

## **Written evidence submitted by Dignity in Dying (ADY0418)**

### **Summary**

Dignity in Dying is a campaign and membership organisation. We believe that everybody has the right to a good death, which includes terminally ill, mentally competent adults having the option of an assisted death.

We welcome this inquiry and the emphasis on examining different perspectives in the assisted dying debate. We believe particular weight should be given to the views and experiences of dying people and their loved ones.

There is clear evidence that the blanket ban on assisted dying, created by section 2(1) of the Suicide Act 1961, has failed and given rise to a number of unintended consequences that inflict an unacceptable degree of harm on dying people, their loved ones and health and care professionals. Evidence also shows that no amount of palliative care will negate public demand for a change in the law.

Over the last 25 years a growing number of jurisdictions around the world have reformed their legal frameworks in this area by implementing safeguarded assisted dying legislation. These laws are proven to offer greater choice to dying people while also improving the safety and effectiveness of end-of-life care. There is momentum towards a change in the law in jurisdictions across the British Isles and neighbouring countries.

### ***Public support***

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. The largest poll ever conducted on this issue in Britain shows that 84% of the public back a safeguarded and compassionate assisted dying law, including 80% of religious people and 86% of people living with a disability.<sup>1</sup> 73% of adults living with advanced or terminal illness support say they would support a law to allow mentally competent, terminally ill adults with six months or less to live the option of an assisted death.<sup>2</sup>

### ***Language***

We note that the title and content of this inquiry refers to 'assisted dying/assisted suicide'. These terms are not interchangeable and when referring to assisted dying for those at the end of life 'assisted suicide' is inaccurate.

The American Association of Suicidology (AAS), a non-profit association dedicated to the understanding and prevention of suicide, has a position statement which explains the ways in which assisted dying 'is distinct from the behavior that has been traditionally and ordinarily described as "suicide," the tragic event our organization works so hard to prevent.' The AAS has suggested that the phrase physician assisted suicide 'should be deleted from use.'<sup>3</sup>

Majorie Wallace, CEO of SANE, a leading UK mental health charity, has argued that assisted dying and suicide are distinct and that 'conflating the two issues risks doing a disservice both to suicide prevention and to end-of-life care.'<sup>4</sup>

The Government of Jersey's consultation on assisted dying proposals includes as a key principle the statement that 'Assisted dying is not suicide or assisted suicide'.<sup>5</sup> In 2015, an attempt to amend Lord Falconer's Assisted Dying Bill to include the term assisted suicide was rejected by peers.<sup>6</sup>

Research interviews conducted for Dignity in Dying's report *Last Resort: The hidden truth about how dying people take their own lives in the UK*, highlight how these positions align with the views of dying people. One interviewee whose parent wanted an assisted death said: 'My mum wasn't suicidal, the option of living had already been taken away.'<sup>7</sup> Sandy Briden, who campaigned for a change in the law after her diagnosis of terminal sarcoma said: 'suicide is the choice between living and dying. I don't have a choice.'<sup>8</sup> Dr Ryan Spielvogel, a provider of assisted dying in California, USA, wrote in 2022 that: 'In five years and the dozens of cases in which I have participated, I have yet to meet a patient who wants to die. They would gladly relinquish the opportunity for more pain-free time with their loved ones, but that's a choice they don't have.'<sup>9</sup>

For clarity and accuracy we urge the Committee to adopt the term assisted dying when referring to dying people being provided with the legal option to control the manner and timing of their deaths.

### Response to the 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?**

Dignity in Dying believes everybody should have the death that is right for them. This includes dying people having the option of assisted dying subject to robust safeguards, but it also means that all dying people should have access to appropriate care. Parliament should address both these issues concurrently.

In 2019, Dignity in Dying publicly supported Baroness Finlay of Llandaff's Access to Palliative Care Bill and Bambos Charalambous MP's Terminal Illness (Provision of Palliative Care and Support for Carers) Bill, both which sought to improve the ways in which palliative care is commissioned and funded.

Dignity in Dying will always support initiatives that seek to improve the quality and provision of palliative care. However, the Committee should be clear that this will not negate any of the arguments for assisted dying nor reduce demand for a change in the law.

We know that even in specialist palliative care settings suffering cannot be relieved in a small but significant number of cases. The Office of Health Economics conservatively estimates that even if everyone in the UK had access to the level of care available in hospices, over 6000 people would die with unrelieved pain in the last three months of life.<sup>10</sup>

Pain is just one symptom that many dying people find intolerable. Our report, *The Inescapable Truth: How seventeen people a day will suffer as they die*, uncovered a range of symptoms that dying people, bereaved relatives and palliative care specialists had experience of which could not be managed satisfactorily, including extreme nausea and vomiting, constipation, faecal vomiting, rectovaginal fistula, terminal haemorrhages and fungating wounds.<sup>11</sup> The following quotes are from qualitative interviews conducted by Professor Bronwyn Parry and Dr Sally Eales that were used to inform that report:

‘One of the most distressed patients I have ever seen in my life was a man who had had a penile cancer. His penis had been removed and he was left with a big open hole directly into his bladder. He was a very gentle person. He was begging to have his life ended because it had absolutely no meaning [to him]. He was also in pain, but that was not the main thing; it was the utter degradation. I felt so helpless. We could do nothing about that.’ *Palliative care consultant*

‘[The hospice staff] kept saying that she wouldn’t be in pain. She was in pain. She was crying and sometimes she was yelping like a dog. She kept saying, “Nobody told me it would be like this.”’ *Bereaved sister*

‘I think the people who are vocally against a change in the law knowingly miss the point. Because fundamentally it comes down to the fact that there is a group of people who will want this, and who will want to have the option of it. So the argument about how you should fund palliative care more. You should. We can treat the vast majority of symptoms, but that’s missing the point completely.’ *Palliative care consultant*

Experience overseas shows how the legalisation of assisted dying can be a catalyst for improving palliative care. A 2018 report commissioned by Palliative Care Australia concluded there was ‘no evidence to suggest that palliative care sectors were adversely impacted by the introduction of [assisted dying] legislation. If anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced.’<sup>12</sup> In 2022, assisted dying legislation in New South Wales was accompanied by a £400 million investment in palliative care services.<sup>13</sup> The Government in Victoria took similar action in 2017.<sup>14</sup> Baroness Finlay, a palliative care specialist who campaigns against assisted dying, has acknowledged that palliative care services in places where assisted dying is legal have received additional funds.<sup>15</sup> Claims that there has been disinvestment in palliative services in places where assisted dying is legal are false and unsubstantiated.<sup>16</sup>

Palliative care services have not just benefited financially from the implementation of assisted dying. Research in the USA has found law change has led to doctors improving their skills in end-of-life pain management and increased their confidence in caring for other dying people.<sup>17</sup> 25 years after assisted dying came into effect in Oregon, the State still ranks amongst the best performing US States when it comes to access to palliative care.<sup>18</sup> Over 90% of people who have had an assisted death in Oregon have been enrolled in hospice care; in 2021 this figure was 97.5%.<sup>19</sup> There is no evidence to suggest dying people are accessing assisted dying due to a lack of access to palliative care.

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

There are over 25 jurisdictions around the world that have passed some form of assisted dying legislation, covering a population of 250 million people. A full list of these can be found in Appendix A. It is clear from these jurisdictions that permitting the option of assisted dying is safer, more compassionate and more rational than banning it.

The absence of safeguarded, meaningful end-of-life choice in this country forces many dying people to take matters into their own hands. This happens with relatively little oversight and no formal, upfront safeguards.

Because there is no effective monitoring of the current law UK authorities do not have access to exact data, though it is estimated that one Briton a week travels to Switzerland for an assisted death.<sup>20</sup> Dignitas (one of several organisations in Switzerland that provides services to non-Swiss residents) reports 391 British citizens were assisted to die with support of its services between 2009 and 2021.<sup>21</sup> Yet in almost the same period the Crown Prosecution Service considered just 174 cases of assisted suicide.<sup>22</sup> Therefore we can conclude over half of cases where a British person has received assistance to die overseas have not been fully investigated. Investigations that do take place happen after someone has died, when it is too late to determine their capacity or to ensure that they were made aware of all their alternative options, and too late to protect or prevent abuse in any case. This gap in our knowledge of current practice cannot be resolved without transparent legislation that contains clear, upfront safeguards. It is inconsistent to argue against a change in the law because of speculation of risk, while also arguing that the status quo is adequate.

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.

‘I want to impress upon you the anguish me and my family have experienced, not because of this awful illness (though of course this has been incredibly difficult), but because of the law against assisted dying in this country. The blanket ban on assisted dying has not only forced me to spend thousands of pounds and endure months of logistical hurdles in order to secure a peaceful and dignified death overseas, but it has meant that my final weeks of life have been blighted by visits from social services and police. The law in this country robbed me of control over my death. It forced me to seek solace in Switzerland. Then it sought to punish those attempting to help me get there. The hypocrisy and cruelty of this is astounding.’  
*Geoffrey Whaley, letter to MPs, 7 February 2019, sent shortly before his death at Dignitas*<sup>23</sup>

A further consequence of banning assisted dying is that terminally ill people, faced with a lack of meaningful choice, find other means of controlling the manner and timing of their deaths. Analysis by the Office for National Statistics that shows people with severe and potentially terminal health conditions are more than twice as likely to take their own lives than a matched control group.<sup>24</sup> Dignity in Dying estimates that up to 650 dying people end their own lives in this country every year, often in ways that are violent, unsafe and damaging to those who are left behind.

‘I rang his neighbour and I said, ‘Would you mind just popping round and knocking on the window?’ He said okay and I spoke to his wife and had a chat. He came back and he was almost hysterical. He said ‘Oh my god. I’ve got to call the police.’ He put the phone down but then rang back immediately, ‘He’s left a note on the front door.’ The note said *Call the police. I’ve taken my own life. I’m in the garage. Do not come in.* And of course he got the other neighbour and they did go in and I don’t think they’ve ever got over it. He’d hanged himself.’ *Barbara Wall, whose father, Charlie died by hanging aged 95 with terminal oesophageal cancer*<sup>25</sup>

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.<sup>26</sup> 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.<sup>27</sup>

Safe and effective operation of laws has led many people to reassess their view on assisted dying. As a private citizen Senator Ron Wyden voted against Oregon's Death with Dignity Act in ballot measures that were held in 1994 and 1997. In 2006 he testified before the U.S. Senate Committee on the Judiciary's Subcommittee on the Constitution, Civil Rights and Property Rights in support of assisted dying. He said:

*Opponents have combed through the law looking for possible pitfalls to exploit. However, the law still stands. During the eight years the law has been in effect, its opponents have warned there would be abuses and a stampede to Oregon. The law has not been abused. [...] While I do not know how I would vote if the issue were to appear on the Oregon ballot once more, I believe it is time for me to acknowledge that my fears concerning the poor elderly were thankfully never realized [...] For the citizens of Oregon, the Death With Dignity Act has brought about improvement in many areas and encouraged conversations that many would never have had otherwise. For many, it has brought a small measure of peace of mind, knowing that they can remain in control of their lives if they choose to do so. In Oregon, the end of life process has been decriminalized.<sup>28</sup>*

Disability Rights Oregon has never received a complaint from anyone concerned about the negative impact of Oregon's assisted dying law.<sup>29</sup> The Oregon Hospice and Palliative Care Association had campaigned against the law but now 'supports the rights of Oregonians to choose or not to choose any and all legal end-of-life options', including the option of an assisted death.<sup>30</sup>

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

The World Medical Association's Declaration of Geneva outlines the ethical principles that underpin modern medicine. It was designed to replace the archaic and often misquoted Hippocratic Oath.<sup>31</sup> In 2017 the Declaration of Geneva was amended to place more emphasis on self-determination, including the addition of the following pledge: 'I will respect the autonomy and dignity of my patient'.<sup>32</sup> Concerns about what impact a change in the law might have on the patient relationship are speculative and unwarranted; 93% of people say an assisted dying law would either increase or have no effect on their trust in doctors.<sup>33</sup>

In this context there is no conflict between greater end-of-life choice and the ethics of the medical profession, evidenced by the fact that there are doctors participating in assisted dying laws and supporting their patients in every jurisdiction where it is legal, and they do so with support from professional organisations,<sup>34</sup> regulatory frameworks<sup>35</sup> and relevant government departments.<sup>36</sup> Experience also suggests the views of individual healthcare professions evolve over time. Dr Sandy Buchman, Freeman Family Chair in Palliative Care, North York General Hospital, Toronto, Ontario and former President of the Canadian Medical Association, once believed assisted dying was 'anathema' to his role as a doctor but when encountered with requests from his patients came to realise it was 'the most patient centred service [he] could offer.'<sup>37</sup>

Medical opinion in the UK is increasingly favourable to assisted dying. The British Medical Association (BMA)'s survey on assisted dying, the largest of its kind, found more doctors personally support a change in the law on assisted dying (50%) than oppose it (39%). Medical students, retired doctors and practising doctors were all more likely to support assisted dying than oppose it and in every branch of practice a majority of doctors voted for the BMA to drop its opposition to assisted dying.<sup>38</sup> The Royal College of Physicians<sup>39</sup> is neutral on assisted dying as is the Royal College of Nursing<sup>40</sup> and the majority of members of the Academy of Medical Royal Colleges.

Most healthcare professionals do not see a clear ethical distinction between assisted dying and existing end-of-life practices. Only 24% of healthcare professionals think refusing treatment to bring about death is more ethical than giving people the option of an assisted death.<sup>41</sup>

Conscientious objection must be an important feature of assisted dying legislation in UK and is already present in end-of-life practices. The General Medical Council provides guidance on how doctors can 'withdraw from providing care if [their] religious, moral or other personal beliefs about providing life-prolonging treatment lead [them] to object to complying with: (a) a patient's decision to refuse such treatment.'<sup>42</sup> Developing assisted dying legislation that respects an individual doctor's personal beliefs without unduly affecting the autonomy of their patients would be possible by mirroring existing provisions.

Many doctors are already assisting people to die in this country and we recommend the Committee considers the ethical implications of the existing legal framework. 62% of healthcare professionals believe there are circumstances in the UK in which doctors or nurses have intentionally hastened death as a compassionate response to a patient's request to end their suffering.<sup>43</sup> A 2009 survey of doctors found that 28.9% had made decisions involving providing, withdrawing or withholding treatment that they expected would hasten the death of a person under their care. A further 7.4% reported they had made decisions with, to some degree, the intention to hasten a person's death. These decisions were more likely to be made when responding to a person's request for a hastened death.<sup>44</sup>

At present the General Medical Council<sup>45</sup> and BMA<sup>46</sup> state that doctors are permitted to provide a person with their medical records even if they know the person will use them to access assisted dying services overseas. However, they advise doctors are not permitted to write a tailored medical report for that person as this would be considered assisting them to end their own lives. Dignity in Dying has been alerted to the fact that medical indemnity organisations often advise doctors not to give a person access to their medical records if they know they will be used to access assisted dying services overseas. We recommend the Committee investigates this issue as a matter of urgency to ensure consistent practice. Nevertheless, that so many people from this country have accessed assisted dying overseas with the necessary documentation required to make an application illustrates the medical profession already plays a role in assisted dying, just in a way that lacks ethical and legal clarity.

An ethical and legal framework for assisted dying would provide transparency and up front safeguards to better protect individuals and those who care for them.

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

Dignity in Dying believes assisted dying should be an option for dying adults who have a terminally physical illness and mental capacity.

As illustrated in Appendix A, a majority of assisted dying laws in place around the world are for terminally ill, mentally competent adults. No assisted dying laws introduced with these criteria have ever been extended beyond their initial scope.

The Committee should be aware that assisted dying and voluntary euthanasia laws around the world that are accessible to people who are not dying have been broader from the outset. In the Benelux countries this is thought to have reflected existing societal values and clinical practices.<sup>47</sup> In Canada, the 2015 judgement in the Carter case struck down the prohibition on assisted dying and tasked Parliament with developing legislation.<sup>48</sup> Neither the scope of the Carter judgement nor the subsequent legislation in Canada were ever limited to terminally ill people.

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

Protection from coercion must be a key element of assisted dying proposals but this is not unique to assisted dying. Given the fact that people from potentially vulnerable groups are underrepresented in the numbers of people who access assisted dying where it is legal,<sup>49</sup> it is arguably more of a challenge for other end-of-life practices where there is relatively little monitoring or oversight. The answer to coercion is to make practice safer; it is not to unduly deny people the right to make decisions about their own lives.

The Association for Palliative Medicine (APM) has published guidance for professionals on the withdrawal of assisted ventilation at the request of a patient with motor neurone disease (MND). When someone with MND requests the withdrawal of assisted ventilation they are doing so knowing that this will lead to their death, therefore good practice in this area will have many similarities to assisted dying, including doctors being alert to any signs of coercion. The APM's guidance states: 'Discussion of factors leading to the decision to stop assisted ventilation should be open, without coercion and thorough, seeking to identify any potential for alternative decisions'. It goes on: 'The rationale for the decision to proceed with withdrawal and the process for the evaluation of the decision should be clearly documented. This may include [...] That there is no coercion, nor is the decision driven by mistaken kindness to the family'.<sup>50</sup>

The Department of Health in Victoria, Australia provides training to doctors on all aspects of the assisted dying process. When addressing coercion, the training states: 'We, as doctors, should already be alert to coercion in a range of healthcare decision scenarios, for example which treatment, if any, should a patient undergo and whether surgery is the best option for a particular condition.'<sup>51</sup>

As highlighted above, in the absence of safeguarded choice dying people are turning to a range of options which have very little oversight. A legal framework for assisted dying, with mandatory assessments by two independent doctors means that people would be far better protected from coercion under a change in the law than they are under the status quo. Checks for coercion under an assisted dying law could build on best practice in other types of end-of-life decision-making already used here in the UK, such as the APM's guidance noted above, and from jurisdictions with assisted

dying laws in place. We strongly recommend that any proposed assisted dying legislation – and guidance and regulations that accompany it – instructs assessing doctors to refer individuals to an appropriate specialist if they needed further reassurances about the nature of the person’s request.

It is important that the Committee recognises that coercion is multifaceted and protections must also be in place to prevent people from being coerced out of making an assisted dying request. Queensland’s Voluntary Assisted Dying Act (2021) makes direct reference to this by creating an offence around coercion: ‘A person must not, dishonestly or by coercion, induce another person to make, or revoke, a request for access to voluntary assisted dying.’<sup>52</sup>

### **What capabilities would a person need to be able to consent to assisted dying /assisted suicide?**

Ensuring people have the mental capacity to make a request for assisted dying is a crucial safeguard in the assisted dying process. At present clinicians are routinely required to assess whether or not a person has capacity in a range of decision-making scenarios, including ones that can lead to a person’s death, for example the refusal of life-sustaining treatment. We believe this is an appropriate and workable safeguard in any assisted dying legislation.

### **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?**

In addition to having the mental capacity to make a request for assisted dying people should also be informed of their alternative care options, such as specialist palliative care; given accurate information of their condition and prognosis; given an explanation as to how their condition is likely to progress, including the symptoms they might experience, the treatments available to relieve these and the likely affect of these treatments.

Assisted dying legislation that is currently in place around the world sets out what information a person must be given to ensure their request for assisted dying is informed. For example, legislation in Victoria, Australia, sets out the forms that both the co-ordinating and consulting doctors must complete, which both include the following declaration:

*I have provided the person being assessed with the following information and I am satisfied that the person understands this information—*

*(a) the person's diagnosis and prognosis;*

*(b) the treatment options available to the person and the likely outcomes of that treatment;*

*(c) palliative care options available to the person and the likely outcomes of that care;*

*(d) the potential risks of taking a poison or controlled substance or a drug of dependence likely to be prescribed under this Act for the purposes of causing the person's death;*

*(e) that the expected outcome of taking a poison or controlled substance or a drug of dependence likely to be prescribed under this Act is death;*



*(f) that the person may decide at any time not to continue the request and assessment process;*

*(g) that if the person is receiving ongoing health services from a registered medical practitioner other than the co-ordinating medical practitioner, the person is encouraged to inform the registered medical practitioner of the person's request to access voluntary assisted dying.<sup>53</sup>*

A similar level of information is present in the NHS's definition of what constitutes 'informed' in its overview of consent to treatment: 'the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead.'<sup>54</sup>

### **What should the Government's role be in relation to the debate?**

Successive Governments have taken a neutral position on assisted dying, as is customary in issues of conscience. While this is a defensible position to take in terms of the rights and wrongs of assisted dying, we believe that Government does have a role in terms of gathering evidence and ensuring that time is given to ensure that debates on legislation can take place.

In 2014, Lord Falconer of Thoroton's Assisted Dying Bill was passed at Second Reading. It was granted two days of debate at Committee Stage but a significant number of amendments were tabled, the vast majority of which had been tabled by those who were known opponents of assisted dying.<sup>55</sup> Despite two clear votes in support of the Bill at Committee Stage, the Bill was not granted further time for debate and fell at the end of the session. Baroness Meacher's Assisted Dying Bill in 2021 also passed at Second Reading but there were no further days for debate in Committee. With nearly 200 amendments tabled to that Bill,<sup>56</sup> it would have been almost impossible for the Bill to have completed its Committee Stage under the usual allocation of time to Private Members' Bills (PMBs).

It is obvious that an issue with such public interest and passionate support on both sides cannot be legislated upon as other, less contentious PMBs; even with support at Second Reading, a Committee Stage would undoubtedly require many days and the number of sitting Fridays does not meet this demand. The ballot system in the House of Lords ensures that there is only a limited chance (as there was in 2021 but not in 2022) that a bill on assisted dying will receive an allocation of time for Second Reading, while the House of Commons system requires an MP to volunteer to bring forward legislation with the anticipation and expectation that it will not become law unless Government time is given to it.

As with previous PMBs on high-profile matters of conscience – for example the legalisation of abortion and the decriminalisation of homosexuality – we believe that Government must guarantee time for full debate on an assisted dying bill if it is not prepared to introduce legislation of its own. Such a position was, we believe, indicated in a Westminster Hall debate in July 2022, when Justice Minister James Cartlidge said: 'If, at a future date, it became the clearly expressed will of Parliament to amend or change the criminal law so as to enable some form of assisted dying, the Government would of course undertake the role of ensuring that the relevant legislation was delivered as effectively as possible.'<sup>57</sup> It is unclear at present what is necessary for a demonstration of the 'clearly

expressed will of Parliament’, i.e. whether it requires an affirmative vote at Second Reading of a bill, or a vote on a motion or on an amendment.

Outside of legislation, we believe it is right and proper for Government to conduct research on the issues relating to assisted dying. Former Health Secretary Matt Hancock said in November 2020 that the Government ‘would consider collecting data on assisted dying if it was felt that that would improve and contribute to a sensitive debate in Parliament on this subject’<sup>58</sup> and later requested data from the Office of National Statistics on suicides amongst people with a terminal illness.<sup>59</sup> There is much more data, for instance on the numbers of UK citizens who end their own lives in countries with assisted dying laws, that is unknown or only partially known. Data that was previously collected on bereaved relatives’ experience of their loved ones’ final days (the VOICES survey) would also enable Parliament to have a good understanding of the limits of palliative and end-of-life care if it were to be reinstated and expanded. We urge the Committee to recommend to Government that this data is collected routinely and presented to Parliament.

Finally, the realistic prospect that assisted dying laws will change in Scotland, Jersey and the Isle of Man before the end of this Parliament will require Government to consider what mechanisms it should have in place in order to facilitate the operation of assisted dying laws in those jurisdictions where there are reserved powers such as regulation of health and care professionals.

Polling commissioned to inform this response found that a clear majority of the public want the Committee to recommend the Government take positive steps towards assisted dying reform as an outcome of the inquiry.<sup>60</sup> Just 3% of respondents said the Committee should recommend the Government take no action. The preferred actions that Government should take include putting forward a Government Bill (36%), making Parliamentary time for a free vote (25%), gathering more evidence before proceeding to a vote (22%), and establishing a citizens’ assembly to consider the issue (18%). Just 4% of those polled said the Committee should recommend the Government actively opposes the legalisation of assisted dying.

## **Appendix A: Jurisdictions that allow or have passed some form of assisted dying legislation, or are considering proposals**

### ***Jurisdictions where eligibility criteria includes explicit reference to terminal illness***

Australia:

*South Australia*

*Western Australia*

*Tasmania*

*Victoria*

*Queensland*

*New South Wales*

New Zealand

USA

California  
Colorado  
Hawaii  
Maine  
Montana  
New Jersey  
New Mexico  
Oregon  
Washington DC  
Washington State  
Vermont

***Jurisdictions where eligibility criteria is explicitly broader than terminal illness or undefined***

Belgium  
Canada  
Colombia  
Luxembourg  
Netherlands  
Switzerland  
Spain  
Austria

***Jurisdictions that have agreed in principle to permit assisted dying or are actively considering proposals***

Australian Capital Territory  
France  
Isle of Man  
Jersey  
Germany  
Portugal  
Republic of Ireland  
Scotland

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<sup>1</sup> Populus (2019)

<sup>2</sup> YouGov (2019)

<sup>3</sup> <https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf>

<sup>4</sup> <https://www.sane.org.uk/campaigning-media/news-and-comment/end-of-life-care-and-assisted-dying>

<sup>5</sup> <https://www.gov.je/SiteCollectionDocuments/Health%20and%20wellbeing/Assisted%20Dying%20Consultation%20Report.pdf>

<sup>6</sup> <https://publications.parliament.uk/pa/ld201415/ldhansrd/text/150116-0001.htm#15011659001145>

<sup>7</sup> <https://www.dignityindying.org.uk/wp-content/uploads/Last-Resort-Dignity-in-Dying-Oct-2021.pdf>

<sup>8</sup> [https://cdn.dignityindying.org.uk/wp-content/uploads/DiD\\_True\\_Cost\\_report\\_FINAL\\_WEB.pdf](https://cdn.dignityindying.org.uk/wp-content/uploads/DiD_True_Cost_report_FINAL_WEB.pdf)

<sup>9</sup> <https://issuu.com/ssvmedicine/docs/2202-ssvmed>

<sup>10</sup> <https://www.ohe.org/publications/unrelieved-pain-palliative-care-england>

<sup>11</sup> [https://www.dignityindying.org.uk/wp-content/uploads/DiD\\_Inescapable\\_Truth\\_WEB.pdf](https://www.dignityindying.org.uk/wp-content/uploads/DiD_Inescapable_Truth_WEB.pdf)

<sup>12</sup> [https://palliativecare.org.au/wp-content/uploads/dlm\\_uploads/2018/12/Experience-internationally-of-the-legalisation-of-assisted-dying-on-the-palliative-care-sector-APEX-FINAL.pdf](https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/12/Experience-internationally-of-the-legalisation-of-assisted-dying-on-the-palliative-care-sector-APEX-FINAL.pdf)

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- 13 <https://www.nsw.gov.au/media-releases/budget-2022-palliative-care>
- 14 <https://www.premier.vic.gov.au/palliative-care-boost-support-terminally-ill-victorians>
- 15 <https://www.bbc.co.uk/programmes/p0dh32rh>
- 16 <https://www.dignityindying.org.uk/blog-post/palliative-medicine-must-engage-honestly-in-the-assisted-dying-debate/>
- 17 <https://pubmed.ncbi.nlm.nih.gov/25082569/>
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**Jan 2023**