

Assisted Dying: The Implications of the Legislation

Thursday 8th – Friday 9th January 2026

A St George's House Consultation



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Summary

The consultation on "Assisted Dying: The Implications of the Legislation" met at St George's House in January 2026 to discuss the impact of the proposed bills on assisted dying within England, Wales, Scotland and other domestic jurisdictions. While it occurred, the Terminally Ill Adults End of Life Bill (2024) was under scrutiny in the House of Lords. Members of the consultation provided several recommendations for this Bill based on their experience, which included acute care, social care, religious leadership, general practice, legal practice, ethics and academia. Key recommendations were:

1. **Clear Guidelines:** Develop national guidelines for assisted dying, informed by international experience, to ensure consistency which can be adapted for different regional needs. This needs to be done alongside legislation, not after it, to allow for preparation.
2. **Separate Service Structure:** Establish assisted dying as a distinct regional or national service, independent from existing healthcare providers, to optimise resources and improve current end-of-life care structures without taking resources from existing services.
3. **Panel Reform:** Redesign the proposed Assisted Dying Panel for timely practitioner access, focusing on safeguarding without mandating the presence of every professional role, and consider legal input where necessary.
4. **Clear Messaging:** Simplify the legislation and communication, including staff training and national public health messaging, to integrate assisted dying as part of wider end-of-life care.
5. **Social Sector Involvement:** Ensure social carers, not just social workers, are included in information sharing, with clear referral pathways and defined roles, while recognising their unique contribution to enabling a 'good' death.
6. **Responsible Public Messaging:** Communicate carefully with the public to dispel the notion that assisted dying is a 'cheaper option', making clear it is not a substitute for other medical treatments.
7. **Promote Open Dialogue:** Encourage broader public understanding and open conversations about death, involving faith and community groups to prevent excessive medicalisation and foster patient-centred, individualised approaches.
8. **Code of Practice:** Create a working group to develop and publish a comprehensive code of practice in parallel with the law, including input from legal, clinical, faith, and community representatives, and the findings of this consultation.

Background

The consultation on "Assisted Dying: The Implications of the Legislation" met at St George's House in January 2026 to discuss the impact of the proposed bills on assisted dying within England, Wales, Scotland and other domestic jurisdictions. While it occurred, the Terminally Ill Adults End of Life Bill (2024) for England and Wales was under scrutiny in the House of Lords with 1017 amendments proposed. It was a topic of national news that was referred to throughout the consultation. While the consultation did not know whether the Bill would be passed through the House of Lords, it was agreed that a similar bill would likely pass in the near future. As a result, it was deemed one of the most important topics of discussion that we could have as a society.



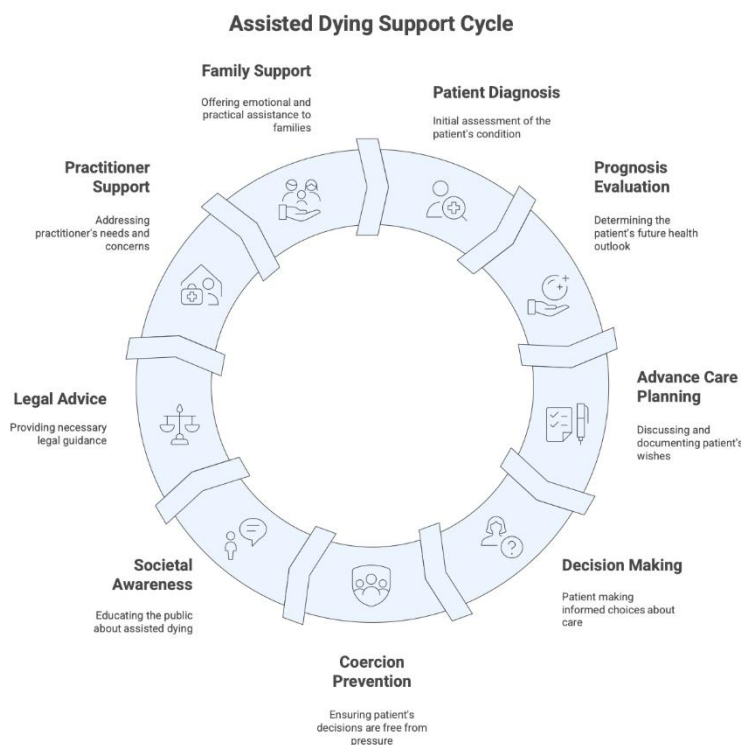
The consultation took place under Chatham House Rules over two days as part of the St George's House approach of "nurturing wisdom" through open conversation. Creating a safe space to share honestly was a priority for the consultation. Guests of the House stayed overnight, enjoyed scheduled coffee breaks and shared meals. The aim of this was to create a residency-style approach to the topic where discussions were not limited to the main sessions but could continue in a relaxed environment which supported trust and vulnerability.

It was acknowledged that a gathering of 28 people was small compared to the range of voices the consultation wished to include. The co-chairs of the consultation encouraged the group to share the discussions they had at St George's House widely. The individuals present reflected a range of invested parties such as:

- Clinicians, including GPs, psychiatrists, ICU workers, acute medical staff, palliative care workers, nurses, psychologists and Allied Health Professionals (AHPs).
- Religious leaders from Islam, Hinduism, Christianity, and Judaism.
- Social workers.

The consultation opened with three speakers to provide background to the consultation as well as the legal and ethical contexts of assisted dying. The consultation then broke into groups which were kept consistent on the first day to build trust and confidence. These smaller groups were designed to include a balance of perspectives and experience rather than focusing on different topics based on shared expertise. Conversations from these breakout groups were fed back to the entire consultation after each session for wider discussion. The first breakout session focused on responses to the opening speakers' presentations to establish key areas of focus and concern among those present. The second breakout session focused on "wish lists" around who will be responsible for different aspects of assisted dying and what does 'good' look like when it comes to assisted dying.

Members often referred to the Assisted Dying Cycle of Support, which was provided as part of the pre-reading for the consultation. It was developed to capture a very complex conversation in an easy-to-understand model by Professor Denise Turner and the University of Hertfordshire following focus groups held at the university in 2025.



Opening Speeches on the Context of Assisted Dying

The first speaker welcomed the group and provided context on the meeting of the consultation. They said it was their intention to bring together different perspectives and continue conversations that are currently being had on the topic of assisted dying. They referenced complex focus group conversations which had involved some of the members present. They hoped that these discussions could continue and hopefully it would lead to greater progress in coming to shared conclusions, learning more about different perspectives, and helping to influence the outcome of proposed legislation. It was stated that the focus of the consultation should go beyond the "person at the centre of assisted dying" to include the impact it might have on others involved such as families, medics, and spiritual leaders.

They noted that the group was limited to 28 but they would like to open the discussion to as many people as possible including people in the networks of those present. Additionally, they encouraged members of the consultation to join in research around the previous focus groups and this consultation. They noted that it was unknown whether the Terminally Ill Adults End of Life Bill (2024) would pass through the House of Lords, but they said it was likely to return in another form if it did not pass this time. Before introducing the next speakers, they concluded that assisted dying is one of the biggest societal conversations of our time.

The Legal Context

The second speaker at the consultation shared information about the legal context of assisted dying based on their expertise lecturing on medical law and ethics for over two decades. This introduction included:

- How it might function in England, Wales, Scotland and other domestic jurisdictions (such as the Isle of Man).
- How it functions elsewhere in the world (primarily in Australia, Canada and Oregon, USA).
- What comparisons could and should be made between assisted dying legislation in these jurisdictions.

The term 'assisted dying' does not have a legal definition but became part of bioethical discussions on end of life approximately 50 years ago. It refers to where a mentally competent adult would be prescribed lethal drugs by a medical practitioner to self-administer to end their life. The term is deliberate and attempts to shift the focus from the stigma which still surrounds suicide and end of life care and the desire for a 'good death'. However, opponents argue there is no difference between assisted dying and assisted suicide, which is a criminal offence under Section 2 of the Suicide Act 1961 (as amended). Upon conviction a person could be sentenced up to 14 years imprisonment. That said, the term 'assisted dying' (also known as physician assisted suicide in this jurisdiction) has been formally incorporated into several Bills which have been introduced since 2013 and is widely used.

Self-administration is key – the patient must be able to self-administer the drugs prescribed by the medical practitioner. It was noted that mechanisms needed to be put in place to enable self-administration in cases of physical limitations.

Assisted dying must be distinguished from euthanasia which is not envisaged in this jurisdiction. Voluntary euthanasia describes where a doctor administers drugs to end the person's life, at their request. Voluntary euthanasia is permitted in Canada, the Netherlands, Luxembourg and Belgium. If assisted dying were to be legalised, opponents argue that the 'slippery slope' would permit voluntary euthanasia but with tightly regulated legislation, potential slippery slopes, can also be 'sticky'.

The use of the phrase 'assisted suicide' was challenged by a member of the group with experience in end-of-life psychiatric care because they believed associations with 'suicide' or 'murder' increased stigma around assisted dying and added to the complex emotions of families and religious leaders. This individual wanted to impress that there is a difference between suicide and assisted dying which has important moral significance for these groups.



When establishing the details of the Terminally Ill Adults End of Life Bill (2024) for England and Wales, they questioned whether the 1017 proposed amendments by the House of Lords were valuable in terms of analysis and potential improvement of the Bill as presented in the House of Commons or simply filibustering. They believed it would be unusual for the House of Lords, an unelected body, to hinder an elected body in the House of Commons but private members' bills do suffer more from these 'taking out' mechanisms.

They provided the following information on the Terminally Ill Adults End of Life Bill (2024) for England and Wales:

- Eligibility: The Bill applies to terminally ill adults over the age of 18 with capacity and who are expected to die within six months and are resident in England and Wales for at least twelve months.
- Safeguards: the individual makes the first request for assistance, which is witnessed.
- There is a cooling-off period.
- A second declaration is required to reaffirm the decision, making it a 2-stage declaration.
- Two independent doctors confirm capacity and diagnosis.
- The process can be cancelled at any time.
- There are criminal penalties for coercion, dishonesty, pressure, and falsifying documentation.
- There is mandatory monitoring and reporting and investigation after death.
- The Bill clarifies that there is no obligation for HCPs to participate in an assisted death.
- HCPs are not obliged to refer the person seeking an assisted death to another medical practitioner but must direct to where they can seek information and have preliminary discussions.
- The Bill provides for codes of practice and guidance to ensure transparency and consistency.
- NB: proposed amendments about introducing 'unbearable suffering' could broaden eligibility to include people suffering severe physical or psychological pain that cannot be relieved by treatment. This would bring the Bill in line with other jurisdictions who provide suffering-based assisted dying.

One of the particular challenges for the Bill is the proposed requirement for a life expectancy of six months which, remains controversial due to issues with prognostication. In addition, mental capacity remains problematic and critics of the Bill argue that the elderly, ill and infirm could be subjected to coercion and that what is introduced as an option, becomes an obligation. The cooling-off period was considered a positive and stronger safeguard than exists in some other jurisdictions.

They also provided the following information on the proposed Assisted Dying Panel from the Bill:

- Judicial oversight replaced by an Assisted Dying Commissioner (monitors compliance and reports).
- The Assisted Dying Panel is a multidisciplinary safeguard composed of a senior judge, a social worker, and a psychiatrist. Its role is to ensure criteria for eligibility are satisfied.
- The Panel acts as an independent reviewer of declarations and receives the supporting documentation from two independent doctors.
- The panel asks the following questions:
 - Has the applicant made a clear, settled and informed wish to end their life?
 - Has the applicant been coerced or has pressure been applied?



- Does the applicant have capacity (which is asked to protect vulnerable individuals)?

The Assisted Dying Panel has been introduced to replace judicial oversight, and the role of social workers and psychiatrists were considered carefully over the two days of the consultation. The issues raised include education, training and potential costs.

While the Terminally Ill Adults End of Life Bill (2024) for England and Wales is in the House of Lords, the Assisted Dying for Terminally Ill Adults Bill (2024) is processing through Scottish Parliament:

- The Bill will allow terminally ill adults 18 years + to request an assisted death.
- They must have a terminal illness: "if they have an advanced and progressive disease, illness of a condition from which they are unable to recover and that can reasonably be expected to cause their premature death."
- They must be ordinarily resident in Scotland for at least twelve months before the first declaration.
- They must be registered with a medical practice.
- They must have capacity.
- HCPs must opt-in, rather than opt-out as in England and Wales.
- Assessment mandates the medical practitioner carrying out assessment to consider making enquiries of other HCPs and social work professionals relevant to the person.
- There is a first declaration, followed by a cooling off period and a second declaration.
- Scotland does not envisage an Assisted Dying Panel but will rely on ministerial duties and statutory offences.

A potential risk for the UK was noted, as there is no time limit in Scotland on a person's life expectancy. This may create a dangerous two-tier system of 'death tourism' where those who can afford it and have the support from family and friends can relocate to Scotland for a year from England and Wales (or other domestic jurisdictions).

The term ordinary resident is used in both the Bill in England and Wales and is less restrictive than the term habitually resident. There is potential for a two-tier system for assisted dying within the UK. An Assisted Dying Panel may be more onerous for an individual, who may then decide to move to Scotland upon diagnosis to avail themselves of a system, without a Panel and where there is prognostication is not an issue. They added that the Isle of Man's Assisted Dying Bill requires five years of residency to lessen the potential of 'death tourism'. The island's small population of only 84,000 means that assisted dying will affect only a small group of people. The Bill is currently waiting for Royal Assent and is expected to be implemented in 2027.

Another reason that it was important for the speaker to differentiate assisted dying from euthanasia was to differentiate the proposed legislation from legislation on assisted dying in Canada. They said that comparisons are often made to Canada in the media, in political discussions, and in private conversations. It is particularly common for critics in the UK to use Canada as an example of a "slippery slope" where people could suffer unnecessary loss of life due to factors like wide eligibility requirements and limited safeguards that impact vulnerable groups. They explained that this is unhelpful because the proposed legislation alongside the previously introduced Bills in England and Wales is based on the Death with Dignity Act (1997) in Oregon USA, which was described in the following way:

- Eligibility is limited to adult terminal illness with less than six months to live.
- Applicants must have a "clear, settled and informed request, free of coercion."
- The Terminally Ill Adults End of Life Bill (2024) matches Oregon's model of self-administration.



- But differs, in that this jurisdiction requires two independent doctors, plus (in England and Wales) an Assisted Dying Panel.
- There is a residency requirement.
- It explicitly excludes disability or mental illness.

The most recent data from Oregon's DWDA 1997 annual audit confirms that, despite fears assisted dying would negatively impact the poor and under-educated, the majority of those who access it are over 65+ years of age, just under half have a graduate degree or higher, are almost evenly split across men and women, and most are enrolled in hospice care. The three most frequently reported reasons for end-of-life concerns were loss of autonomy (89%), reduced ability to take part in activities which make life enjoyable (88%) and loss of dignity (64%). By far the most common underlying illness was cancer, followed by neurological disease and heart disease. The speaker explained that there is no better evidence than this to show that access to good palliative care does not prevent people from choosing assisted dying. It is also common in Oregon for people to request life-ending drugs but keep them "in their back pocket" as a method of reassurance and in 2024, 62% of all patients prescribed end of life drugs can be attributed to DWDA deaths. With a population of 4.2 million, an assisted death or physician-assisted suicide accounted for 377 deaths in 2024.

Assisted dying in the UK is also often compared to Australian legislation, which exists in different forms for all states. The law in Victoria follows the Voluntary Assisted Dying Act (2017), which was presented to the consultation:

- It applies to adults with capacity who have a progressive, incurable illness which is expected to lead to death, which is typically six months, unless the person has a neurodegenerative condition, then it is extended to twelve months.
- Disability and mental illness are not automatic grounds but, combined with a terminal illness, could qualify.
- The individual must have made a "clear, settled and informed decision" for an assisted death.
- It must also be voluntary, free of coercion and can be withdrawn.
- The individual must be ordinarily resident.
- There is a need for two independent doctors to assess eligibility.

The Canadian law on Medical Assistance in Dying was described in the following way:

- The individual must be a Canadian adult with capacity.
- The request for an assisted death must be free from external pressure or influence.
- The eligibility assessment must take at least 90 days.
- The individual must provide informed consent.
- The individual must have a grievous and irremediable medical condition, and the condition causes physical or psychological suffering that the person considers intolerable and cannot be relieved.
- Treatment can be self-administered but it can also be clinician administered, also known as euthanasia.
- BUT 2021 amendments removed the need for the condition to be terminal and may be expanded to include those with a stand-alone mental illness.

The speaker believed that the Assisted Dying Bill could be compared to the Abortion Act in terms of its potential significant impact on society. However, there are also significant differences, particularly with accessing information. For example, HCPs do not have to refer a patient to another medical professional if they opt-out or conscientiously object. This could leave patients to find their own way to another medical professional which is much more difficult



and confusing for them. They stated that the code of practice is needed before full conclusions can be drawn about the Assisted Dying Bill for England and Wales. They were also initially concerned that the Assisted Dying Panel could be a "tick-box or paperwork exercise" but evidence suggests the potential for a far more proactive approach.

The Ethical Context

The speaker stated that it is valuable to consider the ethical issues raised by assisted dying within the context of broader ethical issues in end-of-life care. The ethical implications of assisted dying on patients, families and healthcare practitioners cannot be separated from the present reality of the state of end-of-life care in the UK.

The speaker asked a key question which later inspired members of the consultation: "Why is assisted dying so hard to talk about?". They stated that there are many strong arguments both for and against assisted dying that many of us would agree are valid and true. These arguments go to the core of what it means to be human and the importance of the topic is demonstrated by the level of impassioned argument across the country.

Within further exploration of this topic, they included:

- An overview of ethics of Assisted Dying
- The potential ethical implications for healthcare professionals if the Bill is passed. The ethical challenges faced in existing end of life care practice.

Breakout Conversations

Group 1

The first group were in consensus that the impact of assisted dying cannot be known until the Bill is enacted which will provide different examples for case law. They said, "We feel a bit in the dark with it still." They divided their conversation into the following topics which were mainly focused on the Terminally Ill Adults End of Life Bill (2024) for England and Wales:

1. Prognosis:

- a. What happens if it's wrong?
- b. How do we account for examples like Dame Esther Rantzen who commonly referred to since she has long outlived her prognosis? What happens if people outlive their prognoses too?

2. Access:

- a. Social issues.
- b. Inequities.
- c. The examples provided about Oregon where most assisted dying cases are middle class graduates in their 70s with financial resources.
- d. Who is realistically going to have access?

3. Social Care:

- a. Will they be included in the Panel?
- b. What will the training be like for social care workers? There is a current lack of resources.

4. Law:

- a. What does it look like in itself?
- b. How is it connected with other laws, such as laws surrounding mental capacity and mental health?

5. The Family:

- a. What does support for the family look like?
- b. What's that going to look like?
- c. Who, if anyone, will provide it?



- d. How does the Bill account for family members suing healthcare and social workers?

6. Aging:

- a. How does the Bill and the consultation account for the value of older people? This is an issue in the UK compared to other cultures where their value is assumed.
- b. How much is their value considered in conversations about older people being a burden to their families?

7. Joining Up the Dots of Different Stages of Assisted Dying:

- a. Who will hold the hands of families and individuals as they go through the process?
- b. A death doula or someone similar would provide continuity for them and help with the general lack of education around death that most people experience. This lack of knowledge makes families particularly afraid in the process.

8. Practicalities of Delivering Medication:

- a. This is related to previous discussions of moral injury to medical and healthcare workers.
- b. How can this injury be avoided?

9. Mental Capacity for People with Communication and Learning Difficulties:

- a. Who do we deem to have capacity?
- b. What rights do people have over their lives?

The group also added that the beliefs of professionals will inevitably come into play as well as their own personal experiences. It was noted that most people have experience with difficult end of life care for loved ones who would have preferred assisted dying as an option. They emphasised that the law will be applied to real world scenarios which would be far more complex. "The law can look quite black and white but in practice it isn't." There were no questions from the wider consultation.

Group 2

The second group began with reflections on what had been discussed by the opening speakers. They noted the importance of language and terminology around assisted suicide. "We all felt that the Bill has expanded to include assisted suicide. We might not use that language in public, but that is what it is." They highlighted that nearly every religion is against suicide. Simply by saying 'assisted suicide', those involved can isolate a patient by separating them from their religious and cultural life. "We can't really bring that together. What would assisted dying look like for someone who lives within that culture. And for the family who is left afterwards? There can't help but be an emotional response to it."

The group reflected on a previous speaker's question "why is it so difficult?" A few members of this group worked in critical care. While they were used to providing care which may have the double effect of hastening death, they found the concept of assisted dying much more uncomfortable. Other members of the consultation explained to non-experts that there was a clear legal distinction between actions that may well lead to an earlier death and assisted death even though they may exist under the same context. They gave common examples such as withholding nutrition and hydration or large doses of opium. One member added, "Everything we give is poisonous. It's about the degree." Some people chose to stop life sustaining treatment, either the patient or those caring for them. "There are plenty of legal ways to end someone's life in this country." The group agreed that the difference was intent and the fact that assisted dying will certainly end someone's life. This brought concerns about prognosis. The second group noted that some practitioners feel very confident about their ability to prognose, but most do not. This confidence might give louder voices greater influence. It could also cause access problems for people with more complex conditions since they could fall under the definition of "unbearable suffering".



Another point raised by this group was that Assisted Dying Panels may not be fit for purpose. It was suggested that they were a way to get the Bill through the House of Commons because it is more comfortable for people if there is a strong safeguarding process. However, the cooling-off period is short. Additionally, the social worker or psychiatrist assigned to an individual may not have met them before, especially since professionals can opt-out of participation. "We're quite used to safeguarding which is place-based or holistic, [such as referring to] your local social worker or your local GP." The group also questioned whether the Panel was necessary at all. "Do we need to do that if someone has capacity and their own autonomy? Why are we adding this extra layer to make us feel better? There are lots of opportunity costs and it's not fit for purpose." One member suggested decriminalising Dignitas instead to save NHS funding. Another member added that funds could be put into helping people reach Dignitas considering that the number of people who might access assisted dying is comparatively small compared to the cost of providing the care at scale. It was previously mentioned that members of the consultation had experienced patients requesting their medical records to share them with Dignitas. This created its own kind of moral injury for those staff members.

It was noted that the UK has an unusual cultural approach to death and the language surrounding it that often includes euphemisms and immediate removal of the body. One member shared their opinion that euphemisms might help people see death from a more positive perspective and improve educational conversations around it. A participant shared their concern that assisted dying might provide people with a cheap and easy way out of life, which can be difficult. It was suggested by another member that the large socio-economic inequality throughout the UK made it hard to justify taking even more funding away from care to spend resources on finding people for Assisted Dying Panels. They stated that socio-economic conditions and the state of palliative care needed to be fixed alongside the introduction of assisted dying. Another participant asked whether "this Bill is really workable from a social work perspective" since there are already challenges to providing social care like a lack of funding. Others added that the geopolitical state of the world, such as a need for increased defence spending makes assisted dying less of a political priority. One member said, "It never was." This was generally agreed upon, as was the understandable reality that current world events require greater attention.

The consultation shared concerns about the cultural significance of suicide for different communities. One person shared their concern about the cost of non-adherence to treatment which would eventually bring about the end of an individual's life but would allow them to avoid the term 'suicide' so that they could follow their own cultural or religious norms and spare their families suffering. This passive approach is more expensive for the NHS and more strenuous for the individual than an active approach such as taking a life-ending pill. They expressed concern that passive approaches are not based on quality of life. Their wider point was that the term 'suicide' could be harmfully misapplied to people taking passive approaches due to their cultural or religious beliefs. Another member added that the phrase "committed suicide" should always be avoided since it is not an offence. It was noted that people can make an advance directive setting out how they wish to be treated at a time they no longer have capacity. They also expressed that it is important that recommendations move away from terminal illness to mental illness to psychological suffering.

Group 3

This group used the Cycle of Support which was used in the previously mentioned focus groups because they shared similarities with the topics discussed at the consultation.

1. **Patient Diagnosis:** Initial assessment of the patient's condition.
 - a. It's an inexact science.
2. **Prognosis Evaluation:** Determining the patient's future health outlook.
 - a. Is it informed consent?
 - b. Is it part of the consent process that medics are wrong as often as they are right?
 - c. Is that an acceptable risk to the patient?



- d. Should they be informed about cases like Dame Esther Rantzen so they understand that prognosis can be wrong?
3. **Advance Care Planning:** Discussing and documenting the patient's wishes.
 - a. There is a need for different care settings to be having these conversations.
 - b. All health and social care teams need access to the knowledge that an individual has started the process of assisted dying current systems limitations would potentially compromise this.
 - c. For patients with dementia, it is unlikely that they will have six months left to live at a time when they retain capacity, but under the current proposal they would likely lack capacity at the point they would meet the requirement for prognosis.
 4. **Decision Making:** The patient making informed choices about care.
 5. **Coercion Prevention:** Ensuring the patient's decisions are free from pressure.
 - a. It is important for someone to be involved with assessment who knows the patient, like GPs making home visits. Someone with an established relationship with the patient is needed to help prevent coercion and self-coercion.
 - b. "We're all coerced in different ways all of the time. Don't we all try to adhere to different social norms? Where's the tipping point in that."
 - c. Assessment for coercion and training for this assessment is vital. You will never know what's going on in someone's mind "but the best way to make sure isn't someone who isn't familiar with them and their experience." Ideally the assessment would occur over a period of time rather than on a single occasion and would be carried out by a family doctor or other healthcare provider with an established relationship with the patient.
 6. **Societal Awareness:** Educating the public about assisted dying.
 - a. This needs to account for different regional ideas about assisted dying. What works for London may not work for Yorkshire or Bristol.
 - b. There are different norms for different workforces across the country depending on the communities represented in that area.
 - c. People, including those at the consultation, have different views on assisted dying after a personal experience with a loved one at the end of life.
 7. **Legal Advice:** Providing necessary legal guidance.
 - a. Instead of discussing legal advice, the group discussed training and moral distress/injury.
 8. **Practitioner Support:** Addressing the practitioner's needs and concerns.
 - a. Nursing staff may not feel comfortable to make a decision around making a referral for AD or then supporting patients on that pathway. They are not as safe to follow directives as medics and they may also feel directives are unclear.
 - b. ICPs Health services are in "utter chaos" so it is a challenge for practitioners to interconnect, they'll have to force their own way somehow. Why isn't there something in NHS talking therapies which would accommodate this?
 9. **Family Support:** Offering emotional and practical assistance to families.
 - a. A lot of the population do not think a great deal about death. If we are to call it a successful death, the patient has to go peacefully, and the relatives must think it was appropriate and peaceful too. Relatives would become almost as important as the patient in producing a death which allows everyone to move on.



- b. It depends on where you are but it's not automatic that the relatives will get support.

In response to this group, one member suggested that an individual provider might be a better option than assisted dying through the NHS, such as Dignitas. One person added that, "a state funded assisted dying service is difficult when you don't have a state funded end of life service." It was noted that more people die in home care than in hospice care. Another suggested that grief support may not be a medical task. While faith leaders may never be in favour of assisted dying, they may adapt to the change and provide meaningful pastoral support. Another member encouraged this as a step away from the medicalisation of dying and grief. Assisted dying could cause a different kind of grief. This idea was challenged, "We're talking about this as if they wouldn't die otherwise. It's important we keep coming back to that. This kind of grief could be better. We're not talking about the ways it could be better."

Group 4

This group took the perspective of what is needed to support the people involved. They also looked at the Cycle of Support, including educating the public in a way that accounts for cultural differences. It was noted that Canada requires citizenship whereas the UK only requires 12 months residency which is a positive for the many people who reside in the UK but do not chose citizenship. They discussed the importance of noticing incidents of coercion and making sure that mental capacity checks are robust. Exchanging their own personal stories helped this group to recognise the ways their own opinions had changed after a loved one reached end of life. They continued discussions about language, including what language should be used when people have different views and experiences.

Considering that it would take more effort for people with learning difficulties and communication difficulties to access assisted dying, there is not a potential two-tiered system but a multi-tiered system. They added that health and social care rely on clear roles for different situations. Families bringing in new power dynamics. They expressed that the likely four-year implementation of an Assisted Dying Bill in England and Wales provides an opportunity for those involved to prepare for what the Bill needs rather than believing the Bill would be impossible. Part of the purpose of the consultation, they agreed, is about anticipating the bill and being ready.

In response to this group, one member noted that a decline in mortality rates has made people less aware of death. Another added that there are lots of places around the world which have assisted dying legislation and could help advise the UK.

Group 5

The final group expressed that it was helpful for them to have a member among them with experience providing assisted dying in another country. They also expressed that the proposed legislation will not provide enough information until it includes the code of guidance. This will likely take a couple of years which impacts the four years of preparation greatly. They said that the order for making legislation should be "how can we make it work and what safeguards do we need?" They acknowledged that this is simply not how legislation gets made but the consultation can help decide what the code of practice says so it supports better experiences rather than contributing to resource drains or situations where "people are conflicted up until the last minute." It was reiterated that people often die with home care workers or in a home care setting. Home care workers may have the best experience but for many reasons are not trained to advocate adequately if they are put in front of the Panel. People may often tell home care workers that they wish they were dead, but those workers are excluded from the assessment process. They could feed in an informal way if their skills were recognised.

Regarding family support, a member of this group shared that there is an important difference in the mental health support which could be provided. Talking therapies would not be ideal in these cases since they focus on issues like anxiety and PTSD when related to an individual. ICU psychologists would be a better option but are not universally available. It is difficult to provide better resources for families and to account for their information since they cannot legally be included in the formal process. They do not have the same governance structures in place. A



psychologist on the Panel would be beneficial since a psychiatrist will give a diagnosis but not an "in the round" idea of a person.

A member from this group shared that they had direct experience of assisted dying for many years in several countries. Whilst they acknowledged that there had been many reasonable and sensible questions at the consultation, they expressed some frustration about the discussion, which they felt was indicative of the wider national conversation. "We act like the UK is considering something never tried before whereas assisted dying has been implemented and is working well in more than 15 countries, some for several decades." They explained that New Zealand was able to move from a referendum on its proposed legislation to implementing assisted dying in one year despite a "shoestring budget", a larger land mass than the UK with a much smaller population, far less national wealth, and in a way that only involved doctors. - The New Zealand referendum took place on 17 October 2020 and the legislation came into force / the national service started operating on 7 November 2021. They used the Netherlands as another example. Statistics from the Netherlands and Canada suggest that in countries with a long experience of assisted dying it accounts for roughly 5% of all deaths. "We're talking about a relatively small group of people." Similarly, the Netherlands has a lot of useful data which has been accumulated over 25 years of assisted dying experience. They added that grief is a normal part of life which we experience differently as people are dying later than ever before. Without healthy conversations about death, people become more afraid to visit hospitals since they believe they will die there. This can become a self-fulfilling prophecy since they then only go to hospital when they are dying. "We can safely and sensitively deliver [assisted dying]. If UK legislation is more conservative compared to Canada and the Netherlands, it will not be difficult or challenging. They encouraged those present to do more research into places where assisted dying is already legalised.

In response to this group, one member commented that some people believe certain actions around death can lead to spiritual suffering so their pain cannot necessarily be mitigated by assisted dying. The challenge for the faith community needs to be changing this perception through education, even if the language is euphemistic, even among politicians. Another member added that a timeframe of four years is not a "disaster" but a way to reinforce commitment of any area of care involved so that the process is as robust as possible and works for all. They noted that there are no examples of family support around the world.¹ "I welcome a lengthy implementation. It is what it is." It was suggested that laws might change during implementation, just as has been seen in Canada. In defence of a speedier process, an individual said that Covid showed the NHS is capable of quick, largescale turnarounds. "We have a real propensity to wrap ourselves in red tape which we threw out in first lockdown, and the world did not fall down." Another member added that social work was completely ignored during this time.

The feedback sessions ended with a request for the consultation to consider:

1. Some of the challenges which have emerged, like moral distress.
2. Some of the opportunities for their specific discipline.

Focus

The consultation was then divided into groups based on their expertise to discuss a 'wish list' of recommendations for the Terminally Ill Adults End of Life Bill (2024). They were asked, "What does 'good' look like for your perspective, faith, sector, profession? For delivering something meaningful for your patients and their families?" The groups made up of the following sectors:

- Acute Care
- Social Work and Social Care

¹ Subsequent to the writing of the report, a participant noted that "the following countries explicitly provide family support: Australia, Canada, the Netherlands, and Belgium. Reference https://academic.oup.com/eurpub/article/35/Supplement_4/ckaf161.545/8301657



- Community including GP's, hospices, AHP's etc.

Acute Care

This group divided their discussion into questions they wished to cover.

1. How do we respond to requests?
 - a. Hospitals should prepare staff across MDT to have sensible conversations.
 - b. HCPs should acknowledge the patient for taking the first steps. Terms like "bravery" should be avoided as it implies people who do not make this decision are "cowardly".
 - c. Patients should be referred to an outside service with expertise, and this would be the process through which information will be shared. Referrals can be a challenge in the NHS when it comes to accessing data and records.
2. How do we prepare for end-of-life?
 - a. There should be clarification in the code of practice, especially whether clinicians can raise concerns.
 - b. There should be a holistic needs assessment for those raising or wishing to discuss assisted dying as an option. This should include faith and spiritual leaders.
 - c. There is an opportunity, with the current focus on assisted dying, to improve the practice of offering Advance Care Planning to all with a life-limiting or life-threatening condition.
 - d. Regarding the needs assessment, is there planning for who will be able to address those needs?
3. How do we prepare trusts and organisations?
 - a. Inform staff about escalation pathways for when they are approached by patients about assisted dying.
 - b. In a hospital setting, there are lots of unmet needs already. What do we do with the existing ones and the ones which assisted dying could cause or add to? It requires us to look at existing staff wellbeing services. It should also be acknowledged that those services no longer exist in some places.
 - c. It's hard to prepare an entire sector. Staff should be informed about the details of the Bill as not everyone will be aware, but it is valuable to use existing systems to share information instead of something new where possible.
 - d. Reflecting on successes and current good work can also be beneficial for taking next steps.
4. How do we manage complications?
 - a. What if there is a complication outside of a hospital setting? If someone is brought into intensive care, what now? Clarity of guidelines makes everything easier.
 - b. What access is there to anticipatory medications? If this is being delivered in community settings and patient settings, who is with them? It could be a model to have a physician present like it is in other countries.
5. How do we educate the public?
 - a. We referred to the Cycle of Support and concluded that education is not our role. Of course, we'll communicate if someone is brought to us we'll communicate information pathways.
 - b. A system which is separate to the other sectors could be made in the same way as organ donation either regionally or nationally.
 - c. There are opportunities to strengthen existing practice and education around end-of-life care generally with assisted dying as an add on option. Most people



will not access assisted dying, but it could be seen as an opportunity for good awareness about dying.

- d. If we have a legal requirement to provide access to a regional assisted dying service, this would be a better argument for a legal requirement to provide access to regional palliative care. This would allow for better consent and access too.

The Social Care group added that very little of the process would go through acute care, and this group agreed. They asked why acute care would need to be involved in referrals. This group gave the example of a late-stage lung cancer patient in intensive care who may raise a desire for assisted dying. Both groups agreed that a patient may choose to talk to anyone, including physiotherapists or dieticians, so everyone should feel confident to respond when it is raised.

Social Care

The Social Care group expressed that there is a need to craft the referral process, including establishing what body supports the people around a patient. Additionally, they suggested this process should be short to spare people emotional pain. They suggested an emergency pool of trained social workers who could help. There were concerns that social care staff might feel panic around assisted dying as it is implemented, so there should be accessible information to help them understand it. Many people in social care, especially in care homes, are not fully informed on mental capacity. It's important that this improves before assisted dying is implemented. Perhaps there could be a nominated person in each care home who is informed on assisted dying. They also suggested a more general helpline about assisted dying so that people could gain more information. There was concern that people might get lost in the process and not achieve a 'good' death and that the six-month window might be too narrow for some people. They repeated the idea that people could be supported in going to Dignitas as a way to save resources. Regarding the Panel, they suggested an independent inspection like a CQC, called for all members of the Panel to be valued equally, and suggested that social workers should be informed about capacity assessments and consulted for their safeguarding experience.

Community

The Community group summarised and collated their thoughts into six points:

1. Have an interpreted, co-ordinated, supportive approach to implementation with key professionals who are trusted and skilled to be involved in the process (or part of the process).
2. Learn from key areas of health, social care and MDT services where there are synergies. For example, assisted dying best practice and how abortion and maternity teams are very separate.
3. Have the right conversations at the right time as part of a holistic Advance Care Planning process (with facilitation of communication where the conversation cannot happen verbally).
4. There needs to be a code of practice, and it should be informed by wider work, neighbourhood communities, and faith communities. It should be published prior to implementation.
5. Bring on board bereavement and grief services in expectation to avoid over medicalising dying and grief experiences.
6. Make effective funding and resourcing available to overcome accessibility barriers but not at the expense of current services.

Recommendations

The group were then asked, in accordance with St George's House practice, to come up with recommendations for improvements to the Bill and next steps they could make. They were



encouraged to consider who they should share these actionable steps and recommendations with and how these conversations could be done.

Acute Care

This group suggested the following:

1. A national service specification or framework which is based on international experience and other services. It should have adaptable clinical guidelines so that no one is trying to write guidelines from scratch across different regions and trusts. This would reduce the burden of resources quite significantly.
2. Assisted dying should be a separate service, either regional or national, which is outside of existing providers funded by DoHSC and NHSE. There is an opportunity within this option to improve what already exists.
3. Challenge policymakers about the Panel as it exists in the Bill right now since it does not address safeguarding needs, capacity, coercion, a holistic needs assessment and is resource intensive. Instead, they would suggest that Assisted Dying Practitioners have access to an Assisted Dying Panel which they can refer to in a timely manner as a matter of due diligence, but it does not need to include every proposed professional such as another doctor, a psychiatrist, a social worker etc. It may (but does not have to) include legal input, possibly only if other members of the Panel agree.
4. Parliament should oversee simplification of the act and the messaging, including staff education and training.
5. There should be national public health messaging around end-of-life care as a concept. We should consider assisted dying as one piece of that puzzle. This should be the responsibility of Parliament, DoHSC, DoE and third sector partners.

For completeness of the report, a member of the Social Care group added that parliament has considered best practice from other countries for the formation of the Bill.

Social Care

This group wanted to advocate for the inclusion of those in the social sector since they could be the first point of a conversation about assisted dying. While social workers are included in the Panel, social carers are not. Potentially, an individual may mention a desire to end their life to a social carer. To avoid moral distress for those in the social sectors they suggested an easy route for information exchange, which would be like the Gold Standard End of Life Care Framework since this is already effective.

This group shared concerns about pathways of referral which led to conversations about defining clear roles for those involved. The Acute Care group noted that social care workers would not be able to carry out a mental capacity check or provide informed medical information. They also noted that Acute Care workers would not always be directly involved in the assisted dying process either unless it related to someone in intensive care. A member of the Social Care group suggested that it would be "fine" for social care workers to be less involved. They explained that doctors are open and encouraging if they have questions but that it is not necessary for them to have an interest in areas of medical expertise. The Social Care group also suggested that social care workers could have valuable expertise in creating a 'good' death since it could require coordination to allow someone to die at home or in other preferred space to a hospital.



Community

The Community group funnelled their previous six points into four recommendations:

1. Have a code of practice working group to get started across professions and regions. It should include work done previously such as the work and report from this consultation. The proposed code of practice needs to be released soon. It should be made in parallel to the formation of the law to allow a task and finish group to develop it well. Other groups who could be consulted may be involved in:
 - a. Legal aspects.
 - b. Controlled drugs issues.
 - c. Professional practice issues.
 - d. Patient voice.
 - e. Professional bodies and groups.
 - f. Faith leaders.
 - g. Key functions and roles.
2. Monitoring and oversight should be carried out as part of governance. There should be a minimum data set and recording, mortality reviews, retrospective mortality reviews, and a medical examiner service for cause of death.
 - a. Commissioning should ensure that assisted dying is resourced appropriately and services are commissioned using national care principles.
 - b. Funding for all other services and needs is required to make sure that assisted dying is equitable. This is an important part of consent.
 - c. There should be careful messaging for the public to make sure that people don't think assisted dying is 'the cheaper option'.
 - d. Assisted dying should not be seen as an alternative to treatment.
3. Improve wider public understanding and conversations about death.
 - a. This should help prevent the medicalisation of death through the inclusion of faith and community groups.
 - b. The conclusion of this consultation could be that open conversations about death would be a huge positive for appropriate responses to assisted dying.
4. All work around assisted dying should be patient centred. This individualised response would have the MOT.

Conclusion

The consultation at St George's House encourages those who read this report to share it widely and contribute to it as they see fit. The group welcomes collaboration from the UK and other countries, especially those with experience of assisted dying that could help inform the proposed legislation in England, Wales, and Scotland. With this collaborative spirit, it is believed that legislation on assisted dying can be fair, sensitive, and well-resourced.



Participants

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