Response to the "Assisted Dying in Jersey Consultation"
on behalf of Care Not Killing (CNK Alliance Ltd) and Our Duty Of Care

January 2023

Introductory remarks

A number of issues arise in the report which are not addressed by the questions.

The Government of Jersey's 121-page consultation report states that:

> *"the purpose of this consultation is not to consider whether assisted dying should be permitted in Jersey - as the Assembly have already determined, in principle, that it should be permitted - but instead to understand peoples' response to how an assisted dying service should work."* (p7)

This approach neglects the constitutional principle (*cf* Dicey) that no parliament can bind its successor; Jersey elected a new States Assembly in June 2022, following the earlier vote in November 2021. It also fails to recognise that citizens may for whatever reason have been unable to respond to the earlier consultation, and that members and citizens may decide having considered these proposals that regardless of their view on the principle, "assisted dying" cannot be safely legalised. The States Assembly passed the Proposition in question subject to adequate safeguards being drawn up by officials: our view is that the safeguards proposed are far from adequate and that no system of euthanasia can ever be truly safe for vulnerable people. The current law *is* the safeguard.

The consultation asserts that:

> *"assisted dying is not suicide or assisted suicide – the decision to commit suicide and the taking of your own life are lonely acts, often accompanied by mental and physical pain and fear. Suicide invariably leaves behind a legacy of irresolvable grief for loved ones. Assisted dying can be the exact opposite, it provides a safe, calm and considered environment in which a person – most often with the support of their loved ones – can end their life and associated suffering."* (p11)

This denies reality: "suicide" is "the act… of taking one's own life voluntarily and intentionally."[1] The Jersey Government's definition of "assisted dying" is misleading and repeats the euphemistic campaign messaging of those seeking a change in the law. The Government of Jersey is proposing both assisted suicide *and* euthanasia, for terminally *and* chronically ill people. However, a July 2021 survey in the UK found that more than half of respondents thought the term 'assisted dying' meant "providing hospice-type care to people who are dying" or "giving people who are dying the right to stop life-prolonging treatment."[2] Only 42% realised that it refers to giving lethal drugs to a patient to end their life intentionally. The consultation is only accurate in its statement above in the sense that euthanasia is not assisted suicide and the likelihood is that the overwhelming majority of deaths under the proposed legislation will be acts of euthanasia (as is the case in Canada where over 99% of Medical Assistance in Dying ("MAiD") deaths are by euthanasia). In such deaths, lethal drugs are administered by a doctor or nurse rather than self-administered by a person committing an assisted suicide.

[1] merriam-webster.com/dictionary/suicide
[2] dyingwell.co.uk/wp-content/uploads/2021/09/Survation-Assisted-Dying-Survey-July-2021-Summary-3.pdf

The consultation report states that:

> *"any person seeking an assisted death should be making a real choice. They should not choose an assisted death on the basis that they cannot access – or believe they cannot access – high quality end-of-life or palliative care services. Hence, it is envisaged that the report and proposition which be presented to the Assembly in early 2023 will ask Members to agree, in principle, that legislation permitting assisted dying should not be brought into force until the Assembly is satisfied that all Islanders can access good palliative and end-of-life services."* (p11)

This conclusion is the wrong way around: the States Assembly should not consider ***passing*** "assisted dying" legislation before they can guarantee access to not just *"high quality end-of-life or palliative care services"* but also social support (including affordable housing) for people with chronic illnesses and disabilities. Canada has seen many examples of medically eligible people applying for euthanasia or assisted suicide not because of their condition but because of a lack of support. One recent example was that of 54-year-old Amir Farsoud who hit the headlines in November 2022 when he applied for MAiD because he was in danger of losing his housing and feared being made homeless.[3] Another of the many examples is that of Roger Foley who recorded a hospital employee offering him a MAiD death, citing the financial cost of his care and being unwilling to provide the care package Mr Foley desired.[4]

Questions on us

Q. 1 Do you give permission for your comments to be quoted?

No ☐ Yes, anonymously ☐ Yes, attributed ☑

Name to attribute comments to: (N/A)

Organisation to attribute comments to, if applicable: Care Not Killing, and Our Duty of Care

Q. 2 Do you, or the organisation on whose behalf you are responding, hold a strong view on whether or not assisted dying should be permitted?

Yes ☑ No ☐ Prefer not to say ☐

Q.3 If yes, do you think assisted dying:

should be permitted ☐ should not be permitted ☑

Questions on the proposals

Q.4 Do you agree that the eligibility criteria should be changed to allow for those with a neurodegenerative disease to become eligible for assisted dying when they have a life expectancy or 12 months or less?

Yes ☐ No ☑ Don't know ☐

[3] toronto.citynews.ca/2022/10/13/medical-assistance-death-maid-canada/
[4] https://www.dyingwell.co.uk/stories/roger-foley/

Please tell us the reasons for your response: It is very disturbing that the consultation document proposes different terminology from that approved by the States Assembly, especially since the Proposition was only approved subject to adequate safeguards being drafted. In fact, the new terminology is less safe than the previous language used. The reference to "tolerable" alleviation is entirely subjective, providing no objective criteria by which doctors can be expected to judge whether the suffering is at a degree to qualify for an assisted suicide or euthanasia death. The Netherlands' law uses similar language, requiring that "there was no reasonable alternative solution for the situation in which he [the applicant] found himself."[5] This broad criterion has not only seen the numbers of deaths rise year on year, but has also seen the rate of increase accelerate. The latest regulatory report states that: "In 2021, the number of notifications of euthanasia (7,666) was 10.5% higher than in the previous year and was also higher as a percentage of the total number of deaths (170,839): 4.5% compared to 4.1% in 2020."[6] Belgian law also uses similar terminology and specifically the concept of 'unbearable' suffering. As in the Netherlands, the number of deaths by euthanasia has risen over time in Belgium from just 24 in 2004 to 2,699 in 2021. The Belgian Federal Control Committee itself has stated: "The unbearable nature of the suffering is largely subjective and depends on the patient's personality, ideas and values."[7]

The reliance on the two routes brings us to the precedent in Oregon where without any amendment to the statute, which only allows assisted suicide for terminally ill people with a 6-month prognosis for death, health officials now interpret the law as including chronically ill people who forego "administration of life-sustaining treatment".[8] In Oregon, illnesses prompting assisted suicide include anorexia, arthritis, arteritis and complications from a fall.[9]

The process proposed in the Jersey Government's consultation supposedly allows

> *"time to ensure that all other options for the person have been explored in terms of treatment, pain relief and the provision of any other services that may be able to alleviate the person's suffering"* (p34)

The term "explore" is not defined and indeed is mainly used in conjunction with "dialogue" (p39): applicants need not *try* such options to find out if they would make a difference.

The framing of the prognosis requirement ("reasonably expected") concedes the well-known fact that prognostication, especially many months from death, is far from an exact science: a 2017 UCL study found that over half (54%) of those predicted to die within a specified time period lived longer than expected.[10]

Q. 5 Do you agree that the definition for Jersey resident should only include those ordinarily resident in Jersey for 12 months?

Yes ☐ No ☐ Don't know ☐

Other, please state ☑ ___

Please tell us the reasons for your response: We agree that non-residents shouldn't be allowed to access euthanasia or assisted suicide, but we also note that other jurisdictions have seen such

[5] wetten.overheid.nl/BWBR0012410/2021-10-01/0
[6] euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/jaarverslagen/2021/maart/31/jaarverslag-2021
[7] Federal Control Committee, First Report, 2004, p.16
[8] carenotkilling.org.uk/articles/six-months-redefined/
[9] Oregon Death with Dignity Act Data Summary 2021, Footnote 3, Page 14.
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf
[10] carenotkilling.org.uk/articles/longer-than-expected/

restrictions successfully overturned. The report notes (p16) that while most earlier consultation respondents were averse to *"death tourism"*, some *"noted the potential financial benefits of providing assisted dying to non-residents."* Just last year, the same campaign group which co-wrote Oregon's assisted suicide law forced the state, through the courts, to abandon its residency requirement[11], and is now engaged in similar action against Vermont[12]. It is to be expected that similar pressures will be brought to bear in Jersey and that legal challenges to the any new law may ensue.

Q.6 Do you agree that assisted dying should only be permitted for people aged 18 or over?

Yes ☐ No ☐ Don't know ☐

Please tell us the reasons for your response: We believe children should not be included, but both "yes" or "no" indicate acceptance of euthanasia and assisted suicide for adults and so we decline to answer. Noting that the earlier consultation process had seen a degree of support for under-18s having access, the report states that:

> *"it is proposed that the law should only provide for assisted dying for people aged 18 or over. It is recognised, however, that the law should allow for the Assembly, by Regulation, to lower the age limit if, at some point in the future, they determine it was the correct course of action."* (p16)

Canada's law is barely six years old and they are considering such a move to include children – having already extended from terminal illnesses to chronic illnesses, and with a further extension to mental illnesses in 2023 only "temporarily" paused in December. Belgium extended its law to children in 2014 by primary legislation, but politicians in the Netherlands – where the current laws already apply to children as young as 12 and disabled infants aged under 12 months – are considering a similar move *also* by regulation. Notably the Groningen Protocol in the Netherlands, applying to disabled infants, has never been written into law by the Dutch Parliament. It highlights the dangers of incremental extension, without Parliamentary scrutiny, of euthanasia to include those who cannot give informed consent once it becomes accepted medical practice.

Q. 7 Do you agree that the Jersey Assisted Dying Service should be free to people who want an assisted death and who meet all the criteria?

Yes, it should be free ☐ No, it should be paid for ☑ Don't know ☐

Please tell us the reasons for your response: While emergency treatment is free in Jersey, everyone has to pay for access to doctors (GPs), dentists, pharmacists and ante-natal clinics. Aside from there being no logical basis to provide euthanasia and assisted suicide freely in that context, to do so would also send a worrying message about the value of those who are nearing the end of their lives, or are severely disabled.

Prior to the extension of Canada's MAiD law beyond terminal illnesses, the Parliamentary Budget Office there produced a report which estimated that under the then-law, 6,465 people would die by MAiD in 2021 - 2.2% of all deaths - with net healthcare savings of $86.9m. The PBO expected amending the law to add 1,164 deaths to that figure in the first year alone, leading to increased healthcare savings in 2021 of $149m - almost £87m.

[11] npr.org/2022/03/30/1089647368/oregon-physician-assisted-death-state-residents
[12] cbsnews.com/news/woman-sues-over-residency-requirement-for-assisted-suicide-vermont/

Earlier that same year (2020), the journal *Clinical Ethics* published a controversial paper in which, as *The Times* reported:

> *'David Shaw, an ethicist, and Alec Morton, a health economist, argue that granting terminally-ill patients help to die would save money and potentially release organs for transplant.'*
>
> *'Dr Shaw, who is based in Glasgow… described the potential savings of allowing assisted dying as "the elephant in the room". He said: "We are simply arguing that the economic costs of denying assisted dying should not be ignored; they should not be the key driver of any legal change, but it would be irresponsible not to consider them."*[13]

Q.8 Do you agree that health professionals should have the right to refuse to undertake a supporting assessment (or provide their professional opinion), if that information may be used by an Assessing Doctor to make a determination on the person's eligibility for an assisted death?

Yes, they should have the right to refuse ☑ No, they should not have the right to refuse ☐

Don't know ☐

Please tell us the reasons for your response: We read in the report:

> *"It is proposed that the assisted dying law provides for a conscientious objection clause which relates to directly participating in the assisted dying assessment and delivery process… any objection clause that is cast too 'wide' could potentially have the effect of negating the underlying policy intent."* (p23)

Reflecting movements in Canada (where courts have required doctors with conscientious objections to involve themselves in the process by making "effective referrals"[14]), staff and service providers could not (p24) refuse tasks including *"delivery of equipment or medical supplies that may be used for… the delivery of an assisted death", "booking appointments for additional assessments, undertaking residency checks" or "financial planning tasks associated with the delivery of the service."* They must also (p25) provide people who want information with *"contact details of the Care Navigators."* The consultation report leaves open the possibility of requiring objecting staff to provide *"supporting opinions or assessments requested by an Assessing Doctor to help support their determine [sic] of whether a person is eligible for an assisted death."*

To be clear, the conscience rights of doctors and nurses will be seriously undermined if this proposal goes ahead. This may well lead to professionals being unwilling to work in Jersey under such conditions, adding to existing recruitment pressures. The World Medical Association is clear that doctors should not be required to participate in assisted suicides and euthanasia deaths and *"nor should any physician be obliged to make referral decisions to this end"*.[15]

[13] https://www.carenotkilling.org.uk/articles/widening-canadas-euthanasia-law-set-to-save-149m/
[14] theglobeandmail.com/canada/article-religious-doctors-must-make-referrals-for-assisted-dying-abortion/
[15] https://www.wma.net/policy-tags/euthanasia/#:~:text=The%20WMA%20reiterates%20its%20strong,euthanasia%20and%20physician%2Dassisted%20suicide.

Q.9 Do you think that conscientious objection clause should provide a premise owner / operator the right to refuse an assisted death on their premises (for example, a care home provider may choose not to permit a resident to have an assisted death in their room, even though it is the person's place of residence or care)

Yes, they should have the right to refuse ☑

No, they should not have the right to refuse if the person who wants an assisted death is resident or being cared for in the premises ☐

Don't know ☐

Please tell us the reasons for your response: The report says a location for an "assisted death":

> *"cannot be approved unless permission has been given… for example, if the person wishes to die in their residential care home (or similar) the consent of the care home manager or provider will be required."* (p75)

Belgium passed a new law in 2020, prohibiting bans on euthanasia in institutional care settings (and forcing objecting physicians to make effective referrals.)[16] The report says that:

> *"if the assisted death is to take place in a care facility, there will need to be consideration of other individuals that may be present or close by during the assisted death (for example, patients and staff in the same hospital ward, even if the assisted death takes place in a private room)."* (p75)

How meaningful would "consideration" for patients who don't want to live in a setting where the practice is permitted be?

Would state funding be in question for homes and hospices which refused such permission?[17] At least one hospice in Canada has lost funding owing to its unwillingness to provide euthanasia deaths on its premises.[18]

Q.10 Do you agree that the assisted dying register should be public?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: The possibility of making that register public means that determined patients would be able to contact healthcare professionals predisposed to view assisted suicide and euthanasia as acceptable responses to distress. In Oregon, doctor shopping has become a standard feature of the practice of assisted suicide. Oregon Health Authority reports on assisted suicide show patents often being approved by doctors they have only known for a few days.[19] While conscious of the risk of doctor-shopping, transparency is important. The extent of involvement in the euthanasia and assisted suicide process by particular individuals must be open to scrutiny. These factors present a significant tension.

[16] ieb-eib.org/en/news/end-of-life/euthanasia-and-assisted-suicide/breaking-news-the-belgian-constitutional-court-rejects-the-appeal-relating-to-the-2020-law-on-euthanasia-2086.html?backto=search
[17] scoop.co.nz/stories/AK2006/S00673/euthanasia-referendum-threat-to-hospice-movement.htm
[18] https://toronto.citynews.ca/2020/02/25/b-c-hospice-loses-funding-after-refusing-to-provide-assistance-in-dying/
[19] carenotkilling.org.uk/articles/oregon-2021-anorexia-hernias-feeling-a-burden/

Q. 11 Do you agree that the nine proposed steps are all necessary?

Yes ☐ No ☐ Don't know ☐

Please tell us the reasons for your response: The more steps that are involved in the process, the greater potential opportunity for the detection of coercion, abuse, depression or undue pressure. However, experience in other jurisdictions shows that often, these steps are technical formalities which are insufficient to protect those who are vulnerable.

A survey in England and Wales conducted by the charity SafeLives found that on average, victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help. 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse.[20] If this is the degree of difficulty in seeking assistance for and detection of high-risk abuse, it is not clear how the current steps would provide sufficient protection for those in abusive or coercive relationships. However, since we do not agree with the proposal to legalise euthanasia and assisted suicide, we would not wish to recommend any process.

Q. 12 Do you think there are any further steps / actions that should be included?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: Since we do not agree with the proposal to legalise euthanasia and assisted suicide, we cannot suggest any further steps/actions except that of dropping the proposals to change the law.

Q.13 Do you agree with the proposed minimum timeframe for those with a terminal illness of 14 days?

Yes – I agree ☐ No – I do not agree ☐ Don't know ☐

Please tell us the reasons for your response: Since we do not agree with the proposal to legalise euthanasia and assisted suicide, we would not endorse any arbitrary deadlines.

Q.14. Do you agree with the proposed minimum timeframe for those with unbearable suffering of 90 days?

Yes – I agree ☐ No – I do not agree ☐ Don't know ☐

Please tell us the reasons for your response: Since we do not agree with the proposal to legalise euthanasia and assisted suicide, we would not endorse any arbitrary deadlines.

Q. 15 Do you agree that the law should not prohibit professionals for raising the subject of assisted dying?

Yes – I agree ☐ No – I do not agree ☑ Don't know ☐

Please tell us the reasons for your response: We note, first, that the wording of this question is unhelpfully complex: our chosen answer includes a triple negative, and it seems likely that many

[20] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives. Available at: https://safelives.org.uk/policy-evidence/about-domestic-abuse#top%2010

respondents will have been confused. Conscious especially of the statement in the report (p36) that *"the law will not prohibit health and care professionals from talking to their client / patient about assisted dying, even where the client / patient did not raise the subject in the first instance,"* we make clear that healthcare professionals should not be permitted to do this.

The GMC's guidance in *Good Medical Practice* states that:

> "You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including: their condition, its likely progression and the options for treatment, including associated risks and uncertainties."

It is not currently clear where the 'Assisted Dying' Service will sit in terms of it being a treatment option. Normally, doctors are expected to inform patients of all available options, even if they have a conscientious objection to taking part. Will this apply to the Assisted Dying Service?

Consider the impact of this proposal on patients, and on the trust they have in all healthcare professionals from that point on. If a doctor raises the issue of euthanasia or assisted suicide, it may well be perceived by a vulnerable patient to be a suggestion or recommendation. Combined with the inevitable pressures of the cost of treatment and lack of resources, this may well lead to people seeking death by assisted suicide or euthanasia owing to external pressures.

Canada's law states that no healthcare professional commits an offence "if they provide information to a person on the lawful provision of medical assistance in dying," paving the way for a 2019 document issued by the Canadian Association of MAID Assessors and Providers which asserts that "physicians and nurse practitioners… involved in care planning and consent processes have a professional obligation to initiate a discussion about MAiD if a patient might be eligible for MAiD."[21]

Q. 16 Do you agree that the law should not place an explicit requirement on relevant professionals (e.g. those working in GP surgeries or hospital departments) to tell people about the assisted dying service?

Yes – I agree ☑ No – I do not agree ☐ Don't know ☐

Please tell us the reasons for your response: Our comments in response to Q15 apply here also.

The report mentions the "Jersey Assisted Dying Service" making leaflets available, but have States Assembly members considered the danger that the people of Jersey might soon be confronted with this "choice" in far starker terms? An assisted suicide group in Switzerland has advertised on public transport[22] and in Canada, there have even been adverts in hospital emergency rooms[23]. No person with an eligible illness would be able to avoid considering the "choice" on offer and may well feel a public duty to die in order to avoid being a burden on family, friends and care services. This is increasingly the case in Oregon with over 50% of those having an assisted suicide now regularly citing this reason for seeking death.

[21] https://nationalpost.com/news/canada/canada-maid-medical-aid-in-dying-consent-doctors
[22] worldradio.ch/news/bitesize-news/suicide-group-advertises-on-trams/
[23] nationalreview.com/corner/canadian-hospital-waiting-room-promotes-euthanasia/

Q. 17 Do you agree that a person should only be entitled to one second opinion?

Yes ☐ No ☐ Don't know ☑

Please tell us the reasons for your response: The phrasing of the question means that answering yes means one supports allowing one second opinion, while answering no means one supports allowing *more* than one. We feel that allowing any second opinions opens the door (further) to doctor-shopping.

Q. 18 Should the law allow for confirmation of consent to proceed?

Yes ☐ No ☑ Don't know ☐

Please tell us the reasons for your response: Any system allowing third parties to act to cause death when the individual is unconscious (or similarly incapacitated) would be ripe for abuse, as well as placing an additional burden upon healthcare professionals.

Q. 19 Should the law allow for the option of a waiver of final consent?

Yes– the law should allow for a waiver of final consent ☐

No – the law should not allow for a waiver of final consent ☑

Don't know ☐

Please tell us the reasons for your response: Where some earlier respondents had favoured advance decisions, the report's authors have settled on waivers of final consent being available for Route 1 applicants who lose decision-making ability after final approval:

> *"The rational for 'waiver of final consent' is that it ensures a person, who has been approved as eligible for an assisted death, will not be prevented from having their request fulfilled (in accordance with previously agreed arrangements) if their health condition deteriorates rapidly to the point which they lose their decision-making capacity before the assisted death takes place."* (p48)

Later, we read that:

> *"even if the person has in place a waiver of final consent in place the process will not proceed if, during the final review or in the lead up to the assisted dying substance being administered, the person demonstrates a refusal or resistance to the administration of the substance by words, sounds or gestures."* (p79)

It is very dangerous to give doctors and nurses the legal power to end life where there is no explicit consent from the patient. Where doctors or nurses become used to ending their lives of their patients without consent, the boundaries of the law will be blurred. In 2013 in Belgium, 1.7% of all deaths were of physician administered without the explicit consent of the patient which represents over 1,000 deaths that year.[24] Similarly in 2010 in one survey in Belgium, 50% of nurses involved in administering euthanasia admitted to cases where no consent from the patient was obtained.[25]

The plan for final consent waivers also creates a contradiction: if an applicant signs a waiver, could indications of a change of mind be ignored? Where do those present at the end draw the

[24] https://lozierinstitute.org/study-more-than-1000-deaths-hastened-without-patients-explicit-request-in-belgium/
[25] https://www.dailymail.co.uk/news/article-1285423/Half-Belgiums-euthanasia-nurses-admit-killing-consent.html

line before disregarding the waiver itself? The question raises the example of a Dutch woman with dementia whose family restrained her to allow a doctor to euthanise her in line with an advance directive.[26] However, when the doctor and the family sought to conduct the euthanasia procedure, the patient resisted and said no three times. The doctor put a sedative in the patient's coffee and she was held down by her son-in-law whilst the doctor administered the lethal drugs to end her life. At a subsequent trial, the doctor was acquitted and later the Supreme Court of the Netherlands confirmed that doctors acting in this way is compatible with the Dutch euthanasia law. The courts ruled that the doctor "did not have to verify the current desire to die."[27]

It is proposed that there are two different approval routes:

a) ***Route 1 (terminal illness)*** *which will entail approval by the Coordinating Doctor based on their assessment and that of the Independent Assessment Doctor (i.e. two doctor assessments),*

b) ***Route 2 (unbearable suffering)****, which will entail approval by the Coordinating Doctor based on their assessment and that of the Independent Assessment Doctor (ie. two doctor assessments), and then confirmation of that approval by a specialist tribunal*

Q. 20 Do you agree with the two different approval routes as proposed?

Yes ☐

No – all approvals should be by the Coordinating Doctor based their assessment and that of the Independent Assessing Doctor only (i.e. no requirement for a Tribunal) ☐

No – all approvals by the Coordinating Doctor should be confirmation by a Tribunal (i.e. a Tribunal involved in all cases ☑

Don't know ☐

Other, please state ☐ ___

Please tell us the reasons for your response: With regard to the viability of any such tribunal: while the report (p58) indicates significant support from the Citizens' Jury for a tribunal as an *"additional safeguard"*, it also lists a number of concerns raised against it by some (including added costs and time), and it is foreseeable that, the legislation having passed on the strength of such an additional "safeguard", it could be stripped out in relatively short order. Just one year after New Zealand's law came into effect, the politician who championed its passage has called for one of its defining "safeguards" – a six-month prognosis being required – to be excised[28]. Jersey's draft law is already set to admit a far wider range of people than New Zealand's; it is easy to imagine efforts to suppress the tribunal after legalisation, especially given the *"inherent difficulties in ensuring the Tribunal has the skills and knowledge necessary to make assisted dying determinations"* noted later (p66) in the report.

It is proposed that the Tribunal:

- *always reviews a decision of a Coordinating Doctor to approve a Route 2 assisted dying request (on the basis that it provides an additional safeguard)*

[26] bbc.co.uk/news/world-europe-52367644
[27] apnews.com/article/europe-health-courts-dementia-euthanasia-1ed45f0819e788708da51d161b48e9f8
apnews.com/article/a041563e55204279bfb8e335a19c2802
[28] nzherald.co.nz/nz/euthanasia-laws-too-strict-and-should-be-relaxed-act-leader-david-seymour-says/AEC6XMXQRJG35CAAZ42KDU7Y5M/

- *does not review a decision of a Coordinating Doctor not to approve as assisted dying requests (on the basis there can be an appeal to Court).*

Q. 21 Do you agree that the Tribunal should only review decisions of the Coordinating Doctor to approve Route 2 assisted dying requests?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: These proposals concern deliberately ending citizens' lives: if activists and campaigners truly only wish it for those in extremis, no application where eligibility is found to be lacking or in doubt should be able to be reanimated.

Q22. Do you agree that the Law should provide for appeals to the Royal Court?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: ___

Q23. Do you agree with proposed grounds for appeal?

Yes ☐ No ☑ Don't know ☐

Please tell us the reasons for your response: The report envisages allowing second opinions to ease the path to euthanasia and assisted suicide earlier in the process; it cannot then provide an appeals process which is not allowed to question diagnoses and prognoses.

Q.24 Do you agree with there should be at 48-hour time period between approval and the assisted death to allow for appeals?

Yes – I agree ☐

No– I do not agree, there should be no minimum time period for appeals ☐

No– I do not agree, there should be a time period longer than 48-hours ☑

Don't know ☐

Please tell us the reasons for your response: If the appeals process is to have value, it requires time and transparency. The freedom to exclude family members runs great risks, as seen in the case of Godelieva de Troyer, a Belgian woman with long-term depression who was euthanised by the co-chair of the euthanasia review body, to whose pro-euthanasia organisation she had donated money, with her son only finding out the day after she had died.[29]

Q. 25 Do you agree that the right to appeal should be restricted to the person (or their agent) or a person with special interest?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: ___

[29] adfinternational.org/tom-mortier/

Q.26 Do you agree that there should be no expiry date for the approval of an assisted death?

Yes – I agree, there should be no expiry date ☐

No - I disagree, I think there should be an expiry date ☑

Other, please state ☐ ___

Don't know ☐

Please tell us the reasons for your response: The consultation document makes multiple references to considering whether a wish to die is fluctuating. Suicidality is transient and without an expiry date being set on an approval, an individual may act upon an unsettled wish to die during a period of particular strain.

Q.27 Do you agree that there should be an Administering Practitioner with the person or nearby?

Yes ☐ No ☐ Don't know ☐

Please tell us the reasons for your response: Advocates paint euthanasia and assisted suicide as forms of healthcare, but they are not. A 2019 joint statement issued by the Canadian Hospice Palliative Care Association and Canadian Society of Palliative Care Physicians stated that:

> "MAiD is not part of hospice palliative care; it is not an "extension" of palliative care nor is it one of the tools "in the palliative care basket". National and international hospice palliative care organizations are unified in the position that MAiD is not part of the practice of hospice palliative care. Hospice palliative care and MAiD substantially differ in multiple areas including in philosophy, intention and approach."[30]

While this question could be approached from several angles, we decline to support the medicalisation of causing death, and so decline to answer.

We do note, with respect to the final acts of euthanasia and assisted suicide, the report's claim that:

> *"detailed protocols will be developed should an unexpected medical event occur, such as complications with the administration of the assisted dying substance. This could include the person taking longer to die than expected or issues with the administration of the substance."* (p81)

"Unexpected" is an odd description to use, partly because assessing doctors are required (p99) to discuss *"the potential risks of self-administering or being administered the assisted dying substance"* with applicants, and partly because there is a growing body of research on complications in assisted suicide and euthanasia. Research published in the journal *Anaesthesia* suggested that a relatively high incidence of vomiting, prolongation of death and reawakening from coma could render such deaths "inhumane,"[31] while Dr Joel Zivot, writing in the *Spectator*, has observed that "paralytic drugs are used [in euthanasia]. These drugs, given in high enough doses, mean that a patient cannot move a muscle, cannot express any outward or visible sign of pain. But that doesn't mean that he or she is free from suffering."[32]

---

[30] https://www.cspcp.ca/wp-content/uploads/2019/11/CHPCA-and-CSPCP-Statement-on-HPC-and-MAiD-Final.pdf
[31] carenotkilling.org.uk/articles/assisted-dying-inhumane/
[32] spectator.co.uk/article/last-rights-assisted-suicide-is-neither-painless-nor-dignified/

Q.28 Do you agree that a loved one should be able to support the person to self-administer the substance?

Yes ☐ No ☑ Don't know ☐

Please tell us the reasons for your response: The new "service" could not guard against coercion while allowing this.

Q.29 Do you agree that the medical certificate of the fact and cause of death, and hence the register of deaths, should accurately record the cause of death as assisted dying?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: While we object to use of the euphemism "assisted dying", many proposals for euthanasia and assisted suicide seek to obscure the real nature of such deaths on death certificates, instead listing underlying illnesses only. We would agree that the real cause of death – ingestion or injection of lethal drugs – should be listed as the cause of death in such circumstances.

Q. 30 Do you agree that an HCS Service Delivery and Assurance Board is needed to provide oversight of the safety and quality of the assisted dying service?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: At present, there is no regulation at all of community or hospital services. They are only just constructing an independent board to oversee health and community services. There is no CQC or regulator that oversees any services except care homes and a few day care facilities. Regulation is desperately needed to bring assurance to all areas of healthcare so a board to oversee the service would be welcome, but we urge members of the States Assembly to give particular consideration to whether a brand new, complex, life-ending service could be safely inspected and regulated in such a context.

Q.31 Do you agree that post-death administrative review of each assisted death is required?

Yes ☑ No ☐ Don't know ☐

Please tell us the reasons for your response: We recommend careful examination of the European Court of Human Rights' ruling in the case of Tom Mortier (whose mother's euthanasia death we cited in our response to Q24) when considering the immense difficulties of developing a meaningfully robust system of post-mortem review. The Government must be held accountable concerning its ECHR Article Two responsibilities.

Q. 32 Do you agree that the Jersey Care Commission should independently regulate and inspect the Assisted dying service?

Yes ☐ No ☐ Don't know ☑

Please tell us the reasons for your response: We might be inclined to answer "yes", but the JCC has no experience of regulating any community services in Jersey or even the hospital at the moment, so it is going to be a steep learning curve to be able to regulate all these things *and* an assisted

dying service. They are due to begin inspecting hospital wards in 2023, but community services and GPs will be after this. Would they really be ready by 2025 to inspect the assisted dying service?

Q. 33 Do you agree the Jersey Assisted Dying Service should not be considered as an essential service? (i.e., that the JCC should have the powers to close the service down)

Yes – I agree, it should not be considered an essential service ☑

No– I disagree, it should be considered an essential service ☐

Don't know ☐

Please tell us the reasons for your response: ___