2022)

171 Commission fédérale de Contrôle et d’Évaluation de l’Euthanasie, [CFCEE Rapport Euthanasie 2022](#) (2022)

172 [Article 115 Swiss Criminal Code](#), accessed 3 October 2023

173 POST Brief 47, [Assisted Dying](#) (September 2022)

174 House of Commons Library Brief, [The Law on Assisted Dying](#) (July 2022)

175 POST Brief 47, [Assisted Dying](#) (September 2022)

176 BMA, [Physician-assisted dying legislation around the world](#) (August 2021)

177 Dignitas, [‘Who is Dignitas’](#), accessed 3 October 2023

178 EXIT (Deutsche Schweiz), [‘Our Society’](#), accessed 3 October 2023

AS from them must first become a member of the group. As we mentioned in chapter 1, some of these organisations accept requests from foreign citizens, including people from the UK.

Table 7: Swiss residents' AD/AS deaths in Switzerland between 2015–2021

	2015	2016	2017	2018	2019	2020	2021
Number of AD/AS deaths (Swiss residents)	965	928	1009	1176	1196	1251	1391

Source: Bundesamt für Statistik, [Assistierter Suizid nach Geschlecht und Alter - 2003–2019](#) (April 2023)

Canada

108. AD/AS was decriminalised in Canada on 17 June 2016.¹⁷⁹ The relevant Act (known as the Medical Assistance in Dying or MAID Act) was introduced in response to the Supreme Court ruling *Carter v. Canada*,¹⁸⁰ in which the Supreme Court ruled that parts of the Canadian criminal code needed to be changed to satisfy the Canadian Charter of Rights and Freedoms. Under its powers to instruct Parliament to pass federal legislation, the Supreme Court gave the government until June 2016 to create a new law to decriminalise AD/AS.¹⁸¹

109. Individuals requesting AD/AS under the MAID Act are broadly categorised into two groups:

- Those for whom a natural death is reasonably foreseeable. However, unlike legislation in the USA, Australia and NZ for example, there is no requirement to have a set period left to live.¹⁸²
- Those for whom a natural death is not reasonably foreseeable. In order for this group to access AD/AS there are more rigorous eligibility criteria, and the individual has to be informed of “appropriate means to relieve” their suffering, including counselling services, mental health and disability support services, community services, and palliative care. Other safeguards include a mandatory 90-day wait time between a request and being able to access AD/AS.¹⁸³

110. Four annual reports with monitoring data on Canadian AD/AS cases have been published so far. Overall, the number of people accessing AD/AS under the MAID legislation has increased steadily since the introduction of the legislation. AD/AS deaths accounted for 4.1% in 2022, an increase from 3.3% in 2021, 2.5% in 2020 and 2.0% in 2019. 44,958 Canadian adults have accessed AD/AS since it became legal in June 2016. The majority of people accessing AD/AS under the MAID legislation had cancer as their underlying diagnosis (65.6%). In 2022, 3.5% (463) of individuals accessing AD/AS

179 Library of Parliament Canada, [Legislative Summary of Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\)](#) (April 2016, revised September 2018)

180 [Carter v. Canada - Canadian Supreme Court Judgement Feb 2015](#), accessed 23 May 2023

181 Government of Canada, [‘Medical assistance in dying’](#), accessed 23 May 2023

182 Government of Canada, [‘Legislative Background: Bill C-7: Government of Canada’s Legislative Response to the Superior Court of Québec Truchon Decision, Part III – Safeguards for MAID’](#), accessed 31 May 2023

183 Government of Canada, [‘Medical assistance in dying’](#), accessed 31 May 2023

were people for whom a natural death was not reasonably foreseeable. Amongst these individuals, the main underlying medical condition was neurological (50%), followed by ‘other condition’ (37.1%) and multiple co-morbidities (23.5%).¹⁸⁴

111. The fourth annual report includes details of updated reporting requirements and additional data elements to be collected, including procedural safeguard and characteristics of the person accessing AD/AS (for example gender identity and disability).¹⁸⁵ Debate on the provision of AD/AS for those who request it on the basis of suffering caused by a mental health condition is ongoing. Following another Supreme Court ruling on the adequacy of the provision in the Canadian AD/AS framework as originally implemented by the Federal Government, there were plans to extend the eligibility criteria for requesting AD/AS under the MAiD legislation to those with a mental illness as the sole underlying medical condition of the request. In February 2023, the Federal Government introduced new legislation delaying the implementation of this change until March 2024. This was to “allow more time for provinces and territories to prepare, and time to complete and disseminate key resources under development.”¹⁸⁶ However, in February 2024 a press release from Health Canada announced a further delay until 2027:

[...] in its consultations with the provinces, territories, medical professionals, people with lived experience and other stakeholders, the Government of Canada has heard—and agrees—that the health system is not yet ready for this expansion.¹⁸⁷

112. The healthcare professionals involved in assessing, delivering, or involved in both the assessing and delivering, AD/AS reported that most AD/AS recipients (77.6%) in 2022, had received palliative care, as they had in 2019 (82.1%), 2020 (82.8%) and 2021 (80.7%). The majority of AD/AS recipients (49.9%) received palliative care services for a month or more, which is a similar level to that in 2019 and 2020.¹⁸⁸ A joint letter from the Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians in November 2019 set out the position of the two organisations regarding MAiD:

Less than 30% of Canadians have access to high quality hospice palliative care, yet more than 90% of all deaths in Canada would benefit from it. Despite this startling discrepancy, access to hospice palliative care is not considered a fundamental healthcare right for Canadians. In contrast, MAiD has been deemed a right through the Canada Health Act, even though deaths from MAiD account for less than 1.5% of all deaths in Canada.¹⁸⁹

184 Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada in 2022](#) (October 2023)

185 “[Delay of eligibility for medical assistance in dying for persons suffering solely from mental illness proposed by Ministers of Justice and Health](#)”, Health Canada press release 2 February 2023

186 Government of Canada, ‘[Medical assistance in dying](#)’, accessed 23 May 2023

187 “[The Government of Canada introduces legislation to delay Medical Assistance in Dying expansion by 3 years](#)”, Health Canada press release 1 February 2024

188 Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada in 2022](#) (October 2023)

189 CHPCA and CSPCP, [Joint Call to Action](#) (November 2019)

Jurisdictions where AD/AS is partially available

Table 8: Overview of jurisdictions where AD/AS is partially available

Jurisdiction	Italy	Germany	Colombia	Montana (USA)
Legal since (or will become legal as of)	2019	2020	1997	2009
Legal on the basis of an established terminal diagnosis	✓	✓	✓	✓
Legal on the basis of 'unbearable suffering'	✗	✓	✓	Not established
Legal on the basis of a mental illness diagnosis	✓	✓	✗	✗
Legislation extends to minors	Not established	Not established	✓	Not established
Citizens/residents requirement	✓	Not established	✓	✗
Self-administration of drug	✓	✓	✓	✗
Physician assisted administration of drug	✓	✗	✓	✗

Montana: Baxter v. Montana (2009). Montana Legislative Branch, Draft Bill LC1043, accessed 7 February 2024.

Italy: Turillazzi, E et al. "Physician-Patient Relationship, Assisted Suicide and the Italian Constitutional Court." Journal of bioethical inquiry vol. 18 (2021): pp. 671-681; Quadriplegic man is first person to be allowed to die by assisted suicide in Italy", BMJ, 2021; 375 :n2927.

Germany: Wiesing, "The Judgment of the German Federal Constitutional Court regarding assisted suicide: a template for pluralistic states?" Journal of Medical Ethics vol. 48 (2022); pp. 542-546. "German court repeals ban on assisted suicide services", The Guardian, 26 February 2020. "Germany overturns ban on professionally assisted suicide", BBC, 26 February 2020.

Colombia: British Medical Association, 'Physician-assisted dying around the world', accessed 13 November 2023. Gobierno de Colombia Minsalud, Protocolo para la aplicacion procedimiento de eutanasia en Colombia 2015 (2015) "Colombia becomes first Latin American country to decriminalise assisted suicide", BMJ, 16 May 2022; Ministerio De Salud y Proteccion Social, Resolucion Numero 971 De 2021, 1 July 2021.

113. The third group of jurisdictions is where AD/AS is not illegal, but where there is no formal process in place.

114. Montana is the only state in the USA where AD/AS is not illegal but where there are no formal arrangements nor supervision by the state health department. Instead, a court ruling in 2009 stated that a physician assisting the death of a terminally ill, mentally competent adult would not be prosecuted.¹⁹⁰ Similarly in Italy, following a well-publicised case, the Constitutional court ruled that AD/AS is not a crime if the person pursuing it is

190 [Baxter V. Montana DA 09-0051](#), 2009 MT 449

experiencing intolerable suffering.¹⁹¹ In Germany, AD/AS was not explicitly illegal through statute until 2015 when a new law was brought in, making AD/AS via an organisation or physician charging a fee to assist, illegal. In 2020 this law was contested, and the German constitutional court ruled that the German constitution includes the right for a person to determine their own death, including whether to use assistance by a third party to take their own life.¹⁹² Legislation to regulate AD/AS has since been put forward in the German Parliament, the Bundestag, but not agreed.¹⁹³

Reflections on AD/AS practice in international jurisdictions

115. A thematic analysis of the responses to our online form showed that both the individuals who agree and those who disagree with the current law on AD/AS in England and Wales, frequently used examples from international jurisdictions to support their viewpoints. Many respondents who agree with the current law in England and Wales expressed concern that if the law were changed to allow AD/AS, initial eligibility criteria would be widened and intended safeguards would not protect vulnerable groups. Canada was the jurisdiction that was most frequently cited by this group. In contrast, many respondents who disagreed with the current law in England and Wales pointed to jurisdictions where they considered AD/AS to have been introduced without unintended or harmful consequences. New Zealand and Australia were the jurisdictions most frequently cited by this group.¹⁹⁴

116. Some jurisdictions are considering legislating on AD/AS but have not done so. In Denmark in 2023, the Council on Ethics (Det Etiske Råd) concluded, by a majority of 16 to one, that it was “in principle impossible to establish proper regulation of euthanasia” and recommended to the Danish Parliament that the law should not be changed.¹⁹⁵ It was reported by digital news service, The Local, that, after the Council’s recommendation, spokespeople from each of the three parties in Denmark’s ruling coalition said that their parties would not be taking a position on the issue.¹⁹⁶ A law proposal to allow AD/AS in Denmark received 50,000 signatures in support and is due to be considered by the Danish Parliament.¹⁹⁷

117. In the written evidence, the main concerns expressed by those opposed to, or concerned about, the legalisation of AD/AS were that:

- the eligibility criteria will inevitably be extended,
- it is not possible to prevent abuse/misuse, even if AD/AS is introduced for a very specific group of people (for example people with a terminal diagnosis of less than 6 months), and
- palliative and end of life care will be negatively impacted as a result of introducing AD/AS.

191 Turillazzi et al. “Physician–Patient Relationship, Assisted Suicide and the Italian Constitutional Court”, *Journal of Bioethical Inquiry* (2021) vol. 18 pp. 671–681

192 “Criminalisation of assisted suicide services unconstitutional”, Press release 12/2020 from Bundesverfassungsgericht, 26 February 2020

193 “Assisted suicide: Germany weighs in on autonomy and ethics”, DW, 7 April 2024

194 Annex 1

195 Det Etiske Råd, *Det Etiske Råds udtalelse om dødshjælp* (2023)

196 “Denmark’s Ethics Council advises against legalising euthanasia”, The Local DK, 4 October 2023

197 “Markant flertal af Etisk Råd: Klart nej til aktiv dødshjælp”, DR, 4 October 2023

118. The concern that AD/AS inevitably expands once introduced means different things to different people, and it is important to explore what is meant by “extension” or “expansion”. Some used these terms to refer to extending the eligibility criteria, which at introduction were restricted to a small group of people in very specific circumstances, to become progressively wider, so that they apply to more people. Some used it to refer to removing “safeguards” to make it easier to access AD/AS (for example, reducing the time a person must wait between applying for AD/AS and the prescription of the lethal drug). Others argued that expansion also includes increased numbers of cases of AD/AS. The campaign group Living and Dying Well stated:

Wherever the boundaries are set, evidence from other jurisdictions shows that the boundaries are eroded and criteria expanded, with concomitant escalation in numbers, most markedly seen in Canada.¹⁹⁸

119. Dr Alexandra Mullock, Senior Lecturer in Healthcare Law and Co-Director of the Centre for Social Ethics and Policy at the University of Manchester, stated that if AD/AS is legal in cases of “unbearable physical suffering”, then preventing an expansion to include suffering caused by mental illness may be difficult. However, she argued that if it is made legal only on the basis of terminal illness (as is the case in Australia, the US or New Zealand) it “becomes about allowing people to control an imminent death rather than cutting many years off their lives.”¹⁹⁹ Dr Naomi Richards Senior Lecturer and Director of the Glasgow End of Life Studies Group at Glasgow University, added:

I agree with Dr Mullock that there is no inevitable expansion, as we can see from the Oregon model, which is a model across states of the US. It is yet to be seen what will happen in Australia, New Zealand and other places that have legalised more recently and whether they will expand. It is also a question of how we frame the expansion. The population are perhaps deciding that they may legalise for a certain group or a certain category of person. There may be widespread support for that. Other people with other kinds of illnesses and suffering will also want to have access to that mode of dying. The expansion is because it is publicly demanded. The other reason why you might have changes of criteria is that, from practical experience, people have seen what works and what does not work, and they are tweaking their system. It is not necessarily to be categorised as a negative slippery slope.²⁰⁰

120. The Rt Hon Kyam Maher MLC, Minister for Aboriginal Affairs, Attorney General, and Minister for Industrial Relations and Public Sector, Government of South Australia, stated:

We have a model, which Victoria started, that is now, with some degrees of variation, the Australian model, where someone has a terminal illness, is usually in the last six or 12 months of their life and is in insufferable pain. All states have adopted that. Personally, I do not think we are going to see much change one way or another any time soon. The argument often

198 Living and Dying Well ([ADY0489](#))

199 [Q65](#)

200 [Q66](#)

raised by those concerned about the introduction of the model is that it is a slippery slope or the thin end of a wedge, or that there will be creep in how it may operate, but there is absolutely no evidence of that in Australia.²⁰¹

121. Professor Samia Hurst-Majno, Professor of Biomedical Ethics, University of Geneva and member of the Swiss National Advisory Commission on Biomedical Ethics, told us:

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.²⁰²

122. In regard to legislation “expanding” in terms of who is eligible to access AD/AS, some people expressed concerns about it being a “slippery slope” or “legislation creep”. Campaign group Not Dead Yet UK terms stated:

We believe there is a risk of legislative creep in this country if assisted death legislation is introduced. The evidence in other countries indicates a global trend to broaden eligibility criteria. Although this has led some states to reassess the implications of that, the dominant campaigns in the UK advocating a change in the law provide ample evidence that a similar outcome could ensue here.²⁰³

123. Similar concerns were expressed by Professor Theo Boer, who stated that he had previously been in favour of the Dutch legislation and had worked with the Dutch authority reviewing AD/AS cases, but had become increasingly concerned about a “dramatic increase” in the number of cases of AD/AS in the Netherlands, and about unreported cases.²⁰⁴

124. Jurisdictions in which eligibility criteria have been expanded include the Netherlands and Belgium (where eligibility criteria have been expanded to include minors). In Canada, the proposal to extend eligibility criteria to include mental illness is being considered. Dr Lydia Dugdale, Director at the Centre for Clinical Medical Ethics at Columbia Vagelos College of Physicians and Surgeons, Columbia University, stated:

201 [Q91](#)

202 [Q190](#)

203 Not Dead Yet UK ([ADY0485](#))

204 Professor Theo Boer ([ADY0484](#))

As soon as [AD/AS] is legalised it expands. The language shifts; it goes from “guardrails” to “lack of access”. That is very pernicious. Guardrails are there to protect society more broadly and to keep us from becoming a death-inducing state.²⁰⁵

125. Professor James Downar, Head of the Division of Palliative Care at the University of Ottawa, argued that the extension of the eligibility criteria in Canada would not represent further liberalisation of the law. Instead, he argued that it would represent the law becoming compatible with the original Canadian Supreme Court ruling, because the law as originally created placed additional restrictions on access to AD/AS that the ruling did not stipulate were necessary.²⁰⁶ Professor Trudo Lemmens on the other hand, argued that Canada should be considered a “warning sign” for any country which was considering legalising AD/AS, stating:

We have a system that started off in response to the typical more exceptional cases of suffering, where there was a perceived need to allow euthanasia and assisted suicide in the case of a person with a degenerative disease approaching their natural death. For various reasons it has rapidly expanded from a system that focused on an already broad end-of-life context in response to a Supreme Court case to, I would say, the most open-ended system in the world.²⁰⁷

126. Dr Philip Berry, a consultant physician in favour of AD/AS, stated in his written evidence that he is concerned about people gaining access to AD/AS in Canada when the reason they want to die is because of financial issues:

[...] if individuals are applying to MAiD for the wrong reasons, and successfully gaining assistance in dying, it must be accepted that the law is not functioning in the way it was intended. There are no sensible advocates of AD in the UK who would agree that poverty or isolation are valid reasons to die.²⁰⁸

127. In Canada, to be eligible for AD/AS, the person applying “must experience intolerable physical or psychological suffering that is caused by their medical condition or their state of decline and that cannot be relieved under conditions that the individual finds acceptable”. According to data from 2022, 17.1% of those who accessed AD/AS in 2022 cited “loneliness or isolation” as a reason for their suffering. There is no data in the annual report to suggest that applications have been approved based on concerns about someone’s financial situation.²⁰⁹ However in Oregon, since 1998, 125 people who accessed AD/AS cited financial concerns around treatment cost under the US health system as a reason for pursuing AD/AS.²¹⁰

205 [Q129](#)

206 Professor James Downar ([ADY0161](#))

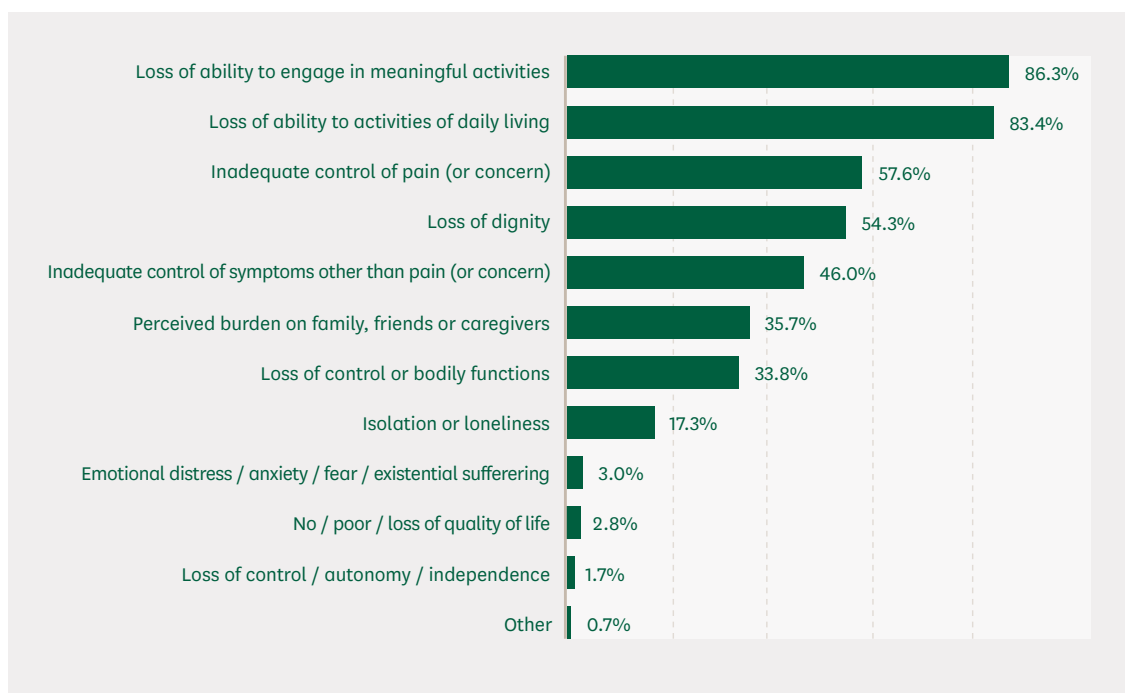
207 [Q163](#)

208 Dr Philip Berry ([ADY0111](#))

209 Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada 2022](#) (October 2023)

210 Oregon Health Authority, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

Figure 3: Chart showing the “nature of suffering” of those who access AD/AS under the MAID Act in 2022



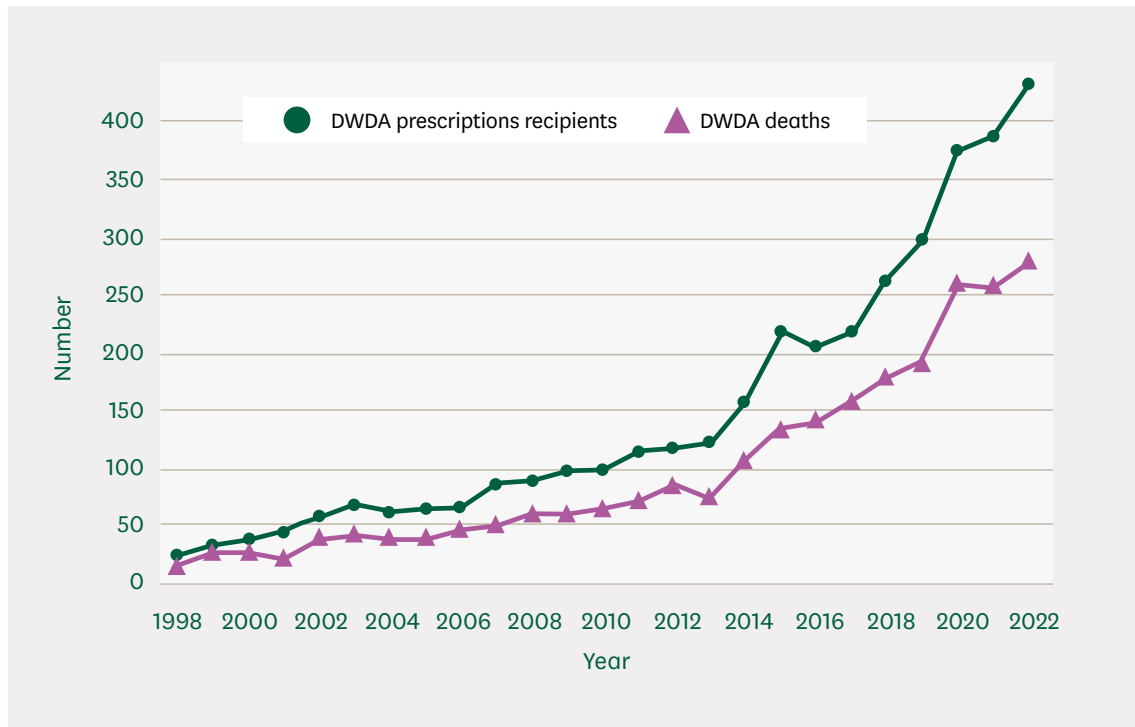
Source: Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada 2022](#) (October 2023)

128. According to our analysis of available reports about AD/AS in the jurisdictions where it is legal and where there is a requirement to publish such reports, the number of cases of AD/AS has increased in every jurisdiction compared to the year of introduction.²¹¹ Oregon is the jurisdiction which has allowed AD/AS on the basis of an established terminal diagnosis for the longest period of time (since 1997) and where, in 2022, it accounted for 0.6% of total deaths in that state.²¹² The below table outlines the number of prescriptions made for AD/AS (in blue) and deaths (in orange) through AD/AS from 1998 until 2022. Since 2016 there has been a consistent increase in both.²¹³

211 Regional Euthanasia Review Committees, [Annual Report 2022](#) (July 2023)

212 Oregon Public Health Division Centre for Health Statistics, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

213 Oregon Public Health Division Centre for Health Statistics, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

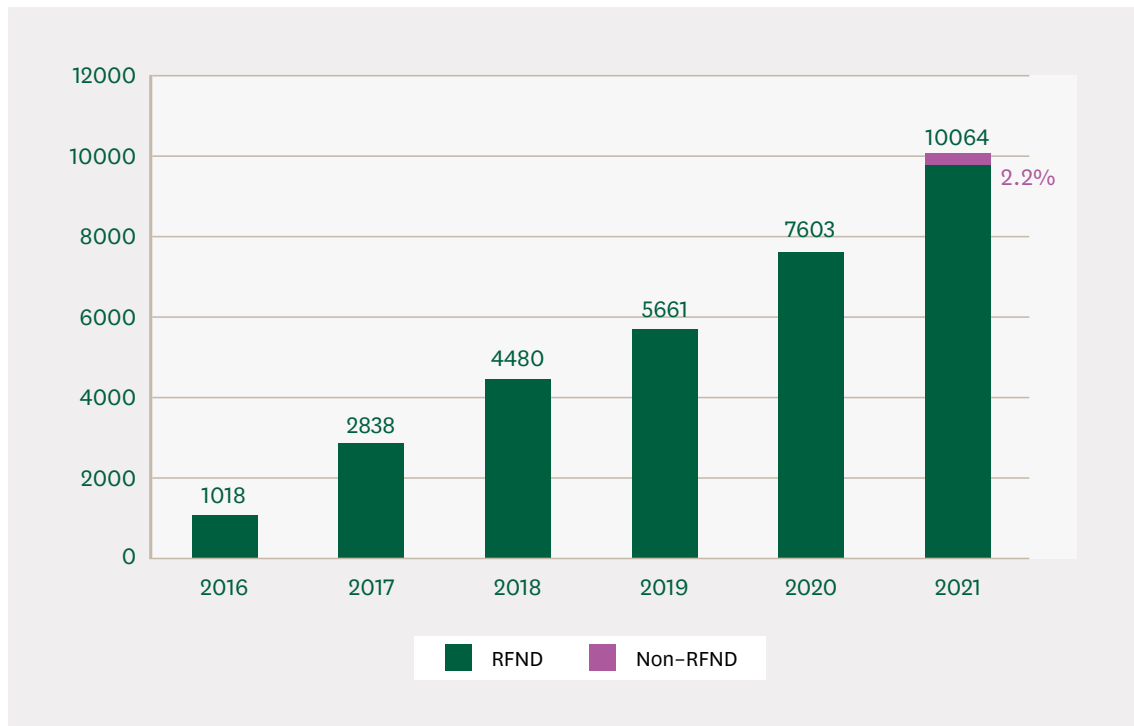
Figure 4: Prescription recipients and deaths through AD/AS in Oregon by year between 1998–2022

Source: Oregon Public Health Division Center for Health Statistics, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

129. In Switzerland, where AD/AS on the basis of intolerable suffering has been legal for the longest amount of time (since 1942), and data has been collected since 1998, there has been a similar trend of an increase in number of people choosing to pursue AD/AS. In 2022 this number was 17.6 AD/AS deaths per 100,000 inhabitants, in contrast to 0.8 AD/AS deaths per 100,000 inhabitants in 1998.²¹⁴ Similarly in Canada, deaths under their AD/AS legislation have increased since introduction, as shown in the graph below. RFND (blue part of the graph) refers to AD/AS deaths where a natural death was reasonably foreseeable, and non-RFND (red part of the graph) refers to cases where a natural death was not reasonably foreseeable.²¹⁵

214 Swiss Health Observatory, 'Suizid und Suizidhilfe', accessed 6 February 2023

215 Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada 2022](#) (October 2023)

Figure 5: Total AD/AS deaths in Canada between 2016–2021

Source: Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada 2022](#) (October 2023)

130. Referring to an increase in deaths from AD/AS over time, Professor David Albert Jones (on behalf of the Anscombe Bioethics Centre, Oxford) stated:

The increases do not themselves demonstrate that the practice is malign but they show that the practice cannot be limited to a small number of people. Over time it will be ‘normalised’.²¹⁶

131. However, some evidence suggests that an increase in the number of people accessing AD/AS following the introduction of relevant legislation need not be seen as a negative, but could instead be seen as a sign of increased access.²¹⁷ We also heard that some people apply for AD/AS to have it as an “insurance” option should their suffering become too great, but do not end up not pursuing it for various reasons. In their 2022 report, the Victoria Assisted Dying Review Board argued that the number of people accessing AD/AS under the legislation “does not represent the full beneficial impacts” of the AD/AS programme, as this number does not include the people who obtain the lethal drug but choose not to use it.²¹⁸ Since the AD/AS law passed in Oregon in 1997, 3,712 people have received prescriptions under the Act but not all died from ingesting the medication. The report states that 2,454 (66%) of those who received the prescription died after ingesting the lethal drug.²¹⁹ However, data on what happened to the prescriptions of the lethal drug in the remaining 34% of cases where the person did not take the prescribed drug is not consistently clear, in contrast with jurisdictions where there is a physician present to administer the drug.

216 Professor David Albert Jones on behalf of the Anscombe Bioethics Centre, Oxford ([ADY0148](#))

217 POST Brief 47, [Assisted Dying](#) (September 2022)

218 Voluntary Assisted Dying Review Board Victoria, [Voluntary Assisted Dying Review Board Annual Report \(July 2022 to June 2023\)](#) (August 2023)

219 Oregon Health Authority, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

132. Kyan Maher from the Government of South Australia stated:

A lot of the evidence shows that, for many people, just the fact that they are accepted and knowing that it is an option has a palliative effect. They have some control over their own life, knowing that there is something they can use. That helps with their mental health, which in and of itself has a palliative effect, improving their end-of-life living standards. The evidence emerging from the statistics in Australia is that only about two thirds who are accepted end up using the substance. For many in that other third it has a great effect knowing that they have the option of control over their life at the very end.²²⁰

133. Some argue that not everyone who want to access AD/AS can do so in time. In their written evidence Professor Ben White and Professor Lindy Willmott at the Queensland University of Technology stated:

The Australian assisted dying systems are operating safely. There is no evidence of ineligible patients gaining access to assisted dying. Instead, the evidence suggests that some patients who are eligible are not able to access this choice because of the system's complexity and design.²²¹

134. Concerns were expressed that introducing AD/AS could make some people who live with disabilities feel as though their lives were not considered equal to the lives of people who do not live with disabilities, as their specific disability may be included in the criteria that make someone eligible for AD/AS. We were also told that some people living with a disability, and elderly people, may worry about being a burden on their family or loved ones, and that the introduction of AD/AS may mean lead to people opting to pursue AD/AS for this reason. In 35.3% of cases of AD/AS in Canada in 2021, “perceived burden on family, friends and caregivers” was cited as a reason for suffering.²²² 48% of people who have pursued AD/AS in Oregon since 1998 cited being a “burden on family, friends/caregivers” as a end-of-life concern.²²³ When we visited Oregon we met with representatives of the group Physicians for Compassionate Care, including a woman who told us that she had considered AD/AS following a terminal diagnosis but was convinced by her physician not to pursue it. She ended up living well beyond her doctor's estimation of having a year left to live, and is still alive today.

135. In response to our terms of reference about what could be learnt from international jurisdictions which had legalised AD/AS, campaign group Disabled People Against Cuts stated:

We need to learn how difficult it is to set limits and safeguards and how once legalisation occurs, how the scope of the law can be expanded through legal challenges and case law. Moreover, we need to learn the extent to which disabled people's lives are devalued and how legalisation encourages the view that disabled people are a burden on society and have a social

220 [Q100](#)

221 Professors Ben White and Lindy Willmott ([ADY0330](#))

222 Health Canada, [Fourth annual report on Medical Assistance in Dying in Canada 2022](#) (October 2023)

223 Oregon Public Health Division Center for Health Statistics, [Oregon Death with Dignity Act 2022 Data Summary](#) (March 2023)

obligation to terminate their lives. We also need to learn from evidence that palliative care and treatments/therapies to prolong life are undermined and disinvested in following legalisation.²²⁴

136. Campaign group Not Dead Yet UK argued that introducing AD/AS would “undermine attempts to remove the societal barriers that preclude disabled people from fully participating in their communities”, concluding that it would “reinforce the damaging notion that disabled lives are not worth living”.²²⁵

137. Professor Stephen Duckworth, however, argued in his evidence that a terminally ill person requesting AD/AS was not choosing between living or dying, but the way in which they wanted to die. He stated:

Disability alone (without terminal illness) will never meet the eligibility criteria set out in the proposed UK legislation^{226, 227}

138. During our roundtables, we heard from participants who live with a disability, some of whom were concerned about AD/AS being legalised. One participant told us:

I think for some people, the idea of having someone else wipe their bottom is horrific, but actually for many of us, that’s how we might live our lives. And there’s nothing wrong with that. And the implication that you’re better off dead than like that. Well that, as [another participant] was saying earlier on, that really devalues our lives as they are.²²⁸

139. Presenting another view on this, was Professor Stephen Duckworth:

A terminally ill person requesting an Assisted Death is not choosing between living and dying. They are choosing between 2 different ways of dying; either enduring avoidable suffering or a peaceful death surrounded by family and friends celebrating life. Disabled People opposing Assisted Dying often do so because they see it devaluing disabled people’s lives. They fail to recognise that opposition on the grounds of disability devalues us even more profoundly by ignoring our diverse voices and refusing to respect our autonomy.²²⁹

140. Professor Samia Hurst-Majno stated:

[...] 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

224 Disabled People Against Cuts ([ADY0491](#))

225 Not Dead Yet UK ([ADY0485](#))

226 The legislation which has been proposed in the UK is listed in chapter 1 of this report.

227 Professor Stephen Duckworth ([ADY0002](#))

228 Roundtable transcript

229 Professor Stephen Duckworth ([ADY0213](#))

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.²³⁰

141. Some evidence called for any introduction of AD/AS not to be restricted to terminal illness. Campaign group My Death, My Decision stated that “not allowing people with disabilities the right to make decisions about their own end of life removes their autonomy and is discriminatory.”²³¹ One of the participants at our roundtable who is living with a chronic condition told us:

As my life starts to end and the myriad increasing comorbidities multiply, I want to die while I’m able to choose and act preserving my dignity and self-respect. I do not want my death to be exported to another country. I do not want to criminalise my family. I want to part from my family with smiles.²³²

142. **In the evidence we received we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD/AS; indeed the introduction of AD/AS has been linked with an improvement in palliative care in several jurisdictions. We also conclude that jurisdictions which have introduced AD/AS on the basis of terminal illness have not changed the law to include eligibility on the basis of “unbearable suffering”. None of the jurisdictions which have introduced it have revoked the legislation.**

143. **When we undertook this inquiry, we were keen to learn as much as we could from international examples and we hope that by putting the evidence we have gathered into the public domain, we can help to further inform the debate on AD/AS in the UK. The fact that people with very different overall views on AD/AS draw on international examples to support their arguments shows the complexity of the issue, but it is possible to look at what is happening elsewhere and to use it to learn more about this difficult and sensitive subject.**

144. **There are as many ways to operate AD/AS as there are jurisdictions which have legalised it, but there are two distinct models: one limiting its availability to those with a terminal illness and the other adding provision for unbearable suffering. What has become clear to us is that better data collection, independently verified and overseen by a dedicated body, leads to a better understanding of how the whole AD/AS process is working. The overall trend is that numbers of AD/AS will increase from the time of introduction, but opinions differ about the cause of the increase. Many of the jurisdictions we have looked at introduced AD/AS very recently, and there is still much to learn as time passes.**

230 [Q200](#)

231 My Death, My Decision ([ADY0282](#))

232 Roundtable transcript

3 Involvement of physicians and assessments of eligibility and capacity to give informed consent

Involvement of healthcare professionals

Views of organisations representing healthcare professionals

145. In all jurisdictions where AD/AS is legal, a healthcare professional is involved in the process. Although some describe the Swiss model of “membership organisations” (see chapter 2) as a way of carrying out AD/AS largely outside of a healthcare setting, physicians still need to assess the person requesting AD/AS in Switzerland, and ultimately write the prescription for the lethal drug. When she gave evidence to us, Professor Samia Hurst-Majno concluded that “Doctors are there at every step”.²³³

146. Not all organisations which represent healthcare professionals have a public position on whether some form of AD/AS should be legalised, and across those that do there is not a unanimous view. Some medical stakeholders have shifted their position over time, and we recognise that organisations may choose to change their positions again. When referring to surveys or internal votes conducted by the different organisations, we have referred to the term relating to AD/AS which they have used in each circumstance, but when referring to the concept more generally we retain our approach of using AD/AS.

147. The BMA surveyed its members on “physician-assisted” dying in February 2020. This is one of the largest survey conducted (in terms of number of people surveyed) amongst doctors in the UK. 19% of the BMA membership responded to the survey. When asked what the BMA’s position on prescribing drugs for eligible patients to self-administer to end their own life should be, 40% of respondents stated “supportive”, 33% “opposed”, 21% “neutral” and 6% “undecided”. 50% of those who responded stated that they were personally supportive of legalising prescribing drugs for eligible patients to self-administer to end their life, and 36% of members surveyed stated they would be willing to participate in such a process themselves, should the law be changed.²³⁴

148. BMA analysis of the survey results suggested that those working in anaesthetics, emergency medicine, intensive care, and obstetrics and gynaecology were more likely to be supportive of a change in the law, whereas those more likely to be opposed to a change in the law worked in clinical oncology, general practice, geriatric medicine, and palliative care.²³⁵

149. Commenting on the BMA survey in their written evidence, Baroness Finlay and Mr Robert Preston, argued:

When the votes were analysed by the BMA, it was found that majorities of members whose work brought them into close and regular contact with terminally ill patients, including palliative medicine doctors, geriatricians

233 [Q189](#)

234 BMA, [Physician-assisted dying survey](#) (December 2021)

235 BMA, [Physician-assisted dying survey](#) (December 2021)

and GPs, were opposed to legalisation, while respondents who had voted for legal change contained a majority of retired doctors, medical students and those in branches of medicine which involve little or no contact with terminally or otherwise incurably ill patients.²³⁶

150. On 14 September 2021 the BMA's policy-making body approved a motion to change the BMA's policy "from opposition to a change in the law" on "physician-assisted dying", to a position of neutrality.²³⁷ In its written evidence, the BMA stated that it is currently conducting "internal discussions about some of the issues that would significantly impact on doctors if the law were to change in the future".²³⁸

151. The Royal College of GPs (RCGP) also conducted a survey of their members, and 13% of the membership responded.²³⁹ The RCGP survey showed that 47% of those who responded wanted the RCGP to oppose legalisation of "assisted dying", whilst 40% wanted RCGP to support laws allowing "assisted dying", pending a regulatory framework and safeguards being in place, and 11% of respondents wanted the RCGP to be neutral.²⁴⁰ Following a discussion and a vote at the RCGP council in February 2020, the RCGP decided to retain its position of opposing a change in the law to allow "assisted dying".²⁴¹ In September 2023, the RCGP announced that, following the passing of a motion brought by nationally elected council members, the RCGP council would be setting up a working group to "ensure that the College is prepared for any potential changes in the law on assisted dying across the UK".²⁴²

152. The Royal College of Physicians (RCP) council voted to adopt a neutral position on "assisted dying" in March 2019, following discussion of the results of its survey,²⁴³ to which 6885 RCP members responded.²⁴⁴ In its written evidence, it stated that this neutral position had been misinterpreted by some:

Following that 2019 poll, the RCP adopted a neutral position on whether there should be a change in the law to permit assisted dying. This means the RCP neither supports nor opposes a change in the law to permit assisted dying. Regrettably, this position was interpreted by some as suggesting that the RCP was either indifferent to legal change or supportive of a change in the law. So that there could be no doubt, we clarified that the RCP does not support a change in the law to permit assisted dying at the present time.²⁴⁵

236 Baroness Ilora Finlay and Robert Preston ([ADY0275](#))

237 BMA, '[BMA position of physician-assisted dying](#)', accessed 13 October 2023

238 The BMA ([ADY0406](#))

239 RCGP, '[Assisted dying RCGP's 2020 decision](#)', accessed 13 October 2023

240 RCGP, '[2019 Assisted Dying Membership Consultation, Unweighted Data Tables – 11th March 2020](#)', accessed 15 October 2023

241 RCGP, '[Assisted dying RCGP's 2020 decision](#)', accessed 13 October 2023

242 RCGP, '[Assisted dying RCGP's 2020 decision](#)', accessed 13 October 2023

243 RCP, '[Update on legal proceedings related to assisted dying survey](#)', 29 October 2019

244 RCP, '[Assisted dying survey 2019](#)', 1 March 2019

245 The Royal College of Physicians ([ADY0354](#))

153. The World Medical Association (WMA),²⁴⁶ and Association for Palliative Medicine of Great Britain and Ireland (APM)²⁴⁷ and the British Geriatrics Society²⁴⁸ have stated their opposition to legalising AD/AS.

154. On the APM's website, they state that:

[...] independent surveys such as those done by the RCP and BMA that have given a breakdown of palliative medicine doctors' views in principle are consistently around 80% in the specialty's opposition to legal change involving doctors.²⁴⁹

155. During our roundtable, on the healthcare professionals who participated stated:

[...] But when you actually drill down into that, palliative care clinicians represent only 9% of clinicians who would support assisted dying. And if you look at other people, in GPs and people working in geriatric areas of care, those people who've been most likely to be at the forefront of managing assisted dying really struggle more than other areas, more than the evidence suggests the general public would, or that people who are dying would, or that other medics would. So I think you've got a really complicated thing there and that the people at the forefront of it are saying they struggle most with it.²⁵⁰

156. We also received evidence from the group Healthcare professionals for Assisted Dying (HAPD) indicating that this was a difficult issue to discuss within the palliative care profession:

[...] there is a culture within palliative medicine around end-of-life choice that is detrimental to honest and open discussion of the issue. This is an area where the speciality of palliative medicine as a whole must improve.²⁵¹

157. In the submission HAPD refer to five anonymous palliative care physicians who in 2019 wrote to the British Medical Journal to conclude that "although views diverge among specialists, palliative medicine's professional association is stifling free speech on assisted dying."²⁵² In response to this, the previous President of the APM Dr Andrew Davies wrote to the BMJ stating:

I can attest to the validity of the concerns, as I have been personally ostracised over my support for a neutral position on assisted dying. Indeed, as a result of recent interactions, I have decided to step down from the APM Executive Committee.²⁵³

246 The World Medical Association (WMA), [WMA Declaration on Euthanasia and Physician-Assisted Suicide](#) (October 2019)

247 Association for Palliative Medicine of Great Britain and Ireland, [APM Physician Assisted Dying Web Materials](#), accessed 9 August 2023

248 British Geriatrics Society ([ADY0192](#))

249 Association for Palliative Medicine of Great Britain and Ireland, [APM Physician Assisted Dying Web Materials](#), accessed 9 August 2023

250 Roundtable transcript

251 Healthcare Professionals for Assisted Dying (HPAD) ([ADY0410](#))

252 "We risk our careers if we discuss assisted dying, say UK palliative care consultants", BMJ, 2 April 2019

253 "Rapid response to: We risk our careers if we discuss assisted dying, say UK palliative care consultants", BMJ, 9 April 2019

158. The Association of Palliative Care Social Workers (APCSW),²⁵⁴ the Royal College of Psychiatrists (RCPsych)²⁵⁵ and the Royal College of Physicians of Edinburgh²⁵⁶ have provided written evidence stating that they do not currently have a position on AD/AS. The Royal College of Nursing (RCN) governing council voted to take a neutral position to “assisted dying” in 2009. In a press release published on their website, the RCN states that this position “rightly reflects our members differing views on the issue”.²⁵⁷

159. The Royal Pharmaceutical Society (RPS) takes a neutral stance in relation to AD/AS, but stated in written evidence that, should any legislation be considered, pharmacists must be involved in developing suitable protocols and guidance for prescribers, arguing that “Policymakers need to recognise and be aware that the role of pharmacists goes far beyond supply of the required medication.”²⁵⁸ The Pharmacists’ Defence Association (PDA) did not provide arguments in favour or against AD/AS, but emphasised that the key issue, should AD/AS be legalised, is to ensure that pharmacists and other healthcare professionals should be able to choose to participate, but not be forced to do so. The PDA stated:

Pharmacists, as healthcare workers, have a specific role in that they are custodians of and responsible for the safe supply of potent licensed medications. This obligation is to ensure that medicines they supply are both appropriate and as required by the prescriber. UK caselaw has confirmed the obligation of UK pharmacists to professionally assess every prescription prior to it being dispensed for appropriateness. In context this would mean the role of the pharmacist goes beyond merely supplying substances as may be specified on an assisted dying prescription. These medicines would in the context of assisted dying be used as unlicensed “off-label” substances for the purpose of ending life and any pharmacist choosing to supply these substances would know the end result of such a supply.²⁵⁹

160. Some suggested that should AD/AS be legalised, healthcare professionals should be able to “opt-out” of involvement, by having the right to make a conscientious objection.²⁶⁰ The Royal Pharmaceutical Society²⁶¹ as well as some participants during our roundtable with healthcare professionals suggested that there should be no requirement to opt-out, and instead suggested an active “opt-in”. A roundtable participant stated:

[...] it shouldn’t be a conscientious objection, it should be a positive opt-in which would ensure that the doctors were properly engaged, properly trained, and that then would lead to patients getting the right service for them.²⁶²

254 The Association of Palliative Care Social Workers ([ADY0335](#))

255 The Royal College of Psychiatrists ([ADY0396](#))

256 The Royal College of Physicians of Edinburgh ([ADY0278](#))

257 RCN, [RCN position on assisted dying](#), accessed 13 October 2023

258 Royal Pharmaceutical Society ([ADY0403](#))

259 The Pharmacists’ Defence Association ([ADY0392](#))

260 For example: The Royal College of Physicians ([ADY0354](#)); The BMA ([ADY0406](#)); The Orders of St John Care Trust ([ADY0432](#))

261 Royal Pharmaceutical Society ([ADY0403](#))

262 Roundtable transcript

161. Hospice UK argued that, so far in the debate on whether to legalise AD/AS, there had been “inadequate consideration” of the involvement of staff and services, and whether there would be a right to “conscientiously object to participation”. It stated:

There are also important questions relating to the risk of conflict with professional and regulatory requirements for physicians and others who might be asked, or expected, to participate in the implementation of such a policy.²⁶³

162. Humanists UK stated in their evidence that they “are not aware of any legislation where doctors cannot conscientiously object to the assisted dying process”.²⁶⁴ However, participants at our roundtable suggested that even with a conscientious objection clause, there is a risk of stigma towards doctors unwilling to offer AD/AS, as has occasionally happened with other matters of conscience. One of the participants told us:

When I was a junior doctor, I worked with a palliative care consultant who had come from gynaecology. He was a strict Catholic and he was told that when the Abortion Act went through, he could conscientiously object and he found pressures within his department and within other departments. When he left his department, nobody wanted to employ him because he wouldn't do abortions. We started with the problems of the medical profession and particularly the problems of palliative medicine. I fear that putting this extra burden on the role of a doctor could have a similar impact on recruitment to the medical profession and retention.²⁶⁵

163. In their evidence, Baroness Finlay and Mr Robert Preston referred to concerns in Canada that doctors had been put under pressure to participate after AD/AS was legalised, and suggested a model where doctor's involvement in the process should be limited and the deciding role lies with the courts:

In our view, if assisted dying were to be legalised, consideration of requests should be placed in the hands of a scrupulously impartial body with experience of assessing evidence from a range of expert sources, including doctors, psychiatrists, social workers and others, as well as from applicants themselves, and reaching an overall judgement. This points clearly to the courts and, given the gravity of what is involved, to the High Court. Doctors would provide the Court with information on the strictly-medical aspects of a request, a role they already play in other contexts. But it would be for the Court, and for the Court alone, to consider the overall picture in light of evidence from this and other sources and to be the sole arbiter of whether a request should proceed.²⁶⁶

263 Hospice UK ([ADY0411](#))

264 Humanists UK ([ADY0298](#))

265 Roundtable transcript

266 Baroness Ilora Finlay & Mr Robert Preston ([ADY0275](#))

Impact of AD/AS on the patient-healthcare professional relationship

164. The BMA told us that it had held “dialogue events” with its members in 2015, and commented:

[...] some considered that legalising physician-assisted dying would have a negative impact on the doctor-patient relationship; others, however, believed that allowing doctors to provide this option would lead to improvements in the doctor-patient relationship. Views were mixed although overall doctors tended to be more negative and have greater fear about the potential impact of physician-assisted dying on doctor-patient relationships than the public.²⁶⁷

165. The extent to which healthcare professionals are involved in AD/AS varies across jurisdictions where the practice is available. During one of our evidence sessions we heard from Dr Chandana Banerjee, Associate Professor of Hospice and Palliative Medicine at the City of Hope National Medical Centre in California, United States. Dr Banerjee told us:

I consider it [AD/AS] a medical practice. Unlike some of my colleagues here, or in the United States, I see it sitting in the medical practice of the other end-of-life options that are available. It is an optional practice, not a mandated practice. It is a highly regulated practice, which makes me comfortable in participating as a provider. I know that there are multiple checks and balances along the way to make sure that patients are using it appropriately, that they are eligible for it and that it is not available to people who are not eligible for it.²⁶⁸

166. Dr Lydia Dugdale gave evidence alongside Dr Banerjee. When asked whether she believed there was a conflict between being a good doctor and providing AD/AS, Dr Dugdale told us that she did not “see it as consistent with being a good physician or with what medicine should be about.”²⁶⁹

167. We also heard from a Dutch physician, Professor Rutger Jan van der Gaag, a former President of the Royal Dutch Medical Association, and currently Professor of Psychosomatic Medicine and Psychotherapy, and Emeritus Professor of Psychiatry. Dr van der Gaag told us that although he “strongly advocate having a [AD/AS] law”, he himself had never been able to “give terminal palliative sedation or assisted suicide because it is against my moral principles”.²⁷⁰

168. When asked about whether she thought the introduction of AD/AS would affect the relationship between a physician and a patient, Baroness Hollins stated:

The culture, the attitude and everything changes. It is such an important relationship. People are in a vulnerable situation, and having a life-limiting diagnosis makes you vulnerable, whoever you are.²⁷¹

267 The BMA ([ADY0406](#))

268 [Q116](#)

269 [Q120](#)

270 [Q141](#)

271 [Q8](#)

169. We also heard evidence from physicians who practiced in jurisdictions where AD/AS is legal, and who provided another view. For example Dr Ryan Spielvogel, a practising physician in California, stated that in his view AD/AS has had a positive impact on the patient-physician relationship:

I can say unequivocally that having this option available has had an enormously positive effect on patients and physicians alike.²⁷²

170. Our roundtable events explored in more detail the role that the introduction of AD/AS could have on healthcare professionals. One participant stated:

[...] it's fair to say that something happens which feels akin to moral injury, where healthcare professionals know that there are other parts of the world where this request could be taken seriously but where in the UK, due to legislation, we are unable to really look them in the eye and say, "I would like to try and help you with that".²⁷³

171. Another participant suggested that offering AD/AS will negatively affect clinicians and, more broadly, the clinician-patient relationship:

If you then look at legislations where these things are legal, then doctors stop looking at resolving symptoms and become preoccupied with completing the process. And so, the very thing that's going to change the suffering of an individual, namely medics, nurses, social workers, psychologists doing what they should be doing, which is caring for the patient, is shifted to going through a process to meet an endpoint which actually isn't going to solve the problem in the first place.²⁷⁴

172. One of the participants, who themselves live with a disability, expressed their concerns about how legalising AD/AS could affect their relationship with healthcare professionals:

Now if this legislation goes through, a doctor would no longer have to work within the confines of, "how do we find a way to support this person to live?". There's an end. There's an end thinking that would happen if that legislation like this was enacted where the doctor can always go, "Oh well, if we don't manage to do that at least we can support them to die". This is a feeling that's grown for me, especially in recent years. It's been increasingly on my mind. Our relationship with health and social care professionals I think would change if they had within the scope of the services that they could offer or suggest, the opportunity to help us die. It bothers me.²⁷⁵

Managing treatment decisions at the end of someone's life

173. Caring for a patient towards the end of their life can involve complex treatment decisions. Dr Perkins, Chief Medical Director at Sue Ryder, explained that treatment decisions are monitored internally within clinical teams and, in some places, by the national

272 Dr Ryan Spielvogel, MD, MS ([ADY0039](#))

273 Roundtable transcript

274 Roundtable transcript

275 Roundtable transcript

medical examiner system.²⁷⁶ The national medical examiner system was established in acute trusts in 2019 to provide “independent scrutiny of deaths and to give bereaved people a voice.” In 2021 the system started to expand to cover non-coronial deaths across all health settings and from April 2024 it will become a statutory requirement.²⁷⁷

174. The General Medical Council’s guidance ‘Treatment and care towards the end of life: good practice in decision making’ states:

Following established ethical and legal (including human rights) principles, decisions concerning potentially life-prolonging treatment must not be motivated by a desire to bring about the patient’s death, and must start from a presumption in favour of prolonging life. This presumption will normally require you to take all reasonable steps to prolong a patient’s life. However, there is no absolute obligation to prolong life irrespective of the consequences for the patient, and irrespective of the patient’s views, if they are known or can be found out.²⁷⁸

175. The NHS constitution for England includes a summary of the legal rights of patients receiving NHS care. This includes:

You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences. [...]

You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.²⁷⁹

176. The Health and Care Act 2022 introduced a statutory requirement for local Integrated Care Systems (ICSs) to provide palliative care services.²⁸⁰

177. Throughout our inquiry, some people in favour of legalising AD/AS have argued that there are choices that people can make towards the end of their life, such as stopping treatment, which will hasten their death, and that this is not all that different from AD/AS. Campaign group Dignity in Dying argue that doctors are already providing or withholding treatments which may hasten a patient’s death, and that the “ethical implications of the existing legal framework” should be considered.²⁸¹ My Death, My Decision, a campaign group in favour of legalising AD/AS for “adults of sound mind who are either terminally ill or suffering intolerably from a physical, incurable condition”, stated that:

276 Q275 [Dr Perkins]

277 NHS England, ‘[The national medical examiner system](#)’, accessed 26 September 2023

278 General Medical Council, [Treatment and care towards the end of life: good practice in decision making](#) (May 2010)

279 DHSC, [The NHS Constitution for England](#), accessed 30 January 2024

280 Health and Care Act 2022, [section 21](#)

281 Dignity in Dying ([ADY0418](#))

There are other situations in healthcare, notably the refusal of life-saving treatment, where coercion is just as hypothetically possible, and the consequences equally profound, yet we allow these decisions, to respect patient autonomy. An assisted dying law would provide a regulated process.²⁸²

178. Kyam Mayer MCL, Minister for Aboriginal Affairs, Attorney-General, and Minister for Industrial Relations and Public Sector, Government of South Australia, told us:

A distinction is made between passive assisted dying and active assisted dying. Passive assisted dying involves the refusal of treatment. In South Australian law, anyone can refuse consent to medical treatment. Active assisted dying is actively taking a substance—in the Australian model's case—when you are at the end of your life with a terminal disease.²⁸³

179. Professor MacLeod, former Senior Consultant and Senior Medical Specialist in Palliative Care, on the other hand, argued:

I do not recognise the terminology of passive euthanasia. I think it was discussed maybe 20 or 25 years ago in the palliative care literature quite strongly. It is all to do with intention. If the intention is to end somebody's life, that is a euthanistic act. The difference is in withdrawing life support, refusing medical treatment or allowing a natural death. In euthanasia and assisted dying, the intention of the doctor or the patient is to immediately end that life; that is all.²⁸⁴

180. The two types of decision most frequently discussed in this context of caring for someone with a terminal diagnosis are withdrawal of treatment and palliative sedation. These terms are explained briefly below.

Withdrawal of treatment

181. Withdrawal of treatment refers to the decision to stop or to not start a treatment when it has the potential to prolong the patient's life. For example, a decision to stop antibiotics for a life-threatening infection; or to not start, or to stop, receiving clinically assisted nutrition and hydration (CANH).²⁸⁵ Dr Matthew Doré, Honorary Secretary, Association for Palliative Medicine of Great Britain and Ireland, argued that there is a difference between withdrawal of care as part of PEOC and “instigating” death through AD/AS:

I guess the palliative care ethos is living until you die. Our role is to let nature take its course, but control what nature throws at us. When we are withdrawing treatment, we are returning to the natural course of events.²⁸⁶

182. The BMA has produced guidance for doctors to establish a patient's best interests when considering a patient's, or someone acting on behalf of the patient's, directives on accepting CANH:

282 My Death, My Decision ([ADY0282](#))

283 [Q83](#)

284 [Q111](#)

285 General Medical Council, [Treatment and care towards the end of life: good practice in decision making](#) (May 2010)

286 [Q255](#)

There will always be a strong presumption that it is in the patient's best interests to receive life-sustaining treatment. That presumption can be rebutted if there is clear evidence that a patient would not want CANH provided in the circumstances that have arisen. This means that it is crucial that proper best interests assessments are carried out and documented.²⁸⁷

183. The BMA and the Royal College of Physicians have produced a document entitled 'Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent', which provides physicians with guidance. Under the heading "Physician-assisted suicide and euthanasia", the guidance sets out:

Some people and jurisdictions refer to withdrawing or withholding life-sustaining treatment as 'passive euthanasia'. This is not the position in the UK, where euthanasia has been given a very specific meaning: the taking of active steps with the intention of terminating the patient's life. The courts in England and Wales proceed on the basis that there is a fundamental distinction between decisions not to provide, or not to continue, life-sustaining treatment and euthanasia. Euthanasia or assisted suicide involves taking active steps with the intention of terminating the patient's life. The intention behind a decision to withdraw treatment, however, is to stop providing medical treatments or interventions that are not able to benefit the patient, allowing them to die from their pre-existing condition.²⁸⁸

Palliative sedation

184. In some situations, severe distressing symptoms at the end of life are treated with "palliative sedation". Palliative sedation is a measure of last resort used at the end-of-life to relieve severe and persistent symptoms. It is the use of medications to induce decreased or absent awareness to relieve otherwise intractable suffering at the end-of-life.²⁸⁹

185. Some of those we heard from who are in favour of legalising AD/AS, such as Professor Rutger Jan Van Der Gaag, highlighted that there is no legal framework or guidelines governing palliative sedation in the UK, and therefore it is "in the hands of the doctor".²⁹⁰ Professor Van Der Gaag said that introducing a formal process for AD/AS would make the system safer for both staff and patients:

[...] we should safeguard our doctors and nurses, and there should be a system of checks and balances to make sure that the will of the patient is respected by all means.²⁹¹

186. In the same evidence session, Professor Tuffrey-Wijne argued:

The intention of palliative care is to make people comfortable—to relieve suffering. The intention is not to bring about death. That is quite a clear principle. Sometimes giving people sedatives or increased doses of pain

287 [Clinically Assisted Nutrition and Hydration - Full Guidance](#), The BMA published Sep 2018, accessed 21/03/23

288 The BMA and the Royal College of Physicians, [Clinically-assisted nutrition and hydration \(CANH\) and adults who lack the capacity to consent](#) (2018)

289 Mayo Clinical Proceedings - [Ethical Decision Making With End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments](#) (2010)

290 Professor Rutger Jan van der Gaag ([ADY0365](#))

291 [Q141](#)

relief may bring about death sooner, partly because it relaxes people into being able to die, but it is not the purpose of what you are doing. In my view, palliative sedation does not have the intention of bringing about the patient's death. It is about making the patient comfortable. That is quite a fundamental difference in principle. British law is quite clear. You cannot intentionally bring about a patient's death. I think that the answer is yes, there are sufficient safeguards.²⁹²

187. The Association of Palliative Medicine for Great Britain (APM) argued that the term “palliative sedation” has a different meaning in the UK compared to many other Europe countries, and that the reason that there is no legal framework for the practice of palliative sedation in the UK is that “palliative sedation” as it is used in some countries in Europe is “not recognised practice in the UK. Furthermore, the AMP stated that:

[...] in many other parts of Europe the phrase ‘Palliative Care Sedation’ has a very different meaning and is a protocol to sedate the patient with the intention of hastening death. The starting doses of sedative drugs used are 5- 10 times higher than in UK practice, and often several drugs are combined. The intention is to render the patient unconscious as a way of treating suffering.²⁹³

188. The GMC’s guidance for healthcare professionals caring for someone at the end of life, includes guidelines for how to assess whether the person has capacity to make decisions about their own medical care:

If you assess that a patient lacks capacity to make a decision, you must:

- a. be clear what specific decisions about treatment and care need to be made
- b. check who has the responsibility to decide which option would be of overall benefit to the patient and make sure that reasonable steps are taken to find out:
 - i. whether there’s evidence of the patient’s previously expressed values and preferences that may be legally binding, such as an advance refusal of treatment
 - ii. whether someone else has the legal authority to make the decision on the patient’s behalf or has been appointed to represent them. You should bear in mind that the powers held by a legal proxy may not cover all types of treatment, so you should check the scope of their decision-making authority.
- c. If there is no evidence of a legally binding advance refusal of treatment, and no one has legal authority to make this decision for the patient, then, if you have lead responsibility for the patient’s treatment and care, you are responsible for deciding what would be of overall benefit to them.

292 [Q144](#)

293 Supplementary written evidence submitted by the AMP and Dr Matthew Doré ([ADY0527](#))

In doing this, if you must:

- i. consult with those close to the patient and other members of the healthcare team, take account of their views about what the patient would want, and aim to reach agreement with them
- ii. consider which option aligns most closely with the patient's needs, preferences, values and priorities
- iii. consider which option would be the least restrictive of the patient's future options.²⁹⁴

189. Medical professionals would have an important role in any system of AD/AS, although the details are for Parliament to determine should it move to legalise AD/AS. During our inquiry we have heard from healthcare professionals who were content to be involved, from others who were supportive of the practice but did not want to participate themselves, as well as from those who were opposed to the practice in its entirety. We heard evidence that in the event that Parliament were to legislate for AD/AS a decision to participate should be freely taken by the individual healthcare professional and never imposed on them.

Safeguards, protections and capacity assessments

190. There are different safeguards and protections in place in the different jurisdictions where AD/AS is legal. The evidence we have received refers to various measures which are intended to act as safeguards to protect people from misuse or abuse of the legislation. People in favour of legalising AD/AS sometimes argue that the lack of safeguards under the current law leads to people travelling abroad to access AD/AS, or choosing to take their own lives.

191. Baroness Finlay raised her concerns around the risk of coercion in relation to AD/AS, and how this is being assessed in jurisdictions where AD/AS is legal:

If you are going to have safeguards, they must be ones that you can verify and can go back and audit afterwards.

192. Limiting the eligibility criteria to people with a terminal diagnosis and an established prognosis of 6–12 months was cited in the evidence we received as an example of a safeguard that would limit access and possibly prevent the expansion of eligibility criteria. Dr Mullock told us:

There is evidence that if you begin with an approach that allows it for unbearable suffering caused by a severe physical condition, it is quite hard to maintain an intellectually convincing or clinical distinction between a physical illness that causes unbearable suffering and a psychiatric illness that causes unbearable suffering. That problem is removed if you have an approach of terminal illness because then it becomes about allowing people to control an imminent death rather than cutting many years off.²⁹⁵

²⁹⁴ General Medical Council, '[Decision-making models](#)', accessed 7 December 2023

²⁹⁵ [Q65](#)

193. According to Dignity in Dying, the statutory AD/AS review and oversight boards in jurisdictions where AD/AS is legal (referenced in chapter 2) could also be seen to act as a safeguard in following up on possible abuse or concerns:

In contrast to end-of-life options currently exercised in the UK, where assisted dying is legal we know there is robust oversight and data about who accesses the law. For example, in Victoria, Australia, a Voluntary Assisted Dying Review Board was established to monitor the functioning of the law through collecting data, ensuring compliance and reporting to Parliament. Published data shows that contrary to speculative narratives about the consequences of assisted dying, potential risks to vulnerable groups have not materialised in places where assisted dying is legal.²⁹⁶

194. The evidence from RCPsych referred to a comparison of official AD/AS reports across jurisdictions. RCPsych notes that Oregon (due to the length of time AD/AS legislation and reporting requirements have been in place) provides the “longest running and most comprehensive data on this topic”. It concludes that even in the Oregon report, “It can be noted how little data are made publicly available to evidence that safeguards are being used, and are effective.”²⁹⁷ The comparison referred to by RCPsych was made in an article published in 2022, titled ““Comparison of official reporting on assisted suicide and euthanasia across jurisdictions”. This article stated that only three jurisdictions (New Zealand, Canada and Victoria) report on the number of people assessed as ineligible, which the authors of the study argue “provides insight into the functioning of patient safeguards and eligibility criteria”.²⁹⁸

195. Assessments of capacity were another safeguard frequently referred to in the evidence. In most jurisdictions, at least two doctors make independent assessments. Jurisdictions differ in exactly how they assess capacity, although most rely on domestic mental capacity legislation and guidance from domestic medical bodies in doing so. Dr Gary Cheung, Associate Professor and Old Age Psychiatrist at the Department of Psychological Medicine at the University of Auckland, told us about the New Zealand system and called for better training for those who make the assessment:

Some people say capacity assessment is one of the main safeguards for assisted dying. In New Zealand, the law requires the person to be assessed by two independent practitioners. The person has to remain competent right through the process, including at the time of medication administration, on the day of assisted dying. In terms of robustness, all medical practitioners are competent to conduct those capacity assessments. One of the issues we have, which is part of the issues for registration, is that there is no compulsory training for the practitioner involved in assisted dying. There is some process that the Ministry of Health uses to ensure that some practitioners are trained, through reimbursement of their fees, but if you choose not to have reimbursement you do not need the compulsory training. That lack of training worries me a bit because it is a very complex area. In the first year of implementation we interviewed 20 practitioners

296 Dignity in Dying ([ADY0418](#))

297 Royal College of Psychiatrists ([ADY0396](#))

298 Worthington, Ana et al. “[Comparison of official reporting on assisted suicide and euthanasia across jurisdictions.](#)” *BMJ supportive & palliative care*, (2022)

directly involved in assisted dying. We asked them directly about their way of assessing capacity. Most of them said that they felt quite comfortable and confident in assessing capacity. That may explain why only six referrals have been made to psychiatrists, which was unexpected. We were expecting more referrals to psychiatrists, certainly in the first year, but there were only six. What happened to the six referrals? Five were confirmed to have capacity and the sixth person died before the decision was made. There are some safeguards, but I think they can be improved with compulsory training.²⁹⁹

196. In England and Wales, the relevant legislation to assess mental capacity is the Mental Capacity Act 2005 (MCA).³⁰⁰ According to the NHS website, the MCA is “designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment” and applies to everyone who is 16 years old and older. The MCA sets out that the following principles apply when assessing a person’s mental capacity:

[...] (2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.³⁰¹

197. The MCA also defines a person being unable to make a decision for themselves if they are not able to understand the information relevant to a decision they are about to make, retain the information in relation to it, and use this information to inform their decision, or if they are not able to communicate their decision (by talking, using sign language or other means).³⁰²

198. The NHS website also states that for consent to be valid, it must be “voluntary and informed”, and that consent can be given verbally, in writing or non-verbally.³⁰³ GMC has also published guidance on decision making and consent, which sets out that a patient risks “serious harm” if they are not properly listened to, and given the the information, support and time they need to make an informed decision.³⁰⁴

299 [Q99](#)

300 Mental Capacity Act 2005, [section 1](#)

301 Mental Capacity Act 2005, [section 1](#)

302 Mental Capacity Act 2005, [section 3](#)

303 NHS, ‘[Consent to Treatment](#)’, accessed 7 December 2023

304 GMC, [Decision Making and Consent](#) (September 2020)

199. Commenting on the AD/AS Bills so far introduced in the UK Parliament, Lord Falconer told us:

The Bills that have been proposed say that the person who decides to have an assisted death has to have the capacity to make that decision. That is all the Bill says. The Mental Capacity Act says—in my view correctly—that in determining whether somebody has mental capacity you have to have regard to what sort of decision it is. It is hard to imagine a more serious decision than whether or not you should take your own life. That is a factual decision that both doctors, in some circumstances, and the courts in other circumstances are used to addressing. It is a very serious decision, but it is one that they are capable of taking.³⁰⁵

200. The British Association of Social Workers (BASW) placed an emphasis on mental capacity in their written evidence, stating:

The essence of the mental capacity legislation is to protect people who because of their age, condition or disability may not have the capacity to make significant long-term decisions. Our contention is that for many people suffering extreme long-term pain or disability may have their capacity impaired. While capacity deals with ability to make an informed choice, adult safeguarding legislation is in place to ensure that vulnerable adults (who may include some older people or people with extreme long-term pain or disability) are not coerced by others into situations or decisions.³⁰⁶

201. In their written evidence, RCPsych questioned whether a different threshold for capacity than that already required by law would need to be considered in the context of AD/AS. They argued that:

[...] the threshold and process of capacity determination be set out in some detail on the face of any future Bill, as opposed to being considered later in the subsequent code of practice.³⁰⁷

Assessing capacity and informed consent for people living with a disability

202. Many submissions raised concerns that people living with disabilities may be particularly at risk of being coerced into pursuing AD/AS if there were not adequate safeguards in place to assess capacity and to establish whether the application had been made voluntarily with informed consent. Some people also suggested that disabled people may feel pressure to pursue AD/AS due a perception of being “a burden” to their family and loved ones.

203. Several submissions argued that when considering appropriate safeguards and protections, specific attention needs to be given to people living with disabilities. An academic analysis conducted in 2021 examined 140 disability rights organisations’ position statements on AD/AS in England, Wales and Scotland. This analysis found that

305 [Q39](#)

306 British Association of Social Workers ([ADY0385](#))

307 Royal College of Psychiatrists ([ADY0396](#))

of the 140 organisations, only 10 had a public position; 5 were opposed to a change in law on AD/AS, and 5, including Disability Rights UK, had adopted a neutral position. The researchers concluded that:

DROs [Disability rights organisations] should play an important role in representing their members but our research shows that most are not engaged in that process. As a consequence, there is a risk that the voices of disabled people may carry less weight than they should and that the quality of policy-making on this critically important issue is thereby impoverished.³⁰⁸

204. In their joint evidence, Care Not Killing (CNK Alliance Ltd) and Our Duty of Care set out their opposition to AD/AS, stating:

We hold that legal change to permit assisted suicide and/or euthanasia would be uncontrollable, unethical and unnecessary.³⁰⁹

205. A participant living with a disability who spoke to us during one of our roundtables stated:

For me, assisted dying - an assisted death - is purely for people who are terminally ill with six months or under left to live, who are deemed capable of having the capacity to make a decision about wanting an assisted death. So it makes no difference whether you're disabled or not because the safeguard is there. You are dying. That is the ultimate thing. Assisted suicide, you don't have to be dying. I mean, to be honest, that's the thing that is most likely to be affecting me is not dying, but living in a way that I don't want to. However, at the moment, I worry about the safeguards in terms of people being coerced into choosing an assisted death. People feeling that they're burdens, that they're not worthy, there are many ways and reasons that people could be persuaded into ending their life, whereas with assisted dying, you're not going to get any more people dying than are dying already. They're already dying. It's just giving them choice and control over the manner of their death.³¹⁰

206. Another participant living with a disability argued that disabled people may also be particularly at risk of coercion, as they argued that domestic abuse disproportionately affects disabled people:

[...] we are two to three times more likely to experience domestic abuse and that includes controlling and coercive behaviours. So that is a real concern for us.³¹¹

207. In his written evidence, Tom Shakespeare, Professor of Disability Research, and a bioethicist, stated:

I believe there is minimal risk in allowing people who are terminally ill to have a death that comes a few days or weeks earlier than their natural

308 Box, G. et al. "[Views of disability rights organisations on assisted dying legislation in England, Wales and Scotland: an analysis of position statements](#)". *Journal of Medical Ethics*, Vol 47 (2021)

309 Care Not Killing (CNK Alliance Ltd) and Our Duty of Care ([ADY0343](#))

310 Roundtable transcript

311 Roundtable transcript

death. In opting for assisted dying, people in this category are deciding how they will die, not when they will die. But there is considerable risk in making death possible for people who would otherwise have lived for many more years or even decades, and who may have experienced a restoration of quality of life as they adapt to their restrictions or discover independent living supports in the community. The two situations are by no means equivalent. In the former case, a person gets a better death than they would otherwise have done; in the latter case, someone's opportunity to lead a meaningful life is forever removed.³¹²

208. Professor Tuffney-Wije, alongside co-authors (including Baroness Finlay and Baroness Hollins), conducted a study considering whether “any particular difficulties arise when the EAS [euthanasia and assisted suicide] due care criteria are applied to patients with an intellectual disability and/or autism spectrum disorder” in the Netherlands. In their study they searched 416 case summaries on the RTE (the Dutch authority monitoring euthanasia practice) website between 2012–2016, looking for intellectual disability and autism spectrum disorder. The conclusion they drew was:

Autonomy and decisional capacity are highly complex for patients with intellectual disabilities and difficult to assess; capacity tests in these cases did not appear sufficiently stringent. Assessment of suffering is particularly difficult for patients who have experienced life-long disability. The sometimes brief time frames and limited number of physician-patient meetings may not be sufficient to make a decision as serious as EAS. The Dutch EAS due care criteria are not easily applied to people with intellectual disabilities and/or autism spectrum disorder, and do not appear to act as adequate safeguards.³¹³

209. In their evidence, the Equality and Human Rights Commission (EHRC) stated:

Sensitive consideration must also be given to the interaction between mental capacity, mental health issues, learning disabilities and conditions such as autism. Refusing assisted dying to someone on the basis of a mental health condition or learning disability, which is unrelated to the reason they are seeking assisted dying, could be discriminatory unless justified in the individual circumstances.³¹⁴

210. Practice across the world where AD/AS is legal is varied in the respect of capacity assessments for AD/AS. We heard that any such assessment should be undertaken by professionals who have undertaken necessary training on capacity assessments, particularly in relation to vulnerable groups.

211. Throughout our inquiry into AD/AS, the importance of safeguards and protections, and the question of whether they can be sufficient, has been a central feature, as has the related question of assessing capacity. Hearing from various representatives of healthcare professionals, as well as from healthcare professionals directly, it is clear

312 Professor Tom Shakespeare ([ADY0021](#))

313 Tuffrey-Wijne I, Curfs L, Finlay I, Hollins S. Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: an examination of nine relevant euthanasia cases in the Netherlands (2012–2016). *BMC Med Ethics*. (2018)

314 Equality and Human Rights Commission ([ADY0317](#))

that there is hesitation around whether it is possible to accurately assess capacity, and safeguard the person, in every case. On the other hand, some people we have heard from argue that there is a similar risk under the current law in assessing capacity and safeguarding people who opt to cease treatment, or to accept end-of-life care, including palliative sedation.³¹⁵

315 Chapter 4 sets out a definition for palliative sedation

4 Palliative and End of Life Care

Palliative and End of Life Care (PEoLC)

212. The World Health Organisation (WHO) defines palliative care as care which:

[...] improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual.³¹⁶

213. Cicely Saunders International states palliative care is “based on the needs of the patient, not on the patient’s prognosis”,³¹⁷ and according to the NHS it is care which can be delivered alongside curative treatment. It can be accessed at any stage of a terminal illness and people may receive palliative care for many years. End-of-life care, which is often seen as a part of palliative care, refers to care received in the last year of life.³¹⁸ Marie Curie stated that palliative and end-of-life care (hereafter PEoLC) encompasses a holistic approach which focuses on managing symptoms, offering emotional, spiritual, psychological and practical support and ensuring good quality of life.³¹⁹

214. PEoLC is delivered by several sectors, including the NHS, social care sector, and third sector (voluntary and charitable) organisations, the private sector, and unpaid carers such as friends and family.³²⁰ In the UK, PEoLC is often divided into two categories:

- “specialist” care delivered by professionals specifically trained in PEoLC to assist someone around the clock, or care and complex symptom management either in hospital, hospice or at home, and
- “non-specialist” or universal care delivered by health and social care professionals in the person’s home by district nurses or social carers, in a primary care setting by GPs, and in secondary care settings by hospital staff.³²¹

215. We heard that there is an increasing trend towards providing PEoLC at a patient’s usual place of residence (often their own home). Hospice UK stated that hospices provide almost 90% of their services in patients’ homes rather than on hospice premises.³²² This seems to be in line with many people’s wishes, as research conducted by Cicely Saunders International showed that 80% of people surveyed would prefer to die at home.³²³

216. We heard from stakeholders both for and against AD/AS that palliative care could not alleviate pain and suffering in all cases. During our first evidence session, when asked whether she agreed that even the best care cannot avert a bad death for some people, Baroness Hollins responded:

316 World Health Organisation, ‘[Palliative care](#)’, accessed 26 September 2023

317 Cicely Saunders International ([ADY0357](#))

318 NHS England, ‘[Palliative and end of life care](#)’, accessed 26 July 2023

319 Marie Curie, ‘[What is palliative care?](#)’, accessed 8 August 2023

320 NHS, ‘[What end of life care involves](#)’, accessed 19 October 2023

321 NHS England, [Specialist palliative and end of life care services – Adult service specification](#) (January 2023), p 6

322 Hospice UK ([ADY0411](#))

323 Cicely Saunders International ([ADY0357](#))

I think that is going to be true, but I don't think it is as widespread as people think.³²⁴

217. In their 2019 report, the Office for Health Economics stated:

There is extensive evidence on the difficulty of controlling pain for patients in palliative care. One of the most recent pieces of evidence for England (Royal College of Physicians, 2016) reports that 73% of case records showed that after a case review pain was controlled in 79% of cases: 21% of palliative care patients dying in hospitals had unrelieved pain. This level of unrelieved pain can be compared to that reported in the VOICES study by family and carers of patients dying in hospitals (Office of National Statistics, 2016b) which can be up to 32%, with 4% of pain having not been at all relieved and 28% of pain being partially relieved.³²⁵

218. We acknowledge that the ability to alleviate pain could be enhanced with specialist palliative care expertise. In written evidence, following up oral evidence to the Committee, Dr Matthew Doré, Honorary Secretary, Association for Palliative Medicine of Great Britain and Ireland, wrote:

Palliative care cannot eliminate suffering or all symptoms. However, there is very good evidence that the involvement of specialist palliative care reduces symptoms and increase quality of life.³²⁶

International evidence on AD/AS and the impact on PEOLC

219. Not all jurisdictions where AD/AS is legal report on the percentage of people applying for AD/AS who were receiving, or had received, some form of PEOLC. This data is not available in the Netherlands, Belgium or Switzerland. The Netherlands and Belgium publish reports which includes the place of death (which includes palliative and hospice care facilities) and some characteristics of the person applying (such as age and education attainment level). Cancer is the most common reason for someone applying for AD/AS in the Netherlands (57.8%),³²⁷ and in Belgium (60%).³²⁸ In Switzerland data is not available as there is no centrally regulated process of requiring the prescribing physician to report the reason for someone wanting to access AD/AS when they prescribe the lethal drug.³²⁹

220. The most recent Health Canada report of data on AD/AS is from 2021 (published in 2022). The report shows that a majority of those who pursued AD/AS (80.7%) had received palliative care. The levels were similar in 2019 and 2020 (82.1% and 82.8% respectively). Most people who went through AD/AS (52.6%) received palliative care services for a

324 [Q29](#)

325 Zamora, B., Cookson, G. and Garau, M., [Unrelieved Pain in Palliative Care in England](#). OHE Consulting Report, London: Office of Health Economics. (2019)

326 Dr Matthew Doré ([ADY0527](#))

327 Ministerie van Volksgezondheid, Welzijn en Sport, [Regional Euthanasia Review Committees. Annual report 2022](#) (March 2023)

328 Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie, [EUTHANASIE – Chiffres de l'année 2022](#) (February 2023)

329 POST Brief 47, [Assisted Dying](#) (September 2022)

month or more, which is again similar to the levels in 2019 and 2020. From 2024 the Canadian Health Department will also be reporting on the type and location of palliative care services applicants for AD/AS received.³³⁰

221. Of the US states which publish reports, evidence shows that a majority of those who apply for AD/AS were enrolled in PEOLC. In Oregon, Washington and California this figure is over 90% (91.4% in Oregon,³³¹ 91% in Washington,³³² and 95.4% in California³³³), and in Colorado 80.2%,³³⁴ and in Hawaii 58% (total number since introduction of legislation in 2019 until 2021).³³⁵ PEOLC is not cost free in the United States and requires the individual to have some form of health insurance to be able to access it. The publicly funded Medicare³³⁶ and Medicaid³³⁷ health insurance schemes (which an individual has to be eligible for according to certain criteria) cover some forms of palliative care.³³⁸

222. In New Zealand, Victoria and Western Australia, most individuals were accessing palliative care at the time of their application for AD/AS: 76% in New Zealand,³³⁹ 81% in Victoria,³⁴⁰ and 85.3% in Western Australia.³⁴¹

223. Dr Clare Fellingham from the East Metropolitan Health Service in Western Australia, stated:

Almost 95% of the patients I have cared for have also been receiving excellent quality Palliative Care; their reasons for seeking VAD [voluntary assisted dying] as their preferred way to die are not due to lack of access to services. Time and again it is existential distress: a loss of the sense of self, dignity, autonomy, meaning, or purpose in life, that causes a kind of hopelessness particularly resistant to palliative interventions. These concerns are particularly prevalent in those seeking access to VAD.³⁴²

224. Similarly, Ann Jackson, the previous CEO of Oregon Hospice and Palliative Care Association, stated that in Oregon:

[...] between 1997 and 2021, more than 90% of persons who used the ODDA [Oregon's Death with Dignity Act] were enrolled in hospice. In 2021 98% of those who hastened their dying under provisions of the law were also hospice patients.³⁴³

330 Health Canada, [Third annual report on Medical Assistance in Dying in Canada 2021](#) (July 2022)

331 Oregon Health Authority, [Oregon Death with Dignity Act](#) (March 2023)

332 Washington State Department of Health, [2021 Death with Dignity Act Report](#) (July 2022)

333 California Department of Public Health, [California End Of Life Option Act 2022 Data Report](#) (July 2023)

334 Colorado Department of Public Health & Environment, [Colorado End-Of-Life Options Act-Year Six: 2022 Data Summary, with 2017–2022 Trends And Totals](#) (2022)

335 Hawaii Department of Health, [Report To The Thirty-Second Legislature State Of Hawaii](#) (July 2022)

336 Medicare.gov, [‘Get started with Medicare’](#), accessed 30 April 2023

337 Medicaid.gov, [‘Medicaid Eligibility’](#), accessed 30 April 2023

338 Get Palliative Care, [‘Frequently Asked Questions’](#), accessed 30 April 2023

339 New Zealand Ministry of Health, [Registrar \(assisted dying\) Annual Report – June 2023](#) (July 2023)

340 Safer Care Victoria, [Voluntary Assisted Dying Review Board Annual Report \(July 2022 to June 2023\)](#) (August 2023)

341 Government of Western Australia Department of Health, [Voluntary Assisted Dying Board Western Australia Annual Report 2021–22](#) (November 2022)

342 East Metropolitan Health Service, Western Australia. [\(ADY0389\)](#)

343 Ann Jackson [\(ADY0276\)](#)

225. Some submissions raised concerns that the introduction of AD/AS in the UK would have a negative impact on PEOLC services. The Cicely Saunders Institute of Palliative Care, Policy and Rehabilitation at King's College pointed to examples of findings from Canada that "palliative care resources were disproportionately consumed by MaiD [AD/AS] requests, while non-MaiD patients had reduced access to palliative care".³⁴⁴ In contrast, others asserted that in some international jurisdictions the introduction of AD/AS had been accompanied by an increase in provision of PEOLC services. Sue Ryder, for example, pointed to increased PEOLC spending commitments in the Australian state of New South Wales following legalisation of AD/AS there. However, Sue Ryder cautioned that as PEOLC in the UK has been "historically underfunded", and requires "significant urgent investment", waiting until after AD/AS is potentially legalised to make improvements in PEOLC is "not enough".³⁴⁵

226. In his evidence to the inquiry, Professor Jan L Bernheim, Oncologist and Emeritus Professor of medicine and medical ethics, End of-Life Care Research Group at Vrije Universiteit Brussels, concluded that "development of palliative care and the process of legalisation of euthanasia can be mutually reinforcing". Referring to a study he was involved in which looked at whether access to AD/AS "impedes" the development of palliative care, Professor Bernheim shared the following excerpt of the study's conclusion:

The hypothesis that legal regulation of physician-assisted dying slows development of PC [Palliative Care] is not supported by the Benelux [Belgium/Netherlands/Luxembourg] experience. On the contrary, regulation appears to have promoted the expansion of PC. Continued monitoring of both permissive and non-permissive countries, preferably also including indicators of quantity and quality of delivered care, is needed to evaluate longer-term effects.³⁴⁶

227. We were interested to hear about trends in spending on and the development of PEOLC in jurisdictions where AD/AS is legal. According to the Canadian Annual Report of the people who pursued AD/AS but did not receive palliative care (16.8% of cases), 88% of them had access to these services (a similar percentage to 2019 and 2020) but chose not to receive PEOLC, which the report concludes:

This result supports other findings that palliative care continues to remain both available and accessible to individuals who have received MAID. However, this result does not offer insight into the adequacy or quality of the palliative care services that were available or provided.³⁴⁷

228. Professor James Downar, Head of the Division of Palliative Care at the University of Ottawa, told us:

Since legalising MAID [Medical Aid in Dying, Canada's AD/AS legislation], the use of palliative care has risen by almost 10% across the board of the population, which is almost certainly the fastest rate of growth of palliative care in Canadian history. That occurred as a result of very substantial investments in home care services and physicians. Despite the pandemic

344 Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King's College London ([ADY0402](#))

345 Sue Ryder ([ADY0256](#))

346 Professor Jan L Bernheim ([ADY0334](#))

347 Health Canada, [Third annual report on Medical Assistance in Dying in Canada 2021](#) (July 2022)

and the staff disruption of the pandemic, we still probably had the strongest growth of palliative care in history. It was probably between two and three times the rate of cases of MAID being provided.³⁴⁸

229. In response to Professor Downar's analysis, Professor Trudo Lemmens, Professor and Scholl Chair in Health Law and Policy at the Faculty of Law at the University of Toronto, stated:

What is particularly striking is that close to 40% actually received palliative care for less than one month. I would leave it up to palliative care specialists, but many may have objections about claiming that that clearly shows they have sufficient palliative care. In the 2021 numbers for disability support, again there is an indication that 43% of the 10,000 people who received MAID needed disability support; 87% received it. That means that there were 4,300 needing it, but it still means that 559 people needed disability support and did not receive it. Whatever those figures mean, we do not have much information about it. These are important things to keep in mind.³⁴⁹

230. A systemic scoping review conducted by Gerson et al in 2020 looking at studies across several jurisdictions where AD/AS is legal (Belgium, Switzerland, the USA and Canada) observes that whilst palliative care was created in parallel with the development of AD/AS in Belgium and is therefore an integrated practice, in the other jurisdictions the introduction of AD/AS was met with resistance from many medical and palliative care associations. The review also concludes:

Although there is a vast amount of commentary, even polemic, before legalization, on the likely effects on palliative care, there appears to be very little research on the impact of assisted dying on palliative care once legislation is introduced. This might be because opposition is often based on principled beliefs, which do not require evidence of their veracity, namely that assisted dying is morally wrong, or it might be that assisted dying is not wrong but should be kept separate from palliative care practices.³⁵⁰

231. Research commissioned by Palliative Care Australia (the national body for PEOLC in Australia) investigated the effect of AD/AS legislation on the provision of PEOLC in Oregon, Washington State, Canada, Quebec Province, the Netherlands and Belgium. The report, which was published in 2018 concluded that there was:

[...] no evidence to suggest that the palliative care sectors were adversely impacted by the introduction of the legislation. If anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced.³⁵¹

232. The report found that all the jurisdictions it studied required patients seeking AD/AS to be informed of alternative treatments, including PEOLC, and that the introduction of AD/AS had in many of the jurisdictions been accompanied by increased investment

348 [Q172](#) [Professor James Downar]

349 [Q174](#) [Professor Trudo Lemmens]

350 Gerson et al. "[Relationship of Palliative Care With Assisted Dying Where Assisted Dying is Lawful: A Systematic Scoping Review of the Literature](#)", *Journal of Pain and Symptom Management*, vol 59 (2020) pp. 1287–1303

351 Palliative Care Australia, [Experience internationally of the legalisation of assisted dying on the palliative care sector](#) (October 2018)

in PEOLC. One example of increased funding pointed to in the report was the Canadian Federal Government's commitment to invest \$6 billion in palliative and home care over 10 years (which represented a significant increase from the preceding two years) when AD/AS was introduced there.³⁵²

233. In Australia, states increased their funding of PEOLC in parallel with legislating for AD/AS. The Acting Premier of Queensland, the Honourable Dr Steven Miles stated in his written evidence to us that Queensland committed "record investment" in PEOLC services and developed and implemented a new PEOLC strategy prior to legalising AD/AS in January 2023.³⁵³ According to the written evidence submitted by Dignity in Dying (a pro AD/AS campaign group) New South Wales and Victoria also increased investment in PEOLC alongside legalising AD/AS.³⁵⁴

234. Professor Jan Bernheim told us that in Belgium, Government investment in PEOLC doubled between 2002, when AD/AS was legalised, and 2011.³⁵⁵ The research commissioned by Palliative Care Australia showed that in the USA, the provision of PEOLC in states that had legalised AD/AS was higher than the national average. For example, in 2015, 93% of hospitals in Washington State and 89% in Oregon had a PEOLC team, compared to 77% in the wider Pacific Coast region and 67% nationally.³⁵⁶ More up-to-date figures from 2019 show that six of the seven US states which had legalised AD/AS by 2019 had higher provision of PEOLC in hospitals than the national average.³⁵⁷

Specialist PEOLC workforce in the UK

235. Specialist PEOLC in the UK is delivered by a multi-disciplinary team comprising specialist doctors, nurses and allied health professionals, including physiotherapists and pharmacists. The Minister for Social Care (Helen Whatley MP) told us that currently there are more than 700 doctors specialising in PEOLC, 400 of whom are consultants. The Minister also highlighted existing training in PEOLC for the "generalist workforce" to support the provision of non-specialist PEOLC: for example, the inclusion of PEOLC in the curriculum for GP trainees and nurses and an e-learning module launched by Health Education England in 2022 available to "a very wide workforce, including social care and the voluntary sector".³⁵⁸

236. Despite this we were told by Dr Matthew Doré, Association of Palliative Medicine, that the PEOLC workforce is "struggling" and that it will be difficult to keep pace with the projected increased demands for PEOLC services due to an ageing population.³⁵⁹ In a report on 'Variations in the delivery of palliative care services to adults', the Healthcare Safety Investigation Branch (HSIB) stated that national bodies in the PEOLC sector had told

352 Palliative Care Australia, [Experience internationally of the legalisation of assisted dying on the palliative care sector](#) (October 2018)

353 Queensland Government ([ADY0272](#))

354 Dignity in Dying ([ADY0418](#))

355 Professor Jan L Bernheim ([ADY0334](#))

356 Palliative Care Australia, [Experience internationally of the legalisation of assisted dying on the palliative care sector](#) (October 2018)

357 Centre to Advance Palliative Care, [Palliative Care, Report Card](#) (2019)

358 [Q282](#)

359 [Q238](#)

them that there was a lack of training packages which limited recruitment into specialist palliative care. HSIB also reported that PEOLC organisations told them that “demand for their services was often greater than the capacity of their workforces”.³⁶⁰

237. Cicely Saunders International stated that in addition to a “major lack of workforce capacity” within PEOLC in general, there are limited opportunities to pursue an academic career in PEOLC. Less than 0.5% of all research spending in the UK is allocated to PEOLC research and yet 20% of health care costs are generated in the last year of life. Illustrating their point, Cicely Saunders International stated: “There are more professors of oncology working in the Royal Marsden Hospital than professors in palliative care working across the world.”³⁶¹ This may indicate a distinct lack of investment in both workforce and treatment in the palliative care sector.

238. In oral evidence Dr Matthew Doré and Jonathan Ellis (Director of Policy, Advocacy and Clinical Programmes at Hospice UK) both observed that the NHS Long Term Workforce Plan (published June 2023³⁶²) did not mention the charitable medical workforce, which often makes up a large part of the hospice workforce.³⁶³ Jonathan Ellis acknowledged that the Plan was always “envisaged as a plan for the NHS workforce”, but told us that:

[...] the workforce who are providing not just palliative and end of life care but health and care across our communities is much more varied. We have 40,000 nurses working in hospice services. We have staff working in care homes and in community services. All of these people are providing essential support to care for people at the end of life. The absence of recognition of those is a very serious problem when we are also facing exactly the same workforce pressures.³⁶⁴

239. When asked about the lack of mention of the charitable workforce in the NHS Long Term Workforce Plan, Professor Stephen Powis (National Medical Director of NHS England) explained that the Plan was “never intended to go to specialty condition level” and that it will be done in the “next stage of work.”³⁶⁵ He also stated that:

[...] by expanding the number of doctors and medical school places, the number of nurses through nurse training and the range of other professionals in the plan, that expansion of the overall workforce will by necessity mean that there will be an expansion of the various specialties that underpin the workforce as a whole.³⁶⁶

Quality of palliative and end of life care in the UK

240. The Economist Intelligence Unit conducted a study ranking end-of-life care across the world in 2010. The study concluded that “the UK leads the world in quality of death;

360 Healthcare Safety Investigation Branch, [Variations in the delivery of palliative care services to adults](#) (July 2023) Following coming into force of the Health and Care Act 2022, the [HSIB](#) has become the Health Services Safety Investigations Body (HSSIB), a fully independent NDPB of the DH&SC, on 23 October 2023.

361 Cicely Saunders International ([ADY0357](#))

362 NHS England, [NHS Long Term Workforce Plan](#) (June 2023)

363 [Q238](#), [Q244](#)

364 [Q246](#)

365 [Q281](#)

366 [Q281](#)

many developed nations must work to catch up.”³⁶⁷ In 2015, the study was revisited and similarly, the report concluded that the UK was the world-leader in palliative care. However, the report also pointed out that, in May 2015 the UK Parliamentary and Health Service Ombudsman concluded, as a result of an investigation into 12 complaints about end-of-life care, that there were regular failings in PEOLC in the UK. The Economist study concluded:

The fact that the UK, an acknowledged leader in palliative care, is still not providing adequate services for every citizen underlines the challenge facing all countries. Because while greater numbers of people are living longer, they are not necessarily doing so in good health. Often they may have several illnesses, making the process of dying more drawn-out and demanding increasingly complex forms of treatment. This places a heavy burden on healthcare systems, most of which are struggling to adapt—and one of the hardest shifts to make is cultural.³⁶⁸

241. The Economist’s “Quality of Death Index” uses an overall score across five categories to establish an overall index (each category has a different “weighting” when the index is calculated which is referred to in the below list). The maximum score for each category is 100. These five categories are:

- i) **Palliative and healthcare environment category** (below abbreviated as PHE) which looks at factors including “a nation’s overall spending on healthcare, the presence and strength of government policies on palliative care, the availability of research-based policy evaluation and the capacity to deliver palliative care services” (20% weighting);
- ii) **Human resources** (below abbreviated as HR) which includes “availability of specialists in palliative care and practitioners with general medical knowledge of palliative care; the presence of certifications for palliative care; and the number of doctors and nurses for every 1,000 palliative care-related deaths” (20% weighting);
- iii) **Affordability of care** (below abbreviated as AC) which assess three indicators “availability of public funding for palliative care, the financial burden palliative care places on patients, and the availability of coverage through national pension schemes. Of these, public funding availability and the financial burden to patients receive the highest weightings, of 50% and 40% respectively.” (20% weighting);
- iv) **Quality of care** (below abbreviated as QC) uses six indicators to determine “the relative quality of care available in different countries: the presence of monitoring standards for organisations (which are in place in 49 of the countries in the Index), the availability of opioid painkillers and psychosocial support for patients and families, the presence of “do not resuscitate” (DNR) policies, support for shared decision-making and the use of patient satisfaction surveys. (30% weighting); and

³⁶⁷ The Economist Intelligence Unit, [The quality of death Ranking end-of-life care across the world](#) (July 2010)

³⁶⁸ The Economist, [The 2015 quality of death index: ranking palliative care across the world](#) (October 2015)

- v) **Community engagement** (below abbreviated as CE) assess “public awareness of palliative care and availability of volunteer workers for palliative care. Public awareness has a weighting of 70% and volunteer workers 30%.” (10% weighting).

242. The scores on the index of the countries that we have looked at in detail during the inquiry are set out in the table below, as is their place amongst the 80 countries included in the study (indicated in brackets after the score in each category).³⁶⁹ The UK ranks first in three of the sub-categories (palliative and healthcare environment, affordability, and quality of end-of-life care) and has the highest overall score.

Table 9: Table showing the Economist Intelligence Unit scores according to its Quality of Death Index for the UK, Australia, New Zealand, Belgium, Netherlands, USA, Canada and Switzerland

Country	Overall	1. PHE	2. HR	3. AC	4. QC	5. CE
UK	93.9 (1)	85.2 (1)	88.2 (2)	100 (1)	100 (1)	92.5 (3)
Australia	91.6 (2)	84.1 (3)	92.3 (1)	100 (1)	96.3 (3)	75 (9)
New Zealand	87.6 (3)	76.7 (8)	81.4 (5)	87.5 (6)	95 (4)	100 (1)
Belgium	84.5 (5)	69.4 (10)	66 (17)	100 (1)	91.3 (7)	100 (1)
Netherlands	80.9 (8)	84.8 (2)	59.6 (22)	87.5 (6)	90 (8)	75 (9)
USA	80.8 (9)	78.9 (6)	70.2 (14)	82.5 (18)	90 (8)	75 (9)
Canada	77.8 (11)	57.5 (18)	78 (6)	77.5 (22)	92.5 (6)	75 (9)
Switzerland	76.1 (15)	64.8 (13)	69.4 (15)	82.5 (18)	90 (8)	57.5 (15)

Source: The Economist Intelligence Unit, [The Quality of Death Index—Ranking Palliative Care Across the World](#) (October 2015)

Demand for PEOLC in the UK

243. Several submissions argued that the current demand for PEOLC services in the UK already outstrips the supply. For example, Sue Ryder stated that despite up to 90% of people being estimated to have PEOLC needs at the end of their life, less than 50% of people dying in the UK currently receive PEOLC.³⁷⁰ Cicely Saunders International also highlighted patient surveys, showing that many people would prefer to die at their home or place of residence, but that in some parts of England and Wales less than half do so because the appropriate services are not in place to support them.³⁷¹

244. According to projections by the Office for National Statistics (ONS), in 50 years’ time there will be an additional 7.5 million people aged 65 years and over in the UK.³⁷² The likelihood of experiencing multiple chronic and complex health conditions amongst those over 65 years old increases with age, leading the ONS to conclude that “as life expectancy increases, so does the amount of time spent in poor health.”³⁷³

369 The Economist Intelligence Unit, [The Quality of Death Index – Ranking Palliative Care Across the World](#) (October 2015)

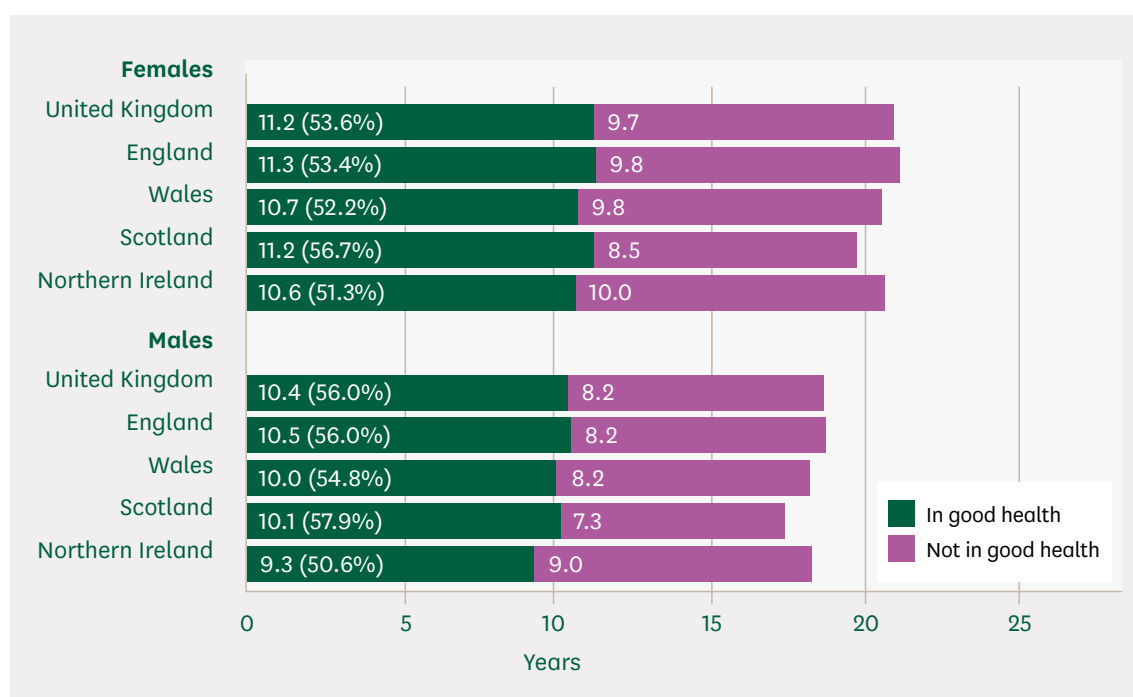
370 Sue Ryder ([ADY0256](#))

371 Cicely Saunders International ([ADY0357](#))

372 Office for National Statistics, [Overview of the UK population: January 2021](#) (January 2021)

373 Office for National Statistics, [Living longer: how our population is changing and why it matters](#) (August 2018)

Figure 6: Office of National Statistics graph of Life expectancy and the proportion of life spent in good health at age 65 years, by sex, 2014 to 2016, UK and constituent countries



Source: Office for National Statistics, [Living longer: how our population is changing and why it matters](#) (13 August 2018)

245. Estimates suggest that by 2040 between 25.4–42.4% more people in England and Wales will have PEOLC needs.³⁷⁴ In their written evidence, Sue Ryder pointed to their modelling which shows that demand for palliative care services will rise from 245,000 people in 2021/22 to 379,000 in 2030/31.³⁷⁵ In his oral evidence, Dr Doré told us:

We have a population in England and Wales of 58 million; that is 10 million who are over 65 and it is going to increase to 16 million by 2037 according to ONS figures. That is going to be a 60% increase in workload, essentially, to transfer to palliative care.³⁷⁶

Variations in access to PEOLC

246. Submissions agreed that there is variation in access to quality PEOLC. For example, Care Not Killing and Our Duty of Care (two campaign groups which oppose legalising AD/AS) concluded:

The UK is recognised as the world-leader in palliative care innovation and provision, but there are still great disparities in what is available to individuals.³⁷⁷

247. This opinion was echoed by Jonathan Ellis, Director of policy, advocacy and clinical programmes at Hospice UK, who told us:

³⁷⁴ Etkind *et al* “How many people will need palliative care in 2040? Past trends, future projections and implications for services” *BMC Medicine*, vol 15 (2017)

³⁷⁵ Sue Ryder ([ADY0256](#))

³⁷⁶ [Q238](#)

³⁷⁷ Care Not Killing (CNK Alliance Ltd) and Our Duty of Care ([ADY0343](#))

Internationally, the UK is frequently rated as among the best in the world in its provision of palliative and end of life care. However, that is not to say that everything is perfect. We know that there are huge inequalities. There are huge gaps and unmet needs that exist within our communities.³⁷⁸

248. Dr Perkins stated that there are variations in the quality of PEOLC across different care settings in the UK:

As for giving a score [for PEOLC] as a nation, I think it depends where you are. If you are lucky enough to be in a hospice, it is a nine [out of ten]. The care is fantastic. The CQC ratings for hospices are very good. If you are in some parts of the country or in some hospitals, you are going to get a low score. The care is patchy.³⁷⁹

249. A clear theme in the responses to our online form, amongst both respondents agreeing with AD/AS being illegal in England and Wales as well as those disagreeing, was the importance of providing equal access to high-quality palliative and end of life care (PEoLC) and social care to all who need it. However, respondents who agree with the current law stated that the focus should be on improving access to PEOLC and social care instead of the provision of “a choice to die”; whilst those who disagreed with the current law called for improvements to PEOLC in addition to a change in the law. A theme amongst the responses in favour of the current law was a concern that legalising AD/AS may lead to de-prioritisation of spending on PEOLC and social care.³⁸⁰

250. In their submission, Sue Ryder state that improved access to PEOLC would not negate all arguments for AD/AS, as some may still want to have access to AD/AS even when offered the best possible PEOLC. They state that, on the other hand:

[...] fair and equal access to high quality palliative care is essential if assisted dying was legalised as it would help to ensure that an assisted death has not been chosen because a person is not aware of, or cannot access, good palliative care.³⁸¹

251. The Health and Care Act 2022 introduced a statutory requirement for local Integrated Care Systems (ICSs) to provide palliative care services.³⁸² It is too soon for us to conclude if the new statutory duty has improved access to (or funding of) PEOLC. However, Dr Doré expressed concern that the Act does not stipulate that ICSs must commission “specialist palliative care” and therefore they may focus on “non-specialist palliative care” which, in his opinion, would not be sufficient and he concluded: “You need both. [...] ICBs just funding GPs doing palliative care does not solve the problem.”³⁸³

252. The Social Care Minister told us:

As of last week, ICBs were submitting their joint forward strategic plans setting out how they are going to commission to meet their statutory duties,

378 [Q237](#)

379 [Q240](#)

380 Annex 1

381 Sue Ryder ([ADY0256](#))

382 Health and Care Act 2022, [section 21](#)

383 [Q262](#)

including palliative care. NHS England is now doing the work of going through those plans and being assured that they will meet those statutory duties.³⁸⁴

253. The Minister was more positive regarding the overall quality of PEOLC services but acknowledged that “variation and inequality of access” were of concern. Regarding overall quality of PEOLC, the Minister stated:

We look to the CQC—the Care Quality Commission—to assure us about the quality of palliative and end of life care. They assess care of the dying as good or outstanding in 88% of settings. Hospices have a 94% rating by the CQC as good or outstanding. If we look at the National Audit of Care At the End of Life for the last year, [...] 74% of families and carers report the care as good, excellent or outstanding. There is a positive story to tell.³⁸⁵

254. The National Audit of Care at the End of Life (NACEL) referred to by the Social Care Minister assesses PEOLC provision to patients who die in NHS inpatient settings.³⁸⁶ The most recent cycle of the audit collected data in April and May 2022, and reported that, when asked about their experience of the care their relative had received, 71% families rated it as good or above and 16% rated it as poor.³⁸⁷

255. In his oral evidence to us Jonathan Ellis set out the reasons for inequalities in access to PEOLC, broadly summarised as:

- “Geographical inequalities” which he explained as access to and availability of palliative care being poorer in rural areas and areas of deprivation.
- “Diagnostic inequalities” - patients with life-limiting conditions that are not related to cancer are less likely to access specialist PEOLC.
- “Inequalities in patient characteristics” whereby communities which are “excluded in society generally” find it harder to access PEOLC.³⁸⁸

256. Many of the written evidence submissions described geographical barriers to accessing PEOLC. The Evangelical Alliance referenced a report by the Institute for Public Policy Research³⁸⁹ which found that people living in the most deprived areas in England are getting £400 less healthcare investment per person in their last year of life.³⁹⁰ This report also stated that a shift to a more community/primary care led end of life care model was happening to differing degrees across the country.³⁹¹

257. The HSIB 2023 report on delivery of PEOLC showed significant geographical differences in access. For example, two of the regions visited during the HSIB investigation had no available inpatient specialist palliative care or hospice facilities. HSIB also reported

384 [Q282](#)

385 [Q279](#)

386 National Audit of Care at the End of Life, [Fourth round of the audit \(2022/23\) report England and Wales](#) (July 2023)

387 National Audit of Care at the End of Life, [Fourth round of the audit \(2022/23\) report England and Wales](#) (July 2023)

388 [Q260](#)

389 Institute for Public Policy Research, [The state of end of life care, Building back better after COVID-19](#) (April 2021)

390 Evangelical Alliance ([ADY0358](#))

391 Institute for Public Policy Research, [The state of end of life care, Building back better after COVID-19](#) (April 2021)

there was often poor visibility (both to patients and to ICBs) of the PEOLC services available in a given area which made it difficult to access care even when it was available. The report highlighted that poor coordination of PEOLC services in the community had a negative impact on the experience of care for patients and their families, and concluded that sometimes holistic assessments focussed too much on physical symptoms at the expense of addressing psychological symptoms.³⁹²

258. Diagnostic inequalities were also mentioned in several of the written evidence submissions we received. During our roundtable, a healthcare professional criticised the reach of palliative care in the UK for patients with illnesses other than cancer:

[...] we only reach a very limited number of people who could benefit. Even by all the official statistics, most of palliative care is given to cancer patients. I trained in oncology, so for cancer, that's fine. But I find it's absolutely inhumane that it is not applied also to many of the non-cancer patients as well. So we know that palliative care has a limited reach across to all of the people who could be dying.

259. The submission by Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation at King's College London stated that most of the people who die in hospices (more than 90%) have cancer, although cancer accounts for about 25% of all deaths.³⁹³ Dr Carl Counsell, a consultant neurologist, stated that the "vast majority" of the patients he sees with incurable neurological conditions could not access PEOLC despite having PEOLC needs.³⁹⁴ In her written evidence to the inquiry Baroness Murphy told us:

Access to palliative care in the UK is too often focused solely on cancer patients and restricted to the last 6 months of life. Patients with other life limiting disorders are rarely referred and certainly rarely included in health plans locally.³⁹⁵

260. Several written submissions mentioned PEOLC access issues for people with certain characteristics. The Cicely Saunders Institute cited research showing that some groups experience barriers in access to PEOLC.³⁹⁶ According to resources on PEOLC produced by the NHS, other groups which may be at risk of experiencing unequal access to PEOLC include people with dementia, people with learning difficulties, travellers, people who are homeless and people in prison.³⁹⁷

261. NICE guidelines state that patients should have 24/7 access to a healthcare professional, a designated out-of-hours end of life care advice line and out-of-hours pharmacy services.³⁹⁸ Therefore, we were very concerned to hear that patients frequently experience difficulties in accessing PEOLC out-of-hours. Dr Perkins told us about how this impacts patients and their families:

392 Healthcare Safety Investigation Branch, [Variations in the delivery of palliative care services to adults](#) (July 2023)

393 Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King's College London ([ADY0402](#))

394 Dr Carl Counsell ([ADY0460](#))

395 Baroness Elaine Murphy ([ADY0099](#))

396 Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King's College London ([ADY0402](#))

397 NHS England, ['Addressing inequalities in palliative and end of life care'](#), accessed 14 August 2023

398 National Institute for Care Excellence, ['NICE guideline \[NG142\] End of life care for adults: service delivery'](#), 16 October 2019

One of the big stresses for patients and families is in the middle of the night when they have pain and are distressed. They call for a district nurse and for advice. In Marie Curie research last year 27% of the country does not have a dedicated advice line, where you can get through to someone sensible. You end up calling 111 perhaps and an ambulance comes and takes someone to A&E. Then someone ends up dying in A&E, which is not what you want.³⁹⁹

262. Similarly, research conducted by Marie Curie found that a single designated PEOLC advice line was not available at all in over a quarter of areas that were surveyed, and in 42% of areas it was only partially available. Even when it was available this was sometimes only accessible by patients who were already known to the service.⁴⁰⁰ Although 91% of respondents of the National Audit of Care at the End of Life audit stated that they could access out-of-hours specialist PEOLC over the telephone, face-to-face access is lagging behind with only 60% NHS organisations providing face-to-face specialist PEOLC 8 hours a day 7 days per week.⁴⁰¹

263. According to the 2022 Marie Curie report, patients also frequently struggle to access pharmacies out of hours (and that this is even harder in rural areas) and even when medication can be obtained, it can be difficult to access a healthcare professional who can administer medication out of hours.⁴⁰² The Social Care Minister told us:

If we look at the National Audit of Care At the End of Life [NACEL] for the last year, the vast majority of hospitals—99%—have access to a specialist palliative care team. The majority of that is 24/7, and a significant proportion of that care and support is available face to face.⁴⁰³

264. The Department of Health and Social Care stated in their written submission that together with the National Institute for Health and Care Research (NIHR) they are commissioning a new Policy Research Unit (PRU) in PEOLC to address issues of access:

This PRU will focus on how best policy makers can respond to a range of issues across palliative and end of life care, including key issues that emerged during the pandemic such as quality of care and inequalities in access to services in different settings. It will also include research into understanding the barriers to discussing palliative and end of life care and the wider role of society in supporting people who are dying and those important to them.⁴⁰⁴

265. The Government's Major Conditions Strategy interim report set out that:

NHSE has funded palliative and end of life care strategic clinical networks to enhance improvements within local populations, including a specific focus on health inequalities. NHSE will continue to work towards improving access, early engagement with services and reducing health inequalities

399 [Q240](#)

400 Marie Curie, [Better End of Life 2022](#) (November 2022)

401 National Audit of Care at the End of Life, [Fourth round of the audit \(2022/23\) report England and Wales](#) (July 2023)

402 Marie Curie, [Better End of Life 2022](#) (November 2022)

403 [Q279](#)

404 Department of Health and Social Care ([ADY0398](#))

through a number of national workstreams for palliative and end of life care that will consider an all-age approach and work with people of lived experience.⁴⁰⁵

Funding of PEOLC in England

266. PEOLC should be universal and easily accessible for all. However, improvements to PEOLC services will not be possible unless they are adequately funded to keep up with demand.

267. We also examined funding of specialist PEOLC. Many witnesses and written evidence submissions argued that the funding for specialist PEOLC is insufficient and unsustainable, leading to geographic inequality in access to and quality of care. Hospice UK stated that, despite hospices being the primary providers of specialist palliative care services, they receive only around one third of their funding from the NHS and are reliant on charitable donations for the rest.⁴⁰⁶ In contrast, specialist PEOLC delivered through secondary care and NHS-led community units, and non-specialist palliative care delivered by NHS organisations, is fully funded by the NHS. Many of those we heard from questioned whether charitable funding should be required to fund such vital care. Dr Paul Perkins, Chief Medical Director at Sue Ryder stated:

I am constantly surprised that as a society it is okay for us to have to sell second-hand cardigans to be able to look after seriously ill people. If people thought that you had to sell second-hand cardigans for their cancer surgery, I don't think that would be acceptable [...].⁴⁰⁷

268. Furthermore, Dr Perkins told us that hospices in affluent areas can raise more money through fundraising and therefore offer more services compared to those in deprived areas, which contributed to geographic inequality in service provision.⁴⁰⁸ Likewise, the HSIB report into PEOLC stated that:

National bodies and charities told the investigation that the location of third sector PEOLC organisations was “haphazard”. This was because of the way in which hospice charities had originally been set up. Different ICB footprints therefore had different third-sector provision available.⁴⁰⁹

269. In addition to causing inequality in access, we heard compelling evidence that the current funding model for hospices is unsustainable and risks hospice closures. Hospice UK stated that, together, hospices must raise £2.8 million every day to supplement the funding they receive from the state.⁴¹⁰ In 2021 Sue Ryder commissioned independent research into the projected cost of funding hospice PEOLC over the next 10 years which found that:

405 Department of Health and Social Care, [Major conditions strategy: case for change and our strategic framework](#) (August 2023)

406 Hospice UK ([ADY0411](#))

407 [Q245](#)

408 [Q248](#)

409 Healthcare Safety Investigation Branch, [Variations in the delivery of palliative care services to adults](#) (July 2023)

410 Hospice UK ([ADY0411](#))

[...] if Government funding continues in line with its current model of covering 37% of costs, hospices will be required to raise £597 million each year through fundraising. This is simply unrealistic.⁴¹¹

270. Sue Ryder also noted in their submission that their modelling was done prior to the recent increases in cost-of-living (which they state have resulted in a 10% increase in the cost of running hospice services), and before the recently agreed NHS pay increases which they estimate will cost the UK hospice sector an additional £120 million a year:

The costs presented within this position must be viewed in this context and regarded as a very conservative estimate—the reality of these recent developments means the situation is far worse than in 2021.⁴¹²

271. Sue Ryder concluded that to ensure the sustainability of the hospice sector, NHS contribution to hospice funding should increase to cover 70% of total palliative care costs and stated:

Without a Government commitment to significantly increase levels of statutory funding to cover clinical costs for palliative care services, there is a genuine and serious risk of services being withdrawn and patients and their families losing out on the specialist, holistic support that hospices offer. The collapse of the independent hospice sector would be disastrous, with the NHS forced to take on the extra demand.⁴¹³

272. A review of ICS commissioning strategies in 2021 (prior to the Health and Care Act 2022) reported that only 6 of 23 ICSs with published strategies had identified PEOLC as a priority.⁴¹⁴ Jonathan Ellis told us that there is a “enormous variation” in how different ICBs prioritise hospice and palliative care, which results in varied levels of resources made available to it across the country.⁴¹⁵

273. In their submission, the think tank Living and Dying Well also referred to historical variation in the commissioning of PEOLC and reported that a freedom of information request in 2016 showed that “clinical commissioning groups’ funding per palliative care patient per annum ranged from £52 - £2329.”⁴¹⁶

274. The HSIB report included testimony from some hospice leaders who argued that where the NHS commissions and funds a larger proportion of PEOLC there is more NHS scrutiny and a more ‘medical’ focus in services. This was felt to limit their ability to broaden services beyond a core set, with less consideration of factors such as wellbeing.⁴¹⁷

275. In his oral evidence to us, Jonathan Ellis of Hospice UK saw some positives about the current model:

There is enormous benefit and value from the charitable contribution.
There is the ability to innovate and experiment. In fact, the whole basis of

411 Sue Ryder ([ADY0521](#))

412 Sue Ryder ([ADY0521](#))

413 Sue Ryder ([ADY0521](#))

414 Chambers et al, “[Inclusion of palliative and end of life care in health strategies aimed at integrated care: a documentary analysis](#)”, AMRC Open Res, vol 4 (2023)

415 [Q244](#)

416 Living and Dying Well ([ADY0489](#))

417 Healthcare Safety Investigation Branch, [Variations in the delivery of palliative care services to adults](#) (July 2023)

the hospice model when it was first envisaged by Dame Cecily Saunders, the founder of the modern hospice movement, was to fix dying outside the NHS and then put it back. The bit we have never done is the putting back and the mainstreaming of good care at the end of life throughout the health and care system.⁴¹⁸

276. Living and Dying Well argued in their submission that charitable fundraising should be used to provide “additional improved environments and services for patients and families” rather than “core NHS provision”.⁴¹⁹

277. Winchester Hospice, in Hampshire in the South of England, has a funding model which relies on both NHS and charitable funding. According to its website, it is run and managed by Hampshire Hospitals NHS Foundation Trust (HHFT) and supported by the Winchester Hospice Fundraising Charity which “work to support and raise funds” to ensure the care that the Hospice provides can “continue for decades to come”.⁴²⁰

278. The UK has long been a world leader in palliative and end of life care, but access to and provision of palliative and end of life care is patchy. The Government must ensure universal coverage of palliative and end of life services, including hospice care at home. It is important that everyone is able to choose what type of support they need at the end of their life, and that their advanced care plan is honoured where possible.

279. As identified in the report of the HSIB (now the Health Services Safety Investigations Body (HSSIB)) on variations in palliative care services to adults, we agree that better data on the population within an ICB catchment area needs to be acquired by ICBs so that they can more fully understand the needs of the population. This will allow commissioners to more effectively support the provision of services.

280. We understand that the flexible nature of the current funding model for hospices is valued by some hospice leaders, and rather than suggesting that the Government funds 100% of hospice operations, we call on the Government to commit to an uplift of funding to guarantee that support will be provided to any hospices which require funding assistance.

Death literacy and management of a terminal diagnosis

281. Several witnesses were concerned that debates around AD/AS would worsen existing misconceptions in the UK about PEOLC: for example, fears held by some people related to its association with death.⁴²¹ Dr Doré told us:

We have spent 50 years trying to remove the misconception that we bump people off—that we kill people in palliative care. It does not happen. People are afraid to go into a hospice because of the lingering thought that you go in and you do not come out. That is not true. There is a 50% discharge [rate from hospices].⁴²²

418 [Q243](#)

419 Living and Dying Well ([ADY0489](#))

420 Winchester Hospice, ‘[Our vision and values](#)’, accessed 21 November 2023

421 Dr Robert Twycross (Emeritus Clinical Reader in Palliative Medicine at University of Oxford) ([ADY0328](#)), Dr Sheila Fisher ([ADY0064](#)), Care Not Killing, and Our Duty of Care ([ADY0343](#)), Dr Caradoc Morris ([ADY0076](#))

422 [Q252](#)

282. Over the course of this inquiry we have heard that high quality PEOLC can alleviate distressing symptoms for many patients, but not for all. Some of the consultants in PEOLC who provided written evidence to us gave examples of this from their clinical experience.⁴²³ Baroness Finlay and Mr Preston suggested that patients who request help to die can change their mind if provided with proper palliative care:

Specialists in hospice and palliative care not infrequently see patients whose symptom relief has been inadequate and who sometimes talk of ‘ending it all’ but who, after receiving treatment in hospices or specialist palliative care units in hospitals, have their symptoms stabilised and are able to lead more fulfilling lives. There is a strong case therefore for requiring that persons seeking assisted dying should be required to experience modern specialist palliative care.⁴²⁴

283. During our first evidence session we heard from Baroness Finlay, Baroness Hollins, Baroness Meacher and Lord Falconer who had all been involved in the debates on AD/AS legislation in the House of Lords. We asked Baroness Finlay, Professor of Palliative Medicine, Cardiff University School of Medicine, whether she thought patients and families are given enough opportunity and support to discuss death and dying. She responded:

Simply, no, they do not have enough opportunity. Even clinicians are slow to refer patients to palliative care early because they are frightened of having the conversation to say that the prognosis is not good, although we have moved a lot from where we were previously.⁴²⁵

284. In response to the same question, Baroness Meacher said:

It is a very serious issue for people that they feel they cannot talk to their doctor about their death and dying. We know from the jurisdictions that have assisted dying that doctors are much more comfortable about talking with their patients about dying, about pain control and about hospice care and so on. It opens up the relationship and the conversations between patients and their doctors when the doctor knows that if things become unbearable for the patient, they can actually help them right the way through. At the moment, at the point of greatest need for the patient—when the patient cannot cope any more—the doctor is unable to help. That interferes with a doctor feeling that they can actually have those conversations.⁴²⁶

285. Lord Falconer stated:

You need to be much more open about the prospects of how one dies. That will have the effect, I suspect, of reducing much of the fear associated with death. [...] For some people, even with the best help in the world, the idea

423 For example, Dr Jennifer Klimiuk ([ADY0203](#)), Professor Rod MacLeod ([ADY0236](#)), Dr Siwan Seaman ([ADY0338](#))

424 Baroness Ilora Finlay and Mr Robert Preston ([ADY0275](#))

425 [Q41](#) [Baroness Finlay]

426 [Q41](#) [Baroness Meacher]

of going through a period when they are completely disabled or dependent on those who love them is unbearable. You need to have the discussion about what you can cope with because people's levels are so different.⁴²⁷

286. Baroness Hollins stated:

We have to learn how to talk through the taboo. That includes death, but it also includes what you are calling dignity. I think the dignity comes in part from the comfort of sharing fear, of understanding, of seeing, of participating, of engaging, of experiencing grief and of understanding that this is part of the life cycle. Let's open the subject up. Let's talk about it.⁴²⁸

287. In their submissions, Right to Life UK (an organisation opposed to legalising AD/AS) and Healthcare Professionals for Assisted Dying (a campaign group in favour of legalising AD/AS) both referred to research from Oregon to illustrate the importance of PEOLC.⁴²⁹ Right to Life UK pointed to a study that found that where the doctor implemented at least one "substantive palliative intervention" (identified as symptom control, new drug treatment, referral to a hospice, or a specialist consultation) 46% of patients changed their mind about AD/AS. In contrast, only 15% of those who did not receive a "substantive palliative intervention" changed their mind.⁴³⁰ Referring to the same study in their submission Healthcare Professionals for Assisted Dying (a campaign group in favour of AD/AS) argued that of the 165 participating patients, not all changed their mind about accessing AD/AS and in turn referred to another study of Oregon healthcare professionals⁴³¹ which suggested that since AD/AS had been legalised, healthcare professionals "often report making greater efforts to improve the level of care they provide to all their patients, not just those who seek the option of an assisted death".⁴³²

288. The Cicely Saunders Institute pointed to research which used structured interviews to study the views of 300 patients referred for hospice care in London.⁴³³ At the time of referral (in other words before receiving hospice led PEOLC), 11% of the patients reported having a "desire for a hastened death". This had been resolved in a third of patients when they were interviewed again four weeks later (after receiving hospice led PEOLC input). The study concluded:

The provision of symptom control and timely detection and intervention for depression coupled with a focus on optimising function, instilling hope and preserving dignity are likely to contribute to alleviation of DHD [desire for a hastened death] in patients with advanced illness.⁴³⁴

427 [Q43](#) [Lord Falconer]

428 [Q42](#) [Baroness Hollins]

429 Right To Life UK ([ADY0404](#)), Healthcare Professionals for Assisted Dying ([ADY0410](#))

430 Ganzini et al "Physicians' experience with the Oregon death with dignity act", New England Journal of Medicine, vol 342 (2000) pp 557 - 563

431 Ganzini et al "Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon Death with Dignity Act", JAMA, vol 285 (2001) pp. 2363–2369

432 Healthcare Professionals for Assisted Dying ([ADY0410](#))

433 Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King's College London ([ADY0402](#))

434 Price A et al. "Prevalence, course and associations of desire for hastened death in a UK palliative population: a cross-sectional study", BMJ Supportive & Palliative Care, vol 1 (2011) pp 140 - 148

289. Several submissions to us from individuals or organisations that supported AD/AS referred to modelling conducted by the Office of Health Economics which concluded that even with the best PEOLC (which they defined as PEOLC delivered in hospices)⁴³⁵:

[...] there would still be 50,709 palliative care patients dying in some level of pain each year. Of these patients, 5,298 would still experience no pain relief at all in the last three months of life.⁴³⁶

290. The report by the Office of Health Economics also notes:

Among cancer patients, O'Brien and Kane (2014) cite rates of refractory pain (pain that cannot be adequately relieved despite optimised use of systematic analgesics) in 10–15% of patients in the clinical literature, whilst as many as 30% of patients self-report unrelieved pain. If 84% of cancer patients experience pain, then between 8–13% (clinical judgement) and 25% (self-reported) of cancer patients may suffer unrelieved pain.⁴³⁷

291. Baroness Meacher told us:

We all want more and better palliative care—of course we do—but however good palliative care is, it will not be able to eliminate the unbearable suffering of many people.⁴³⁸

292. For the first time, in April 2022, the Office for National Statistics (ONS) published data on suicides amongst people diagnosed with severe health conditions in England between 2017 and 2020. The data provides a sobering picture of the increased prevalence of suicide in this group, and the bulletin concludes:

A diagnosis or first treatment for the selected health conditions is associated with an elevated rate of death due to suicide when compared with study participants with similar socio-demographic characteristics; participants known as matched controls.⁴³⁹

293. According to the ONS data, one year after diagnosis the suicide rate for people with low survival cancers and COPD was 2.4 times higher compared to the control group, and the figure for chronic ischemic heart conditions was almost twice as high as the control group. The control group are study participants who had the same socio-demographic characteristics as the patients in these groups but were not diagnosed with a severe condition.⁴⁴⁰

294. Aside from worry about pain and suffering at the end of life, according to many of those we heard from through our online form, “dignity” and “control” were also important

435 Including submissions from Dignity in Dying ([ADY0418](#)), DIGNITAS – To live with dignity – To die with dignity ([ADY0299](#)), Humanists UK ([ADY0298](#))

436 Office of Health Economics, [Unrelieved pain in palliative care in England](#) (September 2019)

437 Office of Health Economics, [Unrelieved pain in palliative care in England](#) (September 2019)

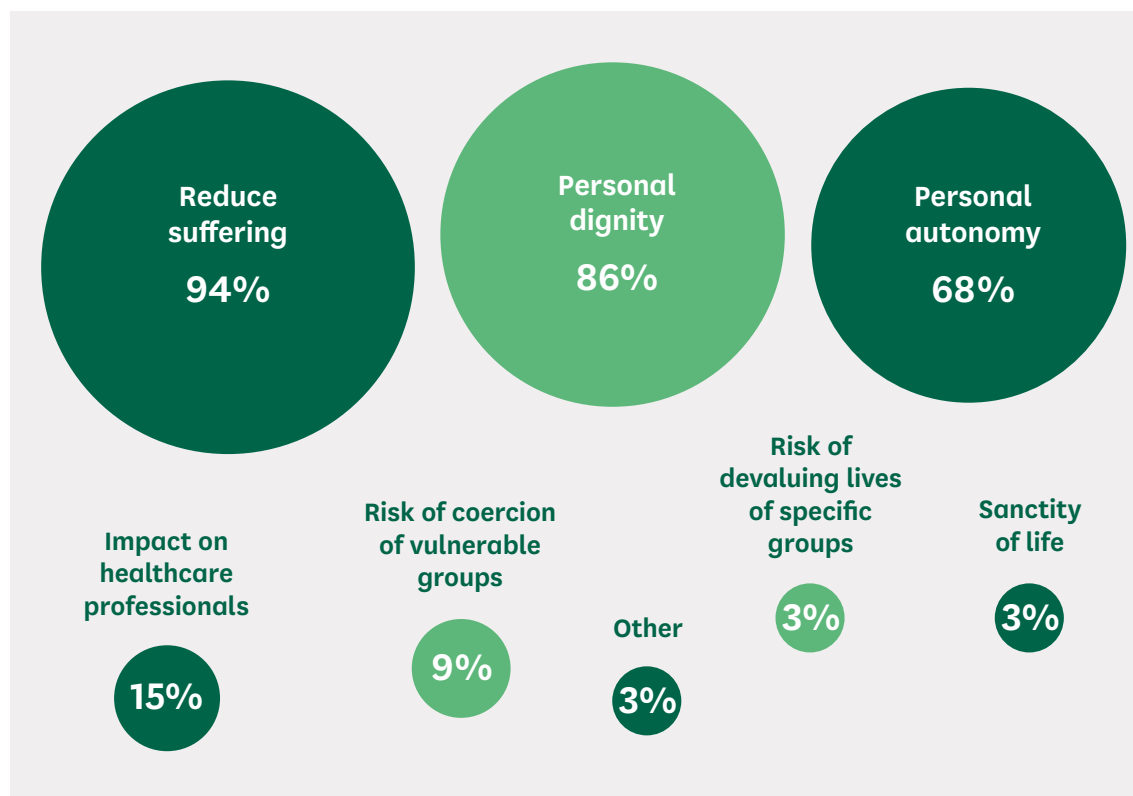
438 [Q3](#)

439 Office for National Statistics, [Suicides among people diagnosed with severe health conditions, England: 2017 to 2020](#) (April 2022)

440 Office for National Statistics, [Suicides among people diagnosed with severe health conditions, England: 2017 to 2020](#) (April 2022)

reasons for disagreeing with the current law. The form asked people who disagreed with the current law on AD/AS in England and Wales to pick up to three main reasons for doing so. The graphic below illustrates the reasons they picked.⁴⁴¹

Figure 7: Visual representation of responses received to the Committee’s online form, showing respondents who stated they broadly disagree with the law on AD/AS in England and Wales, and their three main reasons for disagreeing.



Source: Annex 1: Summary of the Committee’s online form responses

295. One of the participants at our roundtable spoke about their experience watching a loved one die and told us that a change in the law to legalise AD/AS would have spared them and their families the “trauma of watching” their loved one die painfully. The participant also told us about their own plans to end their own life should their multiple sclerosis (MS) diagnosis progress further:

Speaking to other people in my treatment group who have MS, they have said they don’t want to take the chance either. All of us, we’ve already planned our suicides because we don’t want to wait and find ourselves powerless, living in unbearable pain with no way out.⁴⁴²

296. The Association of Palliative Care Social Workers similarly stated:

There are people who find that - despite the most skilful care and tailored medication available to relieve their pain, alleviate symptoms such as nausea and vomiting or breathlessness, or help them to resolve practical issues or relationship problems - the distress or restrictions of their situation and the

441 Annex 3

442 Roundtable transcript

prospect of continuing deterioration is unbearable. Access to assisted dying could provide autonomy and choice for these individuals to die safely and with dignity.⁴⁴³

297. Dr Naomi Richards, Director of the Glasgow End of Life Studies Group at the University of Glasgow, told us:

It is about dependency and people's identity. How people die is seen sometimes to represent something about who they are; to say something about who they are. It is really important that we do not just think it is about pain and symptom management, although it is in some cases. A bad death for some people is not dying on their own terms.⁴⁴⁴

298. And Professor Nancy Preston, Co-Director of the International Observatory on End-of-Life Care at Lancaster University, stated:

It is about continence. It is about mobility. It is about being able to make decisions for yourself.⁴⁴⁵

299. One of the participants at our roundtable told us about their experience of their wife dying from cancer:

It proved resistant to all treatment options, including rather heroic neurosurgery. And she was just dying at home. Her treatment, including specialist palliative care, had been excellent throughout, but she'd simply had enough. And she actually said to me, "They treat cats and dogs better than humans". And it wasn't that she was in pain. She just felt dreadful all the time, and she knew this was only going one way.⁴⁴⁶

300. We heard evidence about how some people diagnosed with terminal or degenerative illnesses decided to take their own life due to the suffering they were experiencing. In April 2022 the Office for National Statistics released a statistical bulletin showing the rate of suicides among people diagnosed and treated with the following health conditions: chronic ischemic heart conditions, low survival cancer, and chronic obstructive pulmonary disease (COPD). The data is based on mortality records, linked to the 2011 Census and Hospital Episode Statistics, in England between 2017 and 2020. The statistical bulletin shows that for those diagnosed with low survival cancers or COPD suicide rates were 2.4 times higher than the suicide rate for matched controls, and for chronic ischemic heart conditions they were nearly two times higher.⁴⁴⁷

301. During our roundtable some of the participants shared stories from their own lives, including a number of examples of people who had witnessed loved ones with terminal illnesses who had committed suicide. This also included one participant who told us that the tragic experience had left their family member with PTSD.⁴⁴⁸

443 The Association of Palliative Care Social Workers ([ADY0335](#))

444 [Q63](#)

445 [Q64](#)

446 Lived experience roundtable

447 ONS, [Suicides among people diagnosed with severe health conditions, England: 2017 to 2020](#), 20 April 2022

448 Roundtable transcript

302. We also heard from several people in favour of AD/AS on the basis that it would provide a regulated, formal process. One of the participants told us:

At the moment we don't know how many elderly or disabled people are being coerced into dying, ending their lives prematurely because there are no controls and safeguards. So actually, having an assisted dying law would put those controls and safeguards in place, so people would be safer because you would have to seek discussions with doctors and other medical professionals. You would have to go to court and get a judge to sign off on your ability to be able to have an assisted death. At the moment, how many people are starving themselves just because their family are telling them that they should just get on with it? Or how many people are going off and jumping into rivers or falling into train tracks or something because their families are telling them that they should just get on with it? That they're costing too much money, or they're causing too much suffering having to be watched.⁴⁴⁹

303. Another person during our roundtable who is in favour of legalising AD/AS summarised their view as:

I want a safe, comfortable, controlled, legal death with the correct medications in the correct doses given by the doctors who are qualified to do that and can do that in a way that ensures that it is final.⁴⁵⁰

304. We were extremely saddened to read and hear about the experiences of people who had experienced a loved one taking their own life, and our thoughts and deepest sympathies remain with them.

305. We are pleased that the ONS is now attempting to monitor the rates of suicide for people with a terminal diagnosis, as this will facilitate scrutiny in the future. The existing data already serves as a sobering reminder that the support and care around people who are managing a terminal diagnosis must be improved.

306. We have heard a lot of evidence around the importance of a “good death” for both the person managing their terminal diagnosis, and their loved ones. Suffering, pain and managing a terminal diagnosis will be a subjective experience, unique to the person experiencing them, and although there may be in the future, there is not currently a medical intervention available to manage every symptom or pain.

307. There is a pressing need to understand how to better provide mental health support, and guidance, for people who are living with a terminal diagnosis. We therefore recommend that the Government commission such research and report back to Parliament.

308. The Government must establish a national strategy for death literacy and support following a terminal diagnosis. This strategy will help healthcare professionals to better support someone and their loved ones, from the moment of a terminal diagnosis.

449 Roundtable transcript

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Conclusions and recommendations

Introduction

1. Our aim for this report is for it to serve as a basis for discussion and debate in future Parliaments. We have therefore endeavoured to bring together a comprehensive and up-to-date body of evidence relating to this difficult, sensitive, and yet, crucial subject. The debate on AD/AS is not new, and our report is not intended to provide a resolution to it, but we do hope that it will be a significant and useful resource for future Parliamentarians. (Paragraph 11)
2. Throughout our inquiry, a common theme across the evidence was the pursuit of the very best end of life care, and what many witnesses called “a good death”, where the person dying was cared for with compassion and high-quality care and provided with as much agency and choice as possible. However, there is spectrum of views on how to best achieve this. (Paragraph 12)

Assisted Dying/Assisted Suicide

3. A view put forward by some who have provided evidence to us was that the current state of the law is unclear. (Paragraph 38)
4. During our inquiry we have heard statements from people who have been involved in assisting a loved one to pursue AD/AS abroad. (Paragraph 39)
5. We also heard about the documentation which has had to be secured as part of the application, including a medical report for the person applying. We note that the General Medical Council’s guidance for Investigation Committees assessing a doctor’s fitness to practice following an allegation of a doctor’s encouragement or assistance in suicide, sets out that that providing access to a patient’s records where the request is made in accordance with the Data Protection Act 1998, should be considered lawful or too distant from being considered encouragement or assistance. However, the BMA’s guidance recommend that doctors should not write medical reports specifically to facilitate assisted suicide abroad. Although it is not illegal to provide medical reports in this circumstance, it does not seem to be entirely clear to doctors what they are allowed to do. We would welcome revised guidance from the GMC and the BMA enabling doctors to assist their patients. (Paragraph 40)
6. *The UK Government must consider how to respond to another jurisdiction in the UK, or the Crown Dependencies, legislating to allow AD/AS, and how it may impact jurisdictions which do not allow it. Following the recommendation by the Jersey Citizens’ Assembly, it looks increasingly likely that at least one jurisdiction among the UK and Crown Dependencies will allow AD/AS in the near future and Ministers should be actively involved in discussions on how to approach the divergence in legislation.* (Paragraph 68)

International examples

7. In the evidence we received we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD/AS; indeed the introduction of AD/AS has been linked with an improvement in palliative care in several jurisdictions. We also conclude that jurisdictions which have introduced AD/AS on the basis of terminal illness have not changed the law to include eligibility on the basis of “unbearable suffering”. None of the jurisdictions which have introduced it have revoked the legislation. (Paragraph 142)
8. When we undertook this inquiry, we were keen to learn as much as we could from international examples and we hope that by putting the evidence we have gathered into the public domain, we can help to further inform the debate on AD/AS in the UK. The fact that people with very different overall views on AD/AS draw on international examples to support their arguments shows the complexity of the issue, but it is possible to look at what is happening elsewhere and to use it to learn more about this difficult and sensitive subject. (Paragraph 143)
9. There are as many ways to operate AD/AS as there are jurisdictions which have legalised it, but there are two distinct models: one limiting its availability to those with a terminal illness and the other adding provision for unbearable suffering. What has become clear to us is that better data collection, independently verified and overseen by a dedicated body, leads to a better understanding of how the whole AD/AS process is working. The overall trend is that numbers of AD/AS will increase from the time of introduction, but opinions differ about the cause of the increase. Many of the jurisdictions we have looked at introduced AD/AS very recently, and there is still much to learn as time passes. (Paragraph 144)

Involvement of physicians and assessments of eligibility and capacity to give informed consent

10. Medical professionals would have an important role in any system of AD/AS, although the details are for Parliament to determine should it move to legalise AD/AS. During our inquiry we have heard from healthcare professionals who were content to be involved, from others who were supportive of the practice but did not want to participate themselves, as well as from those who were opposed to the practice in its entirety. We heard evidence that in the event that Parliament were to legislate for AD/AS a decision to participate should be freely taken by the individual healthcare professional and never imposed on them. (Paragraph 189)
11. Practice across the world where AD/AS is legal is varied in the respect of capacity assessments for AD/AS. We heard that any such assessment should be undertaken by professionals who have undertaken necessary training on capacity assessments, particularly in relation to vulnerable groups. (Paragraph 210)
12. Throughout our inquiry into AD/AS, the importance of safeguards and protections, and the question of whether they can be sufficient, has been a central feature, as has the related question of assessing capacity. Hearing from various representatives of healthcare professionals, as well as from healthcare professionals directly, it is clear that there is hesitation around whether it is possible to accurately assess capacity,

and safeguard the person, in every case. On the other hand, some people we have heard from argue that there is a similar risk under the current law in assessing capacity and safeguarding people who opt to cease treatment, or to accept end-of-life care, including palliative sedation. (Paragraph 211)

Palliative and End of Life Care

13. *The UK has long been a world leader in palliative and end of life care, but access to and provision of palliative and end of life care is patchy. The Government must ensure universal coverage of palliative and end of life services, including hospice care at home. It is important that everyone is able to choose what type of support they need at the end of their life, and that their advanced care plan is honoured where possible.* (Paragraph 278)
14. As identified in the report of the HSIB (now the Health Services Safety Investigations Body (HSSIB)) on variations in palliative care services to adults, we agree that better data on the population within an ICB catchment area needs to be acquired by ICBs so that they can more fully understand the needs of the population. This will allow commissioners to more effectively support the provision of services. (Paragraph 279)
15. *We understand that the flexible nature of the current funding model for hospices is valued by some hospice leaders, and rather than suggesting that the Government funds 100% of hospice operations, we call on the Government to commit to an uplift of funding to guarantee that support will be provided to any hospices which require funding assistance.* (Paragraph 280)
16. We were extremely saddened to read and hear about the experiences of people who had experienced a loved one taking their own life, and our thoughts and deepest sympathies remain with them. (Paragraph 304)
17. We are pleased that the ONS is now attempting to monitor the rates of suicide for people with a terminal diagnosis, as this will facilitate scrutiny in the future. The existing data already serves as a sobering reminder that the support and care around people who are managing a terminal diagnosis must be improved. (Paragraph 305)
18. We have heard a lot of evidence around the importance of a “good death” for both the person managing their terminal diagnosis, and their loved ones. Suffering, pain and managing a terminal diagnosis will be a subjective experience, unique to the person experiencing them, and although there may be in the future, there is not currently a medical intervention available to manage every symptom or pain. (Paragraph 306)
19. *There is a pressing need to understand how to better provide mental health support, and guidance, for people who are living with a terminal diagnosis. We therefore recommend that the Government commission such research and report back to Parliament.* (Paragraph 307)
20. *The Government must establish a national strategy for death literacy and support following a terminal diagnosis. This strategy will help healthcare professionals to better support someone and their loved ones, from the moment of a terminal diagnosis.* (Paragraph 308)

Annex 1: Online form analysis

We invited individuals to complete an online form to contribute their views on the law on AD/AS in England and Wales. The aim of this online form was to understand the factors that individuals consider most important when reflecting on the current law and what further information, or viewpoints they think would be helpful in informing the national debate. We received 68,271 responses.⁴⁵¹

The first question in the online form was:

“Suicide and attempted suicide are not crimes in England and Wales. However, it is a crime for a person to encourage or assist the suicide of another person. You can read more about the law here.”⁴⁵² Which of the statements below best reflects your view?

- *I broadly agree with the law in England and Wales.*
- *I broadly disagree with the law in England and Wales.*
- *I’m not sure.”*

Responses were divided into three groups: individuals who “broadly agree” with the current law, individuals who “broadly disagree” and those who were “not sure”. However, we do acknowledge that the three groups (those that “broadly agree”, those that “broadly disagree” and those that are “not sure”) will contain individuals with a wide range of opinions, experiences and perspectives.

The responses from each of the three groups were then analysed thematically using NVivo.⁴⁵³ NVivo is a qualitative analysis software which uses a machine-based approach to systematically analyse large numbers of responses to identify frequently occurring themes.

We would like to emphasise that the analysis of the online form should not be interpreted as representative of the opinion of UK population, and that establishing the opinion of the UK population was not the aim of running this online form. It is important to point out that the respondents are very unlikely to accurately reflect the demographics of the UK population. Furthermore, individuals with stronger opinions may have been more likely to complete the form, which will lead to ‘self-selection bias’. As such, we intentionally do not report the proportions of individuals who agree or disagree with the current law.

The purpose of the online form was to gather the views of those who wanted to interact with the inquiry and tell us about their experiences or opinions. In this analysis we summarise the factors and themes that are most frequently identified as contributing to the perspective of individuals belonging to each of the three broad groups. The form then explored the factors that contributed to the individual’s perspective and which additional sources of information and/or viewpoints they thought were needed.

⁴⁵¹ There were 73,543 responses to the online form and 104 hardcopy responses which were received through the post. The data were cleaned to remove 5,378 responses from a single IP address, and any further entries where more than 10 responses were received for a single IP address.

⁴⁵² [The law on assisted suicide](#), House of Commons Library, July 2022

⁴⁵³ [NVivo](#) Release 1

What factors affect people's perspective on the current law on AD/AS in England and Wales?

The second question of the online form, asked respondents to describe why they had answered as they had to the first question on their views on the current law on AD/AS. Respondents were asked to select which factors from the following list were most important to them when considering the issue:

- Impact on healthcare professionals
- Personal autonomy
- Personal dignity
- Reducing suffering
- Risk of coercion of vulnerable groups
- Risk of devaluing lives of specific groups
- Sanctity of life
- Other, please specify (respondents could type in 50 words in response)

Respondents stated multiple, inter-related factors that affected their overall perspectives. Those who broadly agreed with the law most frequently selected “risk of coercion of vulnerable groups”, “risk of devaluing lives of specific groups” and “sanctity of life” as the most important factors to them when considering the issue. Whereas those who broadly disagreed with the law most frequently selected “reducing suffering”, “personal dignity” and “personal autonomy” as the most important factors.

The below images display the two groups of “broadly agree” and “broadly disagree” with the current law, and the proportion of those responses which selected which factor, in response to the below question:

“Which of the following factors are most important to you when considering the issue of assisted dying? Please select up to three, in order of importance.”

Figure 11: Most important factors when considering the issue of assisted dying amongst respondents who stated that they broadly agree with the law on this issue in England and Wales.

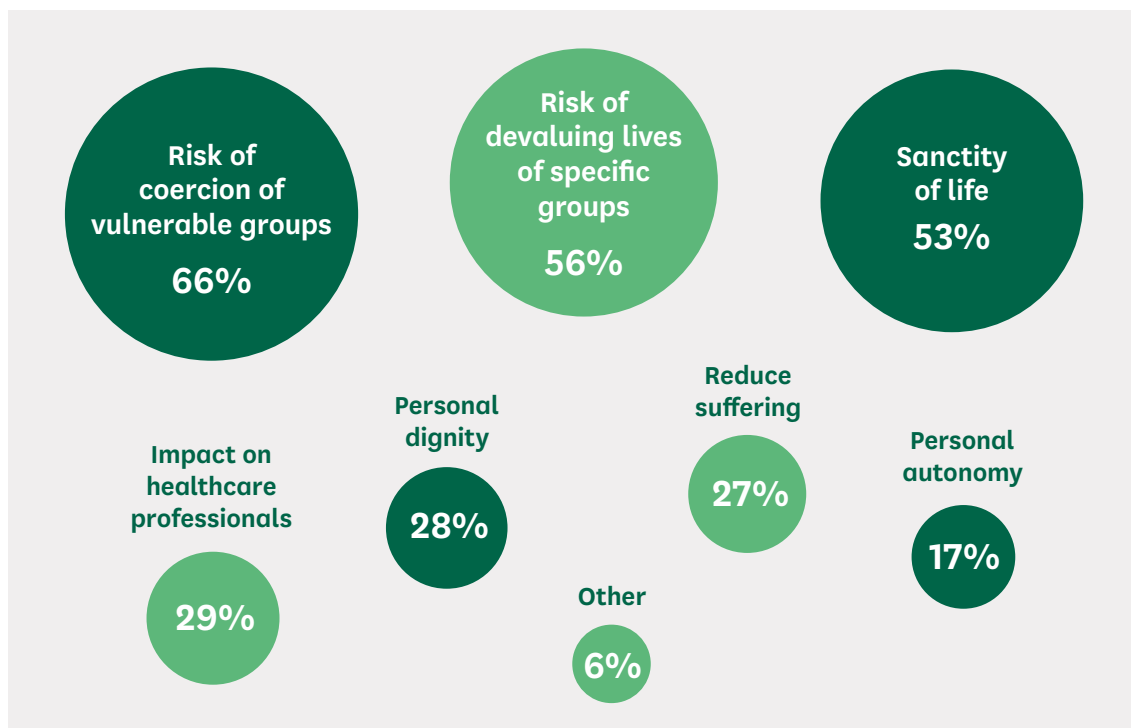
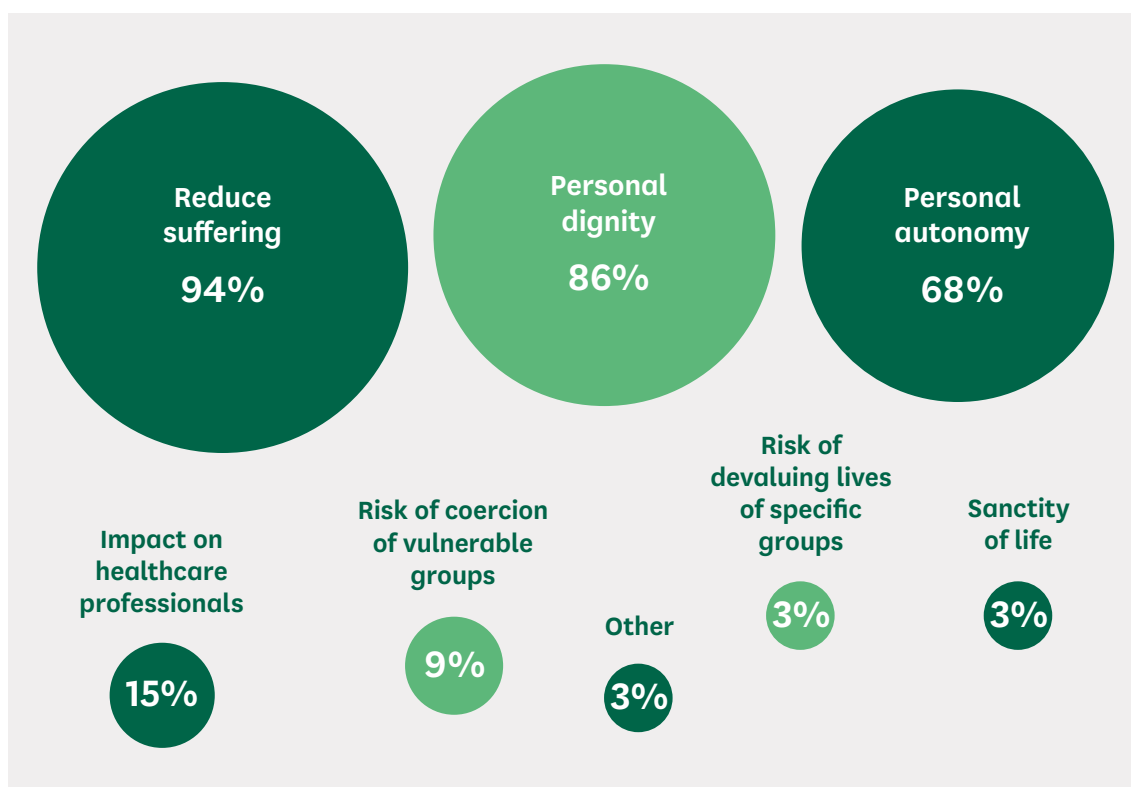


Figure 12: Most important factors when considering the issue of assisted dying amongst respondents who stated that they broadly disagree with the law on this issue in England and Wales.



A thematic analysis of the descriptions of why individuals agree/disagree with the law as it stands, identified some key themes cited by both groups. However, we observed that the two groups (those who agree and those who disagree with the current law) often approached these themes from very different viewpoints.

Themes raised by both groups included:

- Concern about the impact on specific groups,
- current provision of palliative and end of life care,
- the potential impact on healthcare systems, and
- healthcare professionals and international comparisons.

Additional themes raised by individuals who broadly agree with the law as it stands included:

- Sanctity of life, and
- concern about effect on suicide prevention.

Additional themes raised by individuals who broadly disagree with the law as it stands included:

- Dignity,
- autonomy,
- concerns about inequalities in the current law, and
- recommendations of what a change in the law should permit.

Those who responded “not sure” or did not respond to the question asking their view on the current law referred to several of the themes set out above and often focused on:

- What a change in the law would/should permit, and
- whether a change in the law could be balanced against the need to protect vulnerable groups.

Impact on certain groups of people

Both those who agreed and disagreed with the current law acknowledged the risk that a change in the law may result in vulnerable people feeling “coerced” or “pressured” to pursue AD/AS from fear or concern of being a “burden” on family, friends, or society, especially in the context of limited healthcare and social resources.

This was the most frequently selected factor by individuals who agreed with the current law, many of whom stated that a change in the law would “devalue” the lives of vulnerable people, including elderly people and disabled people. Many in this group expressed concern that, if the law was changed, safeguards would not effectively protect vulnerable

groups or people suffering with mental illness. Thus, for those who broadly agreed with the current law, the impact on vulnerable groups was cited as a key reason why they felt the law should not be changed.

In contrast, those who disagreed with the current law stated that it was important to ensure that a change in the law included safeguards to protect vulnerable groups from coercion but tended not to see this as an insurmountable barrier to the law being changed.

Current provision of palliative and end of life care

The importance of providing equal access to high-quality palliative and end of life care (PEoLC) and social care to all who need it was raised by both groups. However, whilst respondents who agree with the current law stated that the focus should be on improving access to PEoLC and social care instead of the provision of “a choice to die”; those who disagree with the current law called for improvements to PEoLC in addition to a change in the law.

Many respondents who agree with the current law stated that when symptoms are managed effectively, a person’s wish to die often decreases. Some thought that a change in the law may de-prioritise spending on PEoLC and social care. And there was concern that this might “push” people with disabilities or individuals close to the end of their life to consider AD/AS through lack of access to appropriate care.

In contrast, some of those who disagree with the current law described experiences of a loved one living with “severe”, “unbearable” and “excruciating” pain towards the end of life that was perceived to be “beyond the reach” of PEoLC. Some described that their loved one had asked for assistance to die, but that they had been unable to help, or were afraid of the legal consequences of assisting them to travel abroad to Dignitas. Some emphasised the negative impact on the dying person’s mental health both from experiencing pain and from the anticipation of future suffering. Others also described the negative impact on the mental health of family and close friends from witnessing a loved one suffering. These feelings of helplessness and of not being able to support their loved one to die as they had wished had left many respondents feeling deeply traumatised. As such, for those who disagree with the current law, the prevention of suffering, which in many cases was perceived to be beyond the reach of PEoLC, was a key reason for believing that the law should be changed.

Potential impact on health systems and healthcare professionals

Individuals from both groups considered the impact that a change to the law might have on the healthcare system and healthcare professionals.

Many respondents who agree with the current law stated that changing the law to allow healthcare professionals to assist a person to die would fundamentally change the role of the NHS and negatively impact the doctor-patient relationship. Some were concerned that even if the law allowed healthcare professionals to opt-out from participating in AD/AS on the grounds of conscientious objection, this would be difficult to put into practice. Others were concerned that healthcare professionals may feel under pressure to promote

AD/AS because of the economic cost of PEOLC. Some of these individuals pointed to the Liverpool Care Pathway⁴⁵⁴ or described their perception/experience of how certain groups were treated during the Covid-19 pandemic to support these concerns.

In contrast, some who disagree with the current law stated that changing the law would have a positive impact on healthcare professionals by enabling them to reduce patients' suffering and respect their autonomy. Some also stated that healthcare workers should be able to "opt out" on the grounds of conscientious objection. Other respondents queried the use of NHS and social care resources to keep people alive if they were suffering unbearably and wanted to die.

International comparisons

Individuals from both groups frequently pointed to jurisdictions where AD/AS is permitted to support their viewpoints.

Many respondents who agree with the current law were concerned that, if the law was changed to permit AD/AS it would be a "slippery slope": eligibility criteria would be expanded over time and intended safeguards would not protect vulnerable groups. Canada was the most frequently cited jurisdiction by this group.

In contrast, many respondents who disagree with the current law pointed to jurisdictions where they considered that AD/AS had been introduced without unintended/harmful consequences. New Zealand and Australia were the most frequently cited jurisdictions by this group.

Additional themes raised by respondents who "broadly agree" with the current law

Some respondents who agree with the current law referred to the sanctity of life, sometimes in relation to stated religious affiliation, as a reason for their stance. This was often intertwined with other considerations outlined above, such as the perceived impact on vulnerable groups, PEOLC and the role of healthcare professionals.

Some respondents were concerned that a change in the law (including the potential expansion of eligibility criteria to include people suffering from mental illness) could deter people who are experiencing psychological distress or feeling suicidal from seeking help and support, and that it could ultimately undermine suicide prevention strategies.

Additional themes raised by respondents who "broadly disagree" with the current law

Two key factors described by respondents who disagree with the current law were the right to personal autonomy and personal dignity. These were the top factors selected as important when considering the issue of AD/AS by individuals in this group. Respondents

⁴⁵⁴ The Liverpool Care Pathway was a framework for good practice to care in the final days of life. It was withdrawn following an independent review in 2013 chaired by Baroness Neuberger, which raised concerns about the quality of care provided to some people. Palliative and end of life care, [POSTnote 481](#), Parliamentary Office of Science and Technology, October 2014

emphasised that these were inter-connected, and that people should be able to choose to die if they felt that they had lost their dignity and found their own suffering to be unbearable.

Many respondents stated that the current law has resulted in inequalities. For example, respondents stated that only some people can afford to, or are physically able to, travel abroad to Switzerland for an assisted death. Respondents suggested that because of the need to be physically able travel abroad, some people have elected to die earlier than they would otherwise have chosen to so as not be hindered by mobility issues. Others expressed concern regarding the lengths that some people would go to when not able to access AD/AS, such as suicide by their own hands, often alone and without the knowledge of family and loved ones.

Many individuals who disagree with the current law described how they thought the law should be changed. For example, many stated that terminally ill, mentally competent adults in their final months of life should have the choice of an assisted death.⁴⁵⁵ Many also thought that healthcare professionals should be permitted to assist in situations where the individual is physically unable to administer the lethal medication. However, there were different opinions as to whether others, such as family members, should also be able to provide this assistance.

Some respondents stated that AD/AS should be available to mentally competent adults who are not terminally ill but are suffering as a result of a life limiting condition which is not going to improve. For these respondents, there were different opinions as to whether or not this should include mental illness.

Some respondents stated that AD/AS should be available to mentally incompetent adults, who, when competent, had formally set out their wishes for an assisted death at a future time (for example, by creating a legal document called an advanced directive). Many respondents also emphasised the difference between “assisting” someone to die following a specified process with appropriate checks and balances, versus “encouraging” another person’s suicide, the latter of which they considered should remain illegal.

Views on what else respondents would find helpful in the debate

Respondents were asked to select which options from the following list they thought would be helpful to inform the debate on AD/AS. They were invited to select as many options as they wished.

- Citizens’ assembly (a representative group of people who are selected at random from the population to learn about and make recommendations in relation to a particular issue)
- Further independent research
- Referendum (when a question is decided by putting it to a public vote)
- Other, please specify [50 words]

⁴⁵⁵ Note: Over 600 responses used identical language “terminally ill, mentally competent adults in their final months of life”, which is what the campaign group Dignity in Dying advocates for, and some respondents directly referred to Dignity in Dying.

Individuals who agree with the current law most frequently responded “other” followed by “further independent research”. Respondents who disagree with the current law most frequently responded “referendum”, followed by “citizens’ assembly”.

Figure 13: What respondents who stated that they broadly agree with the law on this issue in England and Wales think would be helpful going forward.

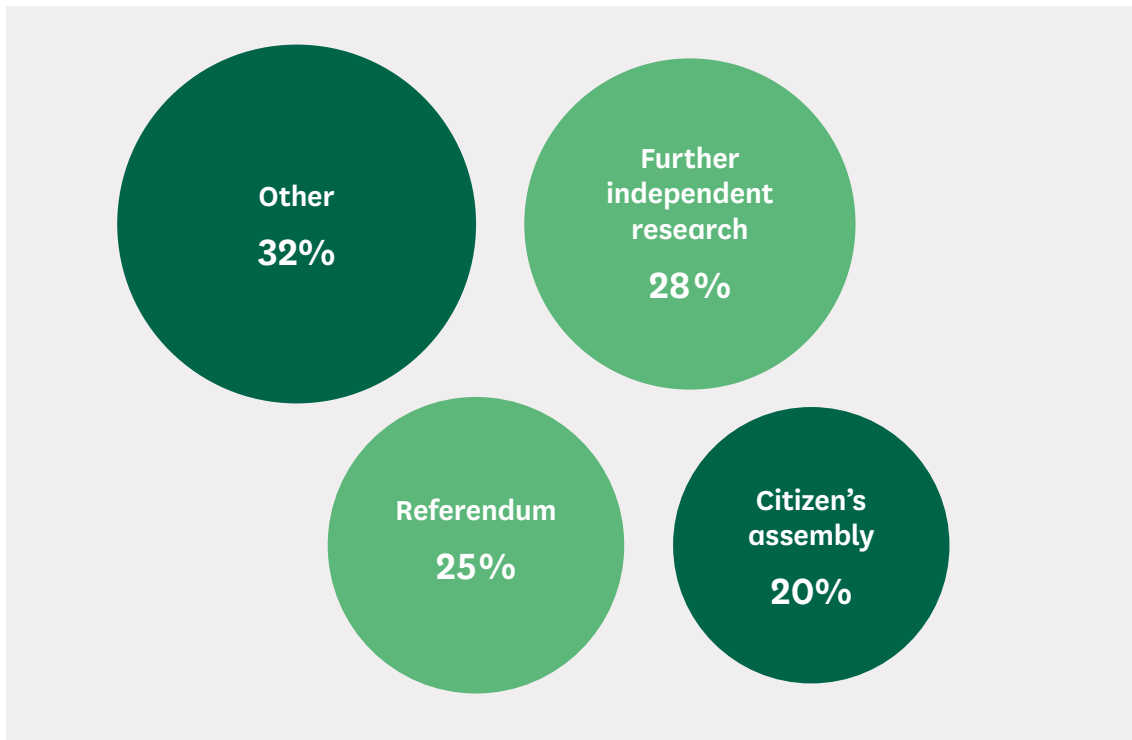
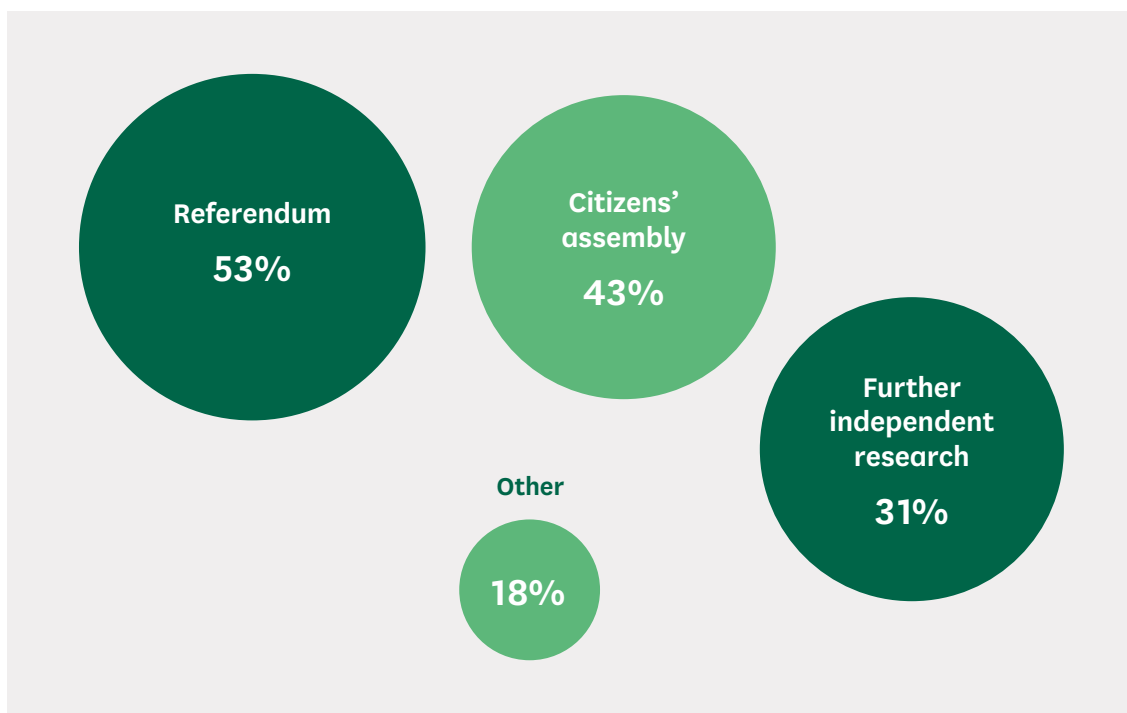


Figure 14: What respondents who stated that they broadly disagree with the law on this issue in England and Wales think would be helpful going forward.



Respondents' suggestions regarding whose voice should be prioritised / listened to

Both groups tended to advocate for the voices of people with lived experience, healthcare professionals and other experts to be prioritised over that of the public and pressure/campaign groups. When considering which groups of people with lived experience should be listened to, individuals who agree with the current law advocated for the voices of vulnerable groups, including disabled people. In contrast, individuals who disagree with the law called for the inclusion of the voices of people dying with terminal illness and their families. Some individuals who agree with the current law also considered that the views of religious groups should be prioritised, whereas some who disagree with the current law felt that the views of religious groups should not be promoted.

Respondents from both groups expressed concern about the over-reliance on the “loudest voices” or snap-shot perspectives of the public, such as a public referendum, when considering the issue. The reason for this was that they thought the general public might not understand the potential ramifications of a change in the law.

Respondents' thoughts on the need for further parliamentary consideration

Some respondents who disagree with the current law called for cross-party cooperation on the issue and for political parties to agree to provide sufficient parliamentary time, to ensure proposed legislation is given the time needed for debate at each stage.

However, many who agree with the current law stated that the law on AD/AS has already been considered multiple times and that further parliamentary consideration would be “fruitless” or was “unnecessary”. Many responses in this group referred to perceived negative consequences in other jurisdictions that permitted AD/AS to demonstrate why further parliamentary consideration was not required. However, a few respondents who agree with the current law stated that it may be beneficial to set up a Joint Committee of both Houses, including experts in PEO LC and disabled people, or to launch an inquiry on what is happening in jurisdictions where it is legal.

Respondents' suggestions for areas for future research

Respondents from both groups also called for further research. However, those who agree with the current law called for research aimed at improving the provision of PEO LC. Whereas those who disagree with the current law called for research into the lived experiences of terminally ill people and their families. In contrast, other respondents who disagree with the current law argued that there was already enough evidence and that calls for further evidence may cause unnecessary delays in changing the law.

Summary

In summary, the form received a huge number of responses which contained wide ranging views. Thematic analysis identified key themes that were raised both by those who agree and those who disagree with the law as it stands. These include the impact on vulnerable groups, current provision of PEO LC, the impact on healthcare systems and professionals

and international comparisons. However, as described above, respondents tended to come at these themes from very different perspectives depending on whether they agree or disagree with the current law.

Many of the themes and opinions summarised here are consistent with other evidence submitted to this inquiry. The responses collected in this form have, along with the written evidence, oral evidence and roundtable discussions all fed into the Committee's consideration on this topic. The Committee would again like to thank all those who have taken the time to provide their view.

Annex 2: Thematic analysis of roundtable transcripts

Background

- We held ten roundtable discussions with three main groups consisting of:
- Healthcare and social care professionals across a range of specialities including palliative care, hospice care and psychiatry.
- Individuals with first-hand lived experience of AD/AS (i.e. seeking or campaigning to access AD/AS for themselves).
- Individuals with second-hand lived experience of AD/AS (i.e. loved ones of people seeking or campaigning to access AD/AS, or individuals who have loved ones who have accessed AD/AS).
- Individuals speaking on behalf of themselves or campaign groups in opposition to or in favour of legalising AD/AS.

We would like to express our gratitude to all those who participated in our roundtables, and who took the time to tell us about their experiences and views. We have drawn upon this testimony frequently throughout the report.

All roundtables were transcribed and anonymised. This thematic analysis was completed using NVivo. NVivo is a qualitative analysis software which uses a machine-based approach to systematically analyse large numbers of responses to identify frequently occurring themes.

This is a summary of some of the main themes identified from the roundtable discussions. Selected quotes are used to illustrate the broader arguments made. The full transcripts are available on the Committee's website: [Assisted Dying /Assisted Suicide - Written evidence - Committees - UK Parliament](#)

Analysis

Theme: Access to palliative care

'Care' was the most frequently mentioned theme. Discussion regarding palliative care often centred around what 'good' or 'excellent' palliative care can achieve, particularly in its role of minimising suffering. Specifically, participants sought to describe 'good symptom control' or 'good palliative care provision' with examples.

Below is a selection of quotes on this topic:

"Despite very good palliative care, dying can still be a very unpleasant experience, let alone the questions of autonomy, dignity, where and when."

"[...] have excellent palliative care at the end of their life, but there are still levels of suffering."

“And palliative care will obviously address, to an extent, the pain issue, but won’t necessarily alleviate it entirely.”

“[...] with good palliative care, it’s not just about good symptom management, I would argue, it’s about the sense of being, sense of dignity, sense of self-esteem, which, when the people come under good palliative care, they start redeveloping again and they started valuing not just life but valuing the dying process as well.”

Several discussions addressed the difference between ‘general’ and ‘specialist’ palliative care services. Some participants argued that people dying without specialist palliative care input can lead to ‘deficits’ in care. For example, geographical disparities in access to 24/7 specialist palliative care input or advice. Below is a selection of quotes on this topic:

“So just looking at my ICS, in the southern part of the county, specialist palliative care is fully NHS funded, with an NHS inpatient unit.”

“My feeling on this is palliative care isn’t good in the area that I live in.”

“If we look at Kent, Surrey and Sussex, you get one palliative medicine consultant to 71,000 heads of population.”

“And I think people who don’t communicate primarily in English, they have a challenge that we face particularly if that is not well recorded and there is not always as good access to interpreting services as there should be for a variety of different reasons.”

Theme: Impact on healthcare practitioners (HCPs)

Some participants discussed how legalising AD/AS, and for it to be offered by healthcare professionals, might affect the clinician-patient relationship. Below is a selection of quotes on this topic:

“Our relationship with health and social care professionals I think would change if they had within the scope of the services that they could offer or suggest, the opportunity to help us die.”

“I think there is... it’s fair to say that something happens which feels akin to moral injury, where healthcare professionals know that there are other parts of the world where this request could be taken seriously but where in the UK, due to legislation, we are unable to really look them in the eye and say, “I would like to try and help you with that”.”

There was discussion about the role of clinicians in assessing a patient’s capacity—with differing views expressed on whether this would be different to the current status quo in the event that clinicians were involved in assessing capacity to pursue AD/AS in England and Wales. Below is a selection of quotes on this topic:

“I was just going to raise the point that we allow people to make the decision now to refuse treatment that will result in their inevitable death, and we are expected to, as medical professionals, make an assessment of their capacity to make that judgment.”

“Whilst someone in another area actually has had access to all of those things and impeccable pain control, and all of that support, and yet they are still, in a balanced way, with capacity saying, “I’d like assisted dying”. So, I think while I’m largely for the principle of people having the right to make the choice, I think there’s just such hugely complex conversations we’ve got to have to really make sure it’s safe and everyone’s well educated.”

“I found it very striking that if an adult goes to the court and asks for a death for themselves, they’re refused. But doctors can go to court and ask to be allowed to withdraw treatment, whether the adult wants that or not, or if the adult doesn’t have capacity themselves, whether the family wants that or not, and the judge can grant an assisted death. By the removal of treatment, you are assisting the death because the person doesn’t die naturally, they are dying because treatment is being removed.”

Theme: vulnerable groups

‘Protection of vulnerable groups’ was often mentioned alongside concerns regarding the impact on healthcare professionals, in the context of their possible responsibility for ‘assessing capacity’ and for ensuring ‘safeguards’ are adhered to. Some participants indicated that they would welcome involvement of healthcare professionals in the process, whereas others suggested that it could fundamentally alter the clinician-patient relationship. This was most frequently mentioned in regard to the impact on people living with disabilities and/or mental health conditions. Below is a selection of quotes on this topic:

“I really wanted to attend today because I’m really aware that many disabled people like ourselves are really fearful of any law that allows assisted death in any way.”

“But when it comes to the mental health care and social care in the UK today I think the idea that it’s good enough for safe assisted dying/assisted suicide law - really it isn’t.”

Some participants were worried that legalising AD/AS for some people could result in a ‘slippery slope’, where more people became eligible as time goes on. This was frequently expressed when participants spoke about concerns for vulnerable groups. Below is a selection of quotes on this topic:

“I’m afraid to say that ... it’s not that there aren’t important things for assisted dying to address and provide safeguards to, there really are, and there’s difficult things, which I’m sure we’ll come on to. But the main arguments of the slippery slope and that the weak and vulnerable will suffer - I believe they’re overblown arguments.”

“I think that what we have seen in jurisdictions across the developed world is changes, legislation getting extended - Participant B mentioned Belgium. You didn’t used to be able to get euthanasia in Belgium if you were under 18

and now you can. I think that that would be inevitable, because that is the nature of legislation - legislation does kind of shift and move and grow and change. And so yes, I think that it's about the slippery slope."

"[...] what you're saying with the slippery slope argument is, "These people must suffer". "Right to die", they say is "duty to die", to which I'd say "No right to die is duty to suffer". And that suffering has to be justified with good evidence which we have now, from the many countries where assisted dying is legal. But this just isn't the case. Yes, there are going to be a few difficult cases. There've been some legal cases in Holland, one or two, there's been the argument in Canada, which is a very difficult question of assisted dying on the grounds of mental illness, which is something probably we need to discuss. But other than that, it seems to work pretty well. We have the evidence. It's no longer a hypothetical issue."

Theme: Role of Government

A significant recurring theme across roundtable groups was the role of Government in relation to the funding of palliative care. Amongst the roundtables with healthcare professionals, there were themes relating to the need for 'better funding for palliative care services', particularly to address 'inequities' in provision of service.

Participants discussed the possible role of the Government in attempting to further the debate, but no consensus emerged across the groups. Below is a selection of quotes on this topic:

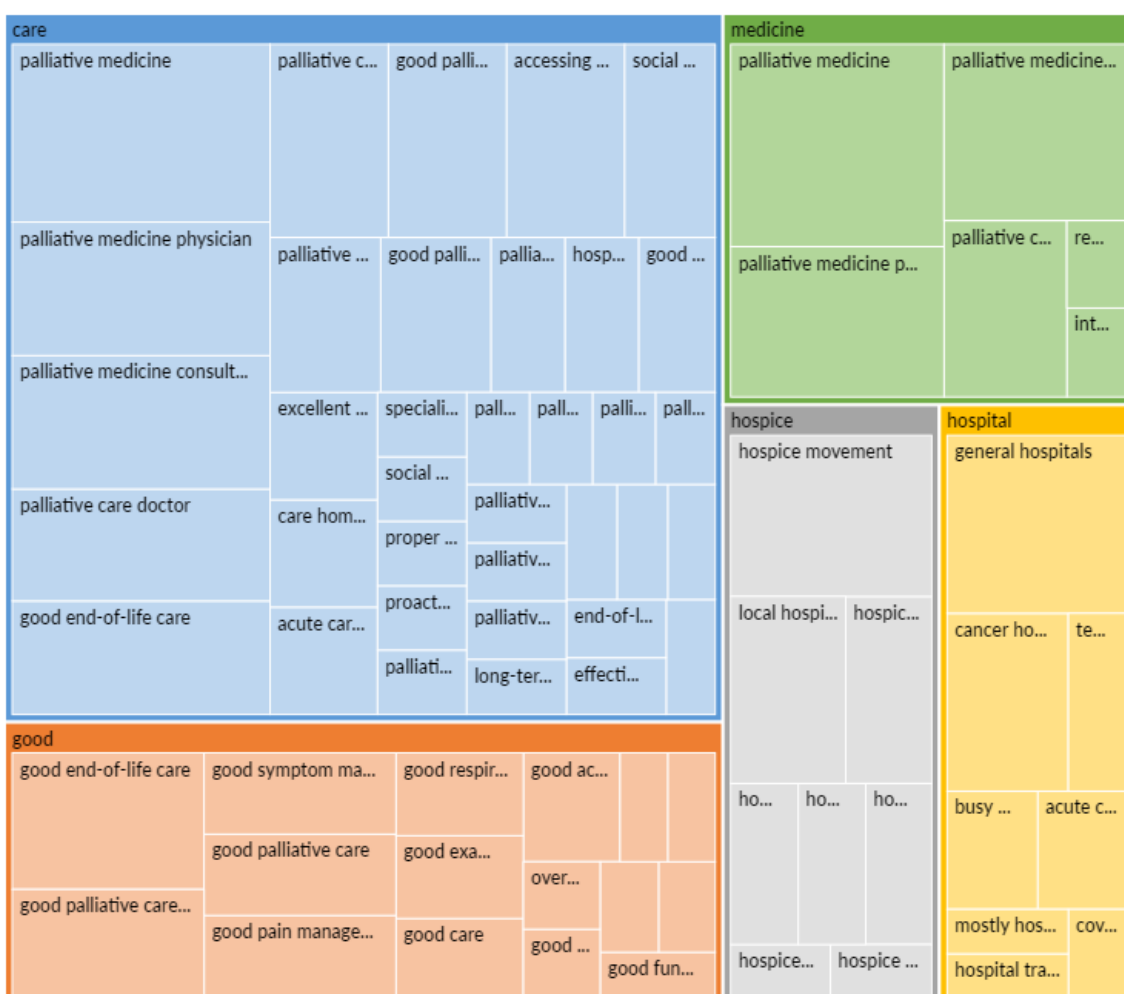
"I think this needs a discourse. We are stuck with the rules of our parliamentary democracy. We are stuck with 30 years of baggage from the recent rounds of court cases and the ever more polarised campaigning for and against. I think we need some kind of intervention that gets us out of this. And if anything, perhaps this might be drawing the canvas too large, the Bill that should be coming forward and perhaps some of the terms of reference for an expert panel of jurists, or citizens' jury of some kind, would probably look at an End-of-Life Bill."

"I don't want to knock MPs, but if you read the Hansard account of the debate against a Bill some years ago, it really was awful on both sides. It really was atrocious. I've read the whole debate. So, I think a citizens' jury à la Macron would be a jolly good idea. And we need a bit of participatory democracy in our country."

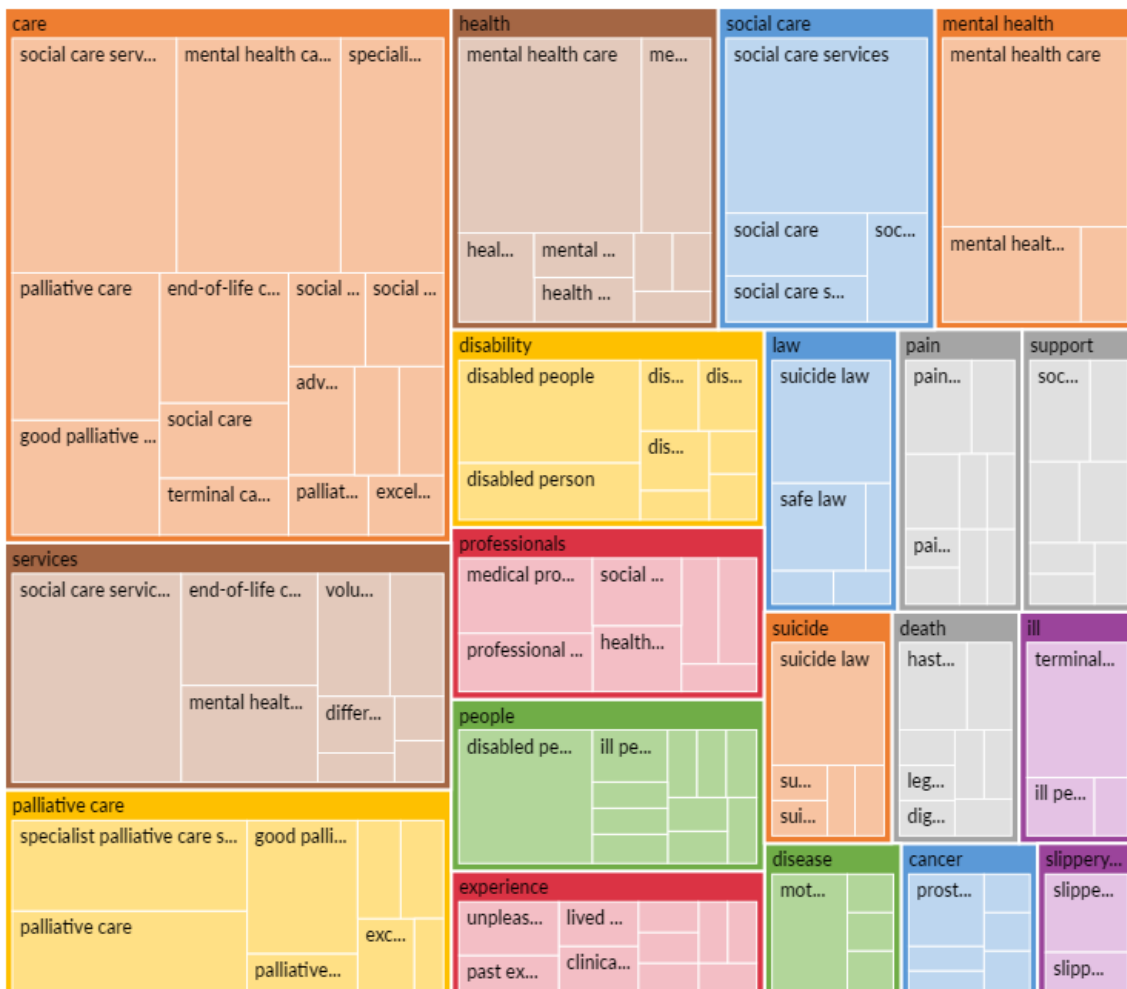
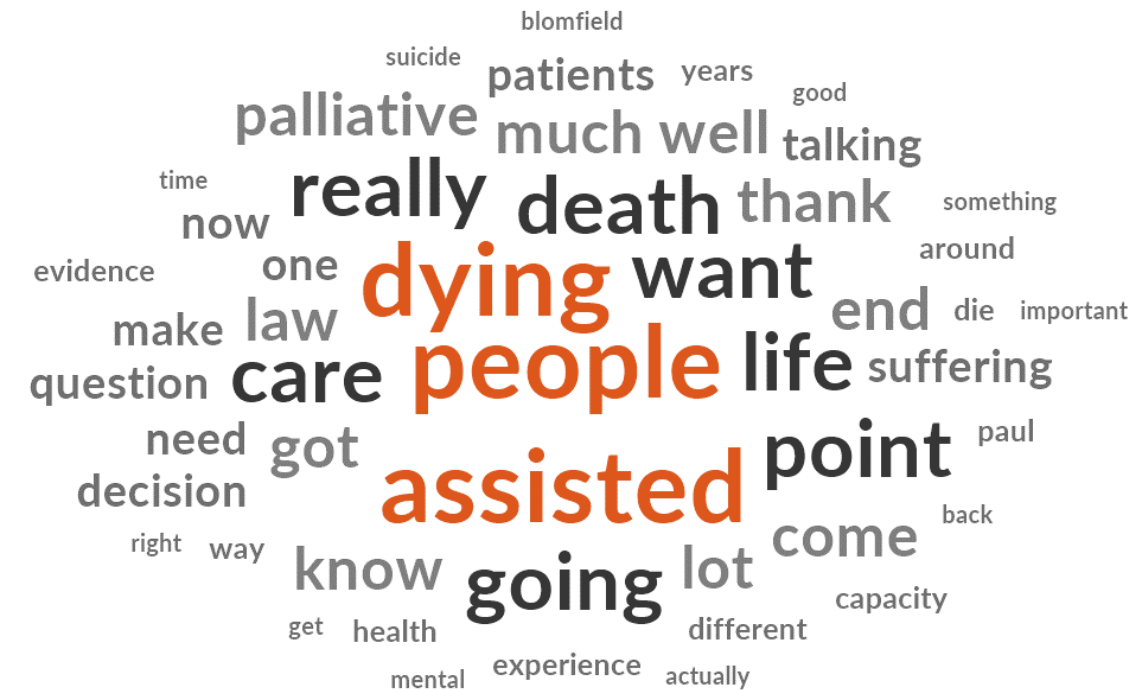
"The debate in this country, it feels to me, is just blocked because what should be second stage, practical issues that can be sorted out, are mobilised to argue against any change of the law at all. Maybe the biggest role the committee could play is by recommending a change of principle and then unleashing what I'm sure will be a huge ferment of activity and planning to work out the 'how'. It's been very frustrating seeing how much shadowy fears and opinions have been used to block change."

Below are a few hierarchical depictions of key themes from roundtables and word clouds to illustrate an overview of the most frequent words/phrases.

Based on responses from health and care professionals:



Based on responses from people with a lived experience of the issue:



Annex 3: Public opinion polling referred to in evidence

Dignity in Dying, a campaign and membership organisation in favour of AD/AS for terminally ill and mentally competent adults, stated in their evidence that there is “consistent and overwhelming public support in this country for a law that enables assisted dying for terminally ill people. This is true regardless of who commissions the poll.” In their evidence Dignity in Dying refer to two polls which they commissioned. The first poll, which they characterised as “the largest poll ever conducted on this issue in Britain”, showed that 84% of respondents “back a safeguarded and compassionate assisted dying law, including 80% of religious people and 86% of people living with a disability.”⁴⁵⁶ This survey was conducted by Populus (now Yonder). The poll was based on interviews with 5,695 adults (over 18 years old) in Great Britain between 22 March and 24 March 2019. On their website Yonder states:

Quotas and weights were used to ensure the sample was representative of the GB adult population. Yonder is a member of the British Polling Council and abides by its rules. Interviews were conducted across Great Britain, with an increased sample level in Scotland, and the results have been weighted to be representative of all British adults.⁴⁵⁷

The second poll referred to by Dignity in Dying is a poll of adults living with an advanced or terminal illness, which showed that 73% of respondents were supportive of a law “to allow mentally competent, terminally ill adults with six months or less to live the option of an assisted death”.⁴⁵⁸ This poll was conducted by YouGov between 30 August and 22 September 2019, and surveyed a sample size of 502 adults who had been diagnosed with cancer, Parkinson’s disease, motor neurone disease, COPD, multiple system atrophy or progressive supra nuclear palsy.⁴⁵⁹ YouGov conducted another survey commissioned by Dignity in Dying on 26 and 27 July 2023, with a sample size of 1844 adults in England and Wales. This poll suggested that 78% support assisted dying if taken to mean “when a terminally ill adult of sound mind can legally seek assistance to end their life via life-ending medication, following the approval of two doctors.”⁴⁶⁰

In their submission *My Death My Decision*, a campaign group also in favour of AD/AS (not only for those who are terminally ill), similarly referred to surveys and polls that they state showed that “a clear majority of the public in England and Wales supports assisted dying.”⁴⁶¹ The polls *My Death My Decision* refer to, in addition to the above mentioned Populus poll, are:

Yonder/Populus poll from 2015 which found that based on a sample of 5018 adults 82% were supportive of AD/AS.⁴⁶²

456 Dignity in Dying ([ADY0418](#))

457 Yonder, ‘[Largest ever poll on assisted dying conducted by Populus \(now Yonder\) finds increase in support to 84% of the public](#)’, accessed 4 December 2023

458 Dignity in Dying ([ADY0418](#))

459 YouGov, ‘[YouGov/Dignity in Dying](#)’, 20 November 2019

460 YouGov, ‘[YouGov / Dignity in Dying Survey Results](#)’, 21 September 2023

461 *My Death My Decision* ([ADY0282](#))

462 Populus, [Dignity in Dying Poll Online Fieldwork 11th-19th March 2015](#), accessed 4 December 2023

The National Centre for Social Research (NatCen) British Social Attitudes (BSA) 2017 survey, which asked respondents “Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient’s life, if the patient requests it?”. 77% of respondents answered “definitely” or “probably should be allowed”. NatCen’s analysis of the data over time concludes that this level of support has remained fairly stable (based on data from 1983 until 2016), but states “It appeared as if there was a slow trend towards increasing support between 1983 and 1994, but that has now halted and the levels of support for voluntary euthanasia are the same in 2016 as in 1983.”⁴⁶³ NatCen has not published further BSA reports on public attitudes regarding euthanasia since this report in 2017.

A YouGov poll of a sample of 1758 UK adults conducted on 23 and 24 June 2021, which found that 73% agreed that the law should be changed to allow doctors to assist in the suicide of someone suffering from a terminal illness, whilst 50% agreed the same should be done someone suffering from a painful, incurable but not terminal illness.”⁴⁶⁴

Some of the evidence we have received criticised the emphasis placed on polls such as those outlined above. Living and Dying Well describes itself as “an independent think tank which examines issues at the end-of-life, including assisted suicide and euthanasia”. Living and Dying Well is not in favour of legalising AD/AS. In its submission Living and Dying Well concludes that there is “poor public understanding of what assisted dying is and what is involved” and refers to a poll they commissioned Survation to undertake in 2021.⁴⁶⁵ This poll was carried out through online interviews with 1032 people on 19 and 20 July 2021. The poll concluded that 42% of respondents thought “assisted dying” meant “Giving people who are dying the right to stop life-prolonging treatment.”⁴⁶⁶

In their evidence, Care Not Killing and Our Duty of Care, two campaign organisations opposed to AD/AS, referred to a 2014 poll which they stated showed that some respondents who were previously in favour of the principle of introducing AD/AS-enabling legislation changed their minds after being presented with some of the arguments against it.⁴⁶⁷ The poll which they refer to was commissioned by Care Not Killing carried out by polling company ComRes, which interviewed 2,055 British adults online between 11–13 July 2014. On Care Not Killing’s website, the organisation draws the following conclusion:

Polls consistently show between 70% and 80% in support of AS. However, the issue is clearly far more complex than a simple ‘support’/‘oppose’ question can do justice to. This polling strongly suggests that when offered evidence about the nature or source of opposition to AS, and some of the key arguments against it, this high level of support rapidly dwindles.⁴⁶⁸

463 NatCen Social Research, [British Social Attitudes 34](#) (2017)

464 YouGov, [‘YouGov - Doctor-assisted suicide’](#), 2021

465 Living and Dying Well ([ADY0488](#))

466 APPG on Dying Well, [‘Survation APPG for Dying Well Survey July 2021’](#), 11 September 2021

467 Care Not Killing (CNK Alliance Ltd) and Our Duty of Care ([ADY0343](#))

468 Care Not Killing, [‘Assisted dying’ & public opinion’](#), 18 July 2014

Formal minutes

Tuesday 20 February 2024

Members present

Steve Brine, in the Chair

Lucy Allan

Paul Blomfield

Paul Bristow

Chris Green

Mrs Paulette Hamilton

Rachael Maskell

James Morris

Assisted Dying/Assisted Suicide

Draft Report (*Assisted Dying / Assisted Suicide*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 10 read and agreed to.

Paragraph 11 read.

Amendment proposed to leave out from “Our aim for this report is” to the end and insert:

“to inform discussion and debate in the next Parliament, as there is insufficient time remaining in the current Parliament to consider legislation. We urge the next Government to find parliamentary time to enable a full debate, recognising the strong and consistent public support for this change which is reflected in the current petition to Parliament. The need for this debate was underlined by the evidence we received on the problems experienced with the current law. We urge Government to conduct a review of the existing legal position and its impact, including its lack of clarity, to assist the future debate.

We have endeavoured to bring together a comprehensive and up-to-date body of evidence relating to this difficult, sensitive, and yet crucial, subject, which we hope will be a useful resource for parliamentarians when debating and voting on this issue. The evidence we heard from other jurisdictions has shown that assisted dying can be introduced safely and successfully, and we have highlighted issues on which we think practice could be improved if introduced in the UK. We have heard evidence from many jurisdictions where the introduction of assisted dying has led to improvements in palliative care, and we would urge more support for those providing it in the UK as part of a comprehensive approach giving people agency and control over their end-of-life journey.”—(Lucy Allan)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 2

Lucy Allan
Paul Blomfield

Noes, 3

Chris Green
Rachael Maskell
James Morris

Question accordingly negated.

Paragraph 11 agreed to.

Paragraphs 12 to 37 read and agreed to.

Paragraph 38 read as follows:

“We understand the view put forward by some who have submitted evidence to us: namely, that the current state of the legislation and 5 guidance for prosecutors on AD/AS in England and Wales is unclear. The current situation means that AD/AS is available for those who are able to travel, and who can afford to pay for it. The status quo not only means some people (who can afford to) travel to Dignitas; it means that some people who break the law as set out in statute in England and Wales by helping them are prosecuted for doing so, whilst others are not. This is at best confusing.”

Amendment proposed to leave out from beginning to end of paragraph 38 and insert:

“A view put forward by some who have provided evidence to us was that the current state of the law is unclear.

During our inquiry we have heard statements from people who have been involved in assisting a loved one to pursue AD/AS abroad.”—(Steve Brine)

Question proposed, That the Amendment be made.

The Committee divided.

Ayes, 3

Chris Green
Rachael Maskell
James Morris

Noes, 2

Lucy Allan
Paul Blomfield

Question accordingly agreed to.

Paragraph 38, as amended and divided, agreed to (now paragraphs 38 and 39).

Paragraph—Paul Blomfield—brought up and read and added to the report (now paragraph 40).

Paragraphs 39 to 65 (now paragraphs 41 to 67) read and agreed to.

Paragraph 66 (now paragraph 68) read.

Amendment proposed, at the end of the paragraph, to add:

“As part of this consideration the Government should review the impact of the current state of the law in this area, in England and Wales. It is crucial that Parliament has all the information it needs to consider this issue and the effect of the current law, going forward.

The Government has stated that it will do its best to assist Parliament in its progress in relation to this debate, within the constraints of maintaining a neutral position on this issue. We call on Government to commission a review of the impact of the existing legislation, including the issues around the lack of clarity, to ensure a future Parliament has robust, accurate, up to date information when debating this issue in future.”—(Lucy Allan)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 2

Lucy Allan

Paul Blomfield

Noes, 4

Chris Green

Paulette Hamilton

Rachael Maskell

James Morris

Question accordingly negatived.

Paragraph 66 (now paragraph 68) agreed to.

Paragraphs 67 to 125 (now 69 to 127) read and agreed to.

Paragraph 126 (now paragraph 128) read.

Amendment proposed, at end to add:

“The graph also illustrates the widening gap between those seeking prescriptions and those using them, highlighting the evidence we heard from several jurisdictions that having agency/control over their death was the most important factor for many people.”—(Paul Blomfield)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 2

Lucy Allan

Paul Blomfield

Noes, 3

Chris Green

Paulette Hamilton

James Morris

Question accordingly negatived.

Paragraph 126 (now paragraph 128) agreed to.

Paragraphs 127 to 139 (now paragraphs 129 to 141) read and agreed to.

Paragraph—Paul Blomfield—brought up and read, amended, and added to the report (now paragraph 142).

Paragraphs 140 to 212 (now 143 to 215) read and agreed to.

Paragraphs—Paul Blomfield—brought up and read, amended, and added to the report (now paragraphs 216 to 218).

Paragraphs 213 to 302 (now paragraphs 219 to 308) read and agreed to.

Annexes 1 to 3 read and agreed to.

Resolved, That the Report, as amended, be the Second Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Monday 4 March at 4.00 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 28 March 2023

The Baroness Finlay of Llandaff; The Rt Hon. the Lord Falconer of Thoroton; The Baroness Meacher; The Baroness Hollins

[Q1–43](#)

Dr Naomi Richards, Senior Lecturer in Social Science and Director of the Glasgow End of Life Studies Group, University of Glasgow; **Dr Alexandra Mullock**, Senior Lecturer in Healthcare Law and Co-Director of the Centre for Social Ethics and Policy, University of Manchester; **Professor Nancy Preston**, Professor of Supportive and Palliative Care, University of Lancaster

[Q44–80](#)

Tuesday 16 May 2023

The Hon Kyam Maher MLC, Minister for Aboriginal Affairs, Attorney-General, and Minister for Industrial Relations and Public Sector, Government of South Australia; **Professor Brian Owler**, Consultant Neurosurgeon at the Children's Hospital, Westmead, the Sydney Adventist Hospital, Norwest Private Hospital and Westmead Private Hospital; **Dr Gary Gheung**, Associate Professor & Old Age Psychiatrist, Department of Psychological Medicine, University of Auckland; **Professor Roderick MacLeod former Senior Consultant and Senior Medical Specialist in Palliative Care**

[Q81–115](#)

Dr Chandana Banerjee, Associate Professor Hospice & Palliative Medicine, City of Hope National Medical Center; **Dr Lydia Dugdale**, Director, Center for Clinical Medical Ethics, Columbia Vagelos College of Physicians & Surgeons, Columbia University

[Q116–140](#)

Tuesday 06 June 2023

Professor Irene Tuffrey-Wijne, Professor of Intellectual Disability and Palliative Care, Kingston University London; **Professor Jan L Bernheim**, Oncologist, Emeritus Professor of medicine and medical ethics, End of-Life Care Research Group, Vrije Universiteit Brussels; **Professor Rutger Jan van der Gaag**, Professor of Psychosomatic Medicine and Psychotherapy, Emeritus Professor of Psychiatry and former President, Royal Dutch Medical Association

[Q141–161](#)

Professor James Downar, Professor and Head, Division of Palliative Care, University of Ottawa; **Professor Trudo Lemmens**, Professor and Scholl Chair in Health Law and Policy, Faculty of Law, University of Toronto; **Dr Scott Kim**, Adjunct Professor Psychiatry, University of Michigan; Senior Investigator, Department of Bioethics at National Institutes of Health USA

[Q162–180](#)

Tuesday 27 June 2023

Dr Georg Bosshard, Practicing geriatrician and nursing home physician, reader for clinical ethics, University of Zürich; **Dr Yvonne Gilli**, President, Swiss Medical Association (FMH); **Professor Samia Hurst-Majno**, Professor of Biomedical Ethics, University of Geneva, and member of the Swiss National Advisory Commission on Biomedical Ethics

[Q181–209](#)

Silvan Luley, Team member, DIGNITAS - To live with dignity - To die with dignity; **Bernhard Sutter**, Director, EXIT (Deutsche Schweiz)

[Q210–236](#)

Tuesday 04 July 2023

Dr Paul Perkins, Chief Medical Director, Sue Ryder; **Dr Matthew Doré**, Honorary Secretary, Association for Palliative Medicine of Great Britain and Ireland; **Jonathan Ellis**, Director of Policy, Advocacy & Clinical Programmes, Hospice UK [Q237–278](#)

Helen Whately MP, Minister of State, Department of Health and Social Care; **Professor Stephen Powis**, National Medical Director, NHS England [Q279–300](#)

Published written evidence

The written evidence related to this report can be viewed on the [inquiry publications page](#) of the Committee's website.

Please note that the written evidence and roundtable transcripts contain details that some readers might find distressing.

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2023–24

Number	Title	Reference
1st	Prevention in health and social care: healthy places	HC 484
1st Special	NHS Dentistry: Government Response to the Committee's Ninth Report of Session 2022–23	HC 415

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
2nd	The impact of body image on mental and physical health	HC 114
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
4th	The future of general practice	HC 113
5th	Pre-appointment hearing with the Government's preferred candidate for the role of Chair of HSSIB	HC 843
6th	Follow-up on the IMMDS report and the Government's response	HC 689
7th	Integrated Care Systems: autonomy and accountability	HC 587
8th	Digital transformation in the NHS	HC 223
9th	NHS Dentistry	HC 964
10th	Prevention in health and social care: vaccination	HC 1764
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112
4th Special	Evaluation of Government commitments made on the digitisation of the NHS	HC 780
5th Special	Government Response to the Committee's Report on Follow-up on the IMMDS report and the Government's response	HC 1286

Number	Title	Reference
6th Special	Government Response to the Committee's Report on Workforce: recruitment, training and retention in health and social care	HC 1289
7th Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce: Government Response	HC 1290
8th Special	Government Response to the Health and Social Care Committee's Expert Panel: evaluation of Government's commitments made on the digitisation of the NHS	HC 1313
9th Special	The future of general practice: Government Response to the Committee's Fourth Report	HC 1751
10th Special	Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England	HC 1310
11th Special	Digital transformation in the NHS: Government Response to the Committee's Eighth Report	HC 1803
12th Special	Government Response to the Committee's Report on Prevention in Health and Social Care: vaccination	HC 1891
13th Special	Government Response to the Health and Social Care Committee's Expert Panel: Evaluation of Government's commitments in the area of the pharmacy in England	HC 1892

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740

Number	Title	Reference
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311