York Student Think Tank

# WHAT SAFEGUARDS NEED TO BE ADDED TO THE ASSISTED DYING BILL TO ENSURE ANY NEGATIVE IMPACTS ON FEMALE PATIENTS ARE MINIMISED?

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# EXECUTIVE SUMMARY

This paper deals primarily with the issue of 'assisted dying' however references have been made to 'euthanasia' and 'assisted suicide' as variants of the process.

The Terminally Ill Adults (End of Life) Bill would allow terminally ill adults in England and Wales to request, and be lawfully provided with, assistance to end their own lives in accordance with clauses 7 to 27 of the Bill, provided they meet the required criteria.

The Assisted Dying Bill is currently being debated in Parliament, and will have profound impacts on medical professionals, caregivers and vulnerable individuals who are terminally ill and their families, if it is enacted into law. It is, particularly as a backbench bill, one of the most contentious pieces of legislation being brought into force in the UK (Gover, 2024). There remains dispute as to who should guide the change; government, policy-makers, lawyers, doctors, or individuals themselves.

The paper deals first with the Bill as it stands on the 22nd of June 2025, identifying its key proposals.

- Those mentally competent aged 18 and over who have been diagnosed with a terminal illness and have 6 months to live can make an informed, independent, voluntary decision to end their life.
- Two independent doctors and a multidisciplinary panel must review each case, however the safeguards within the bill are not gender specific.

The relationship between feminism and assisted dying is then explored to provide context around why safeguards need to be added to the Bill to ensure female patients are protected.
An evaluation of existing legislation is then made using comparative case studies of Switzerland, Oregon, and New Zealand.

The paper concludes with our recommendations to ensure that there is sufficient safeguarding of women in the incoming law.

Our recommendations are:

- Train doctors to detect coercion which includes mentored clinical experience.
- Distribute manuals to the patients and their family members outlining what forms controlling behaviour can take and how to spot it.
- Introduce optional discussions with caregivers or family members in the presence of a mediator, such as a psychiatrist, to assess the relationship dynamics between them and the patient and enable doctors to assess whether the patient is motivated by feelings of burden or pressure from a family member (which would constitute coercion).
- Set a mandatory waiting period before doctors may act on the assisted-dying request.
- Ensure assisted dying is not portrayed as the only viable option whilst ensuring patients should feel free to consider it without fear of judgment.
- Collect data on motivations behind physician-assisted dying to avoid approving the procedure for patients who feel like “burdens” to their family or have been coerced into requesting Physician Assisted Dying.

# INTRODUCTION

Given the ethical and societal gravity of assisted dying (Box and Chambaere, 2024), it is important that there are gender related provisions that protect women sufficiently. Implementation of assisted dying into legislation would mean that terminally ill adults would lawfully be able to end their own life, assisted by a commissioner.

The debate around legalising assisted dying inevitably has feminist connotations, concerning rights of self-determination, autonomy, and resource disparities (Tulloch, 2015). Feminists have been central to 'right to die' movements, from suffragist Anna Hall, who campaigned for legalising assisted dying for the terminally ill in Ohio, to the founders of the British Voluntary Euthanasia Legalisation Society, since renamed Dignity in Dying (Kitzinger, 2015).

There seems to be binary arguments concerning the relationship between assisted dying and women. The first is that women are in danger of assisted dying being too available of an option, perpetuating the notion of 'self-sacrifice' that is prevalent in the literature. Equally, women are in danger of being denied the right to die due to inherent medical gender biases and the patriarchal nature of decision-making bodies. In Britain, 71% of women surveyed supported the right to an assisted death for competent adults with a terminal illness, with appropriate safeguards (Kitzinger, 2015). However the inextricable fears voiced by policymakers that vulnerable groups will be at risk of an involuntary death hinders law making (Kitzinger, 2015).

The purpose of this paper is to evaluate the sufficiency of the incoming bill to provide both protection and sufficient access to assisted dying. An effort must be made to combat any legislative lag that may occur due to ignorance surrounding the implications of a law with such a potentially detrimental effect on more vulnerable recipients like women (Tulloch, 2015).

# THE BILL

The Assisted Dying Bill is a proposed law that will give terminally ill, mentally competent adults in the UK the option to choose assisted dying. The ability to request medical assistance to end their life gives the individual control over the timing and manner of their death.

**Eligibility (criteria to be eligible for assisted dying):**

- Eligibility for assisted dying is restricted to those diagnosed with a terminal illness, expected to live for 6 months or less.
- The individual must be aged 18 years or over.
- Individuals must be mentally competent, with the mental capacity to make the decision.
- Individuals must have a clear, informed wish to end their own life, and have made the decision voluntarily and without coercion.
- They must be a permanent resident of England and Wales.

**Safeguards:**

- A person who uses dishonesty, coercion or pressure to induce another person to end their own life is liable to imprisonment for 14 years.
- Two independent doctors must confirm that the individual meets the eligibility criteria and has made the first declaration voluntarily, free from coercion.
- A multi-disciplinary panel, including a senior lawyer or High Court judge, must review and approve each case.
- There is a mandatory period of reflection after which the individual must confirm they still wish to end their own life.
- The individual must self administer the approved substance.
- While the Bill sets out some safeguards, these are not gender specific, meaning they do not adequately protect women from the distinct risks and vulnerabilities they face.

# FEMINIST THEORY

Sikka (2019) argues that critical feminist theory focuses on the toll that power has on shaping institutions, and can assess how policies like assisted dying can work to perpetuate sources of oppression and marginalisation in unexpected ways. The intersection of identity characteristics, and implicit assumptions by the health care providers on race, gender, class, sexuality, disability influence the quality of care received and the barriers to equitable health care.

Gendered dynamics play a significant role in the ways in which people engage with health care and make end of life decisions. Grant et al., (2024) demonstrates that the social conditioning of women to place the needs of others above their own may lead to an increased sense of obligation to request an assisted death, in response to perceived burdens on family members, particularly in cases where they may already be experiencing chronic illness or physical frailty. Yoo et al. (2010) found that racialised women, and those belonging to minority ethnic groups, face an even stronger sense of duty to manage the emotions of others due to a more pronounced division of gender roles with the additional burden of shame related to dying. This links to the emotional labour that women do when deciding whether to use end of life care, and how they discuss this with their family.

Westwood (2021) advocates creating a right to assisted dying and a right to death for those who wish to exercise that right as long as they have the mental capacity to decide, and embodied rights for pro-assisted dying feminists support the argument that the right to choose what happens to their own bodies prevails over other priorities (Mackenzie, 1992). Downie (2020) shows how these ideas were carefully considered within arguments supporting assisted dying in Canada, arguing that assisted dying reduces suffering, respects relational autonomy and sends positive messages about the capacity of women and the elderly.

Parks (2000) argues that by virtue of the expectation that women will be altruistic caregivers, their own voices and claims to autonomy in requesting death are easily dismissed. Women's choices, their capacity to reason and accurately represent their own interests are undermined, consequently resulting in women's claims to suffering being disregarded. The bill will need to ensure that women's pain is sufficiently recognised, and that their claims are fairly treated.

Cannetto and Hollenshead (2000) argue that women's decisions for assisted dying are influenced by their entrenched social and economic disadvantage and legislation needs to curtail potentially abusive practices that undermine patient autonomy.

# In Law

Those concerned with feminist ethics can acknowledge that men occupy a certain degree of male privilege in both medical and legal sectors of society simply by being the default personality in policy making. In the words of Helena Kennedy KC, equalisation has almost invariably been towards a male norm (Kennedy, 2005). There has existed a double standard in the language used in 'right to die' court decisions, with cases involving men crediting the 'manly rationality' of the decision and the cases involving women deeming them 'unreflective, emotional or immature' on the contrary (Kitzinger, 2015) which creates damaging presumptions that will hinder access to a fair ruling.

The law is a regulatory tool which perpetuates social expectations, governs right and wrong, and should reflect equal standards. Legislators have the capacity to perpetuate systemic oppressions by codifying them in law and policy under the guise of neutrality (Sikka, 2019). If the law continues in its inherent masculinity, social exclusion is an inevitability which is deeply concerning with regard to end-of-life decisions that link the individual and the state.

# In Medicine

Androcentric practice pervades medical practice too. Medical education has historically been focused on a male norm, with women referenced (if ever) as a variation of science. An analysis of recommended textbooks showed that male bodies were used three times as often as female bodies to illustrate 'neutral' body parts (Criado-Perez, 2019); in medical teaching there seems to exist a body and a female body. Women have been similarly excluded from medical research trials (Criado-Perez, 2019). This dismissal of women as separate entities with different needs affects access to relevant, safe medical advice, which is detrimental in relation to assisted dying with its fatalistic outcome.

There often exists a distrust felt by women towards health-care providers, who have frequently experienced 'scepticism,' leaving them feeling 'rejected,' 'belittled,' and 'blamed' for any grievances to their health (Sikka, 2019). Arguments could be made then that improvements need to be made first to the consultation processes to restore confidence in life-affirming treatments to avoid aspects of coercion, misinformation, or undue advertising of the process. On the contrary, a parallel can be drawn from arguments surrounding the legalisation of abortion; legalisation does not create a mandate. The option of an assisted death does not detract from those who wish to be provided palliative care. Provided that training and moderation of the process is undertaken, the requirement that two independent doctors must be satisfied with an individual's wish to die is a beneficial protectionist measure that seeks to ensure certainty, free will and capacity.

The proposed bill refers specifically to terminally ill people who are expected to die within six months. This specificity, whilst important for clarity and confidence in the safeguards constructed by the law, discriminates against those who may be terminally ill without a timeline or may be battling chronic illness, debilitating disability or severe conditions like dementia or Alzheimer's. Feminist psychologist Sandra Bem notably took her own life after losing her capacity for 'critical interests' due to Alzheimer's (Henig, 2015). 65% of those living with dementia in the UK are women (Benham-Hermetz, 2022). The lack of accommodation for these conditions in the proposed law has made it narrow and potentially exclusionary, and undermines significant motivations for legalising assisted dying, being the retention of dignity and autonomy (Tulloch, 2015). On the other hand however, this provision may suffice as a term of compromise to prevent the accusations of modern-day eugenics that has come to be associated with assisted dying by its critics (Kitzinger, 2015). The Bill's six-month parameter, whilst tidy and definitive, is devoid of empathy for chronic conditions and illness that cannot feasibly attract a timeline, which disproportionately affects women and puts undue pressure on medical professionals to produce an accurate prognosis, rendering the service even more inaccessible in addition to structural and attitudinal barriers that exist anyway.

# HOW HAS ASSISTED DYING BEEN USED?

## Case Study: Switzerland

*Introduction and so on*

Active euthanasia in Switzerland is characterised as the administration of death by a third party. A clear distinction is made between this and assisted suicide - which is legal and means to supply the means of dying by a third party. The Swiss Penal Code (Article 115) provides a punishment of up to 5 years of imprisonment for a person who assists in another's death only if it is found that the third party had selfish motives. Euthanasia - termed as 'murder upon request by the victim' in Article 114 - is illegal and punishable as a misdemeanour by an imprisonment of up to 3 years or a fine. This legal framework, especially as Switzerland is one of few countries that permits assisted suicide, has led to the 'death tourism' phenomenon.

In Switzerland, there are no specific laws pertaining to physician-assisted death (PAD), only medical-ethical directives established by the Swiss Academy of Medical Sciences (SAMS) (Brule, 2023). The guidelines on dying and death published by SAMS and Swiss Professional Association for Nurses (SBK/ASI) (2022) outline how a physician is not responsible or obliged to perform an assisted suicide, but if the physician chooses to provide this service, there are circumstances that have to be fulfilled and secondarily reviewed in order for this service to be justified. These requirements would be that the patient has sufficient capacity, expresses an autonomous wish, experiences severe suffering, and has an awareness of and considered alternatives. However, Brule (2023) notes that due to pressures from right to die advocacies like Exit and Dignitas, healthcare institutions in certain cantons can no longer refuse assisted suicides, otherwise state subsidies will be withdrawn.

Switzerland is used as a case study within this project since the distinction between PAD and euthanasia is made clear within the Swiss legislation. Similarly, the UK Bill (Terminally Ill Adults (End of Life) Bill, 2025) states that no doctor is allowed to administer a lethal drug to the patient i.e. euthanasia remains illegal, emphasising the need for the patient to voluntarily self-administer the medication (with appropriate guidance from the clinician if necessary). With the exception of the fact that terminal illness is not a necessary eligibility criterion in Switzerland, the laws concerning PAD in the UK and Switzerland are largely the same, making Switzerland a sufficient case to evaluate which safeguards would make an assisted dying bill more equitable in reference to gender.

*Statistics*

In a study by Steck et al. (2014) investigating whether socio-economic status and factors have influence on any disproportions within rates of assisted suicides, it was found that women were one of a few groups that were most vulnerable to inequalities resulting from a PAD bill. In Table 1 (Table 2, p. 618, ibid.), out of 1301 assisted deaths that happened across 2003-2008, 740 (56.9%) of those deaths were women. Additionally, in Table 2 (Table 4, p. 620, ibid.), across all age groups, the incidence of assisted death was significantly higher among women. More recent supporting studies analysing the increase of assisted suicide in Switzerland by Steck, Junker and Zwahlen (2018) and Montagna et al. (2023) have supported that this proportion has stayed consistent in more recent years as well - the female gender still being an associated factor for higher rates of assisted suicide.

**Table 1**: Socio-demographic characteristics of study population and crude rates of assisted suicide, Switzerland 2003-2008

| Characteristics | | Study population | | Assisted suicides | | Crude rate per 100 000 | |
|---|---|---|---|---|---|---|---|
| | | Number | % | Number | % | Estimate | 95% CI |
| All | | 5 004 403 | 100 | 1,301 | 100 | 4.5 | 4.3–4.8 |
| Gender | Male | 2 402 899 | 48.0 | 561 | 43.1 | 4.1 | 3.8–4.4 |
| | Female | 2 601 504 | 52.0 | 740 | 56.9 | 5.0 | 4.6–5.3 |

**Table 2:** Number and percentage of assisted suicides among all deaths from selected underlying causes* by gender and age

| Cause | Aged 25–64 years | | | | Aged 65–94 years | | | |
|---|---|---|---|---|---|---|---|---|
| | No. of assisted suicides/ total no. of deaths | | Percent (95% CI) | | No. of assisted suicides/ total no. of deaths | | Percent (95% CI) | |
| | Men | Women | Men | Women | Men | Women | Men | Women |
| Cancer | 99/20033 | 124/15323 | 0.5 (0.4–0.6) | 0.8 (0.7–1.0) | 146/32060 | 139/26703 | 0.5 (0.4–0.5) | 0.5 (0.4–0.6) |
| Digestive | 29/6263 | 31/3336 | 0.5 (0.3–0.6) | 0.9 (0.6–1.3) | 40/8856 | 41/8493 | 0.5 (0.3–0.6) | 0.5 (0.3–0.7) |
| Respiratory | 16/6003 | 18/2895 | 0.3 (0.2–0.4) | 0.6 (0.4–1.0) | 12/6711 | 18/2824 | 0.2 (0.1–0.3) | 0.6 (0.4–1.0) |
| Breast | 0/20 | 32/3712 | 0.0 | 0.9 (0.6–1.2) | 0/25 | 34/4407 | – | 0.8 (0.5–1.1) |
| Male genital | 13/1109 | – | 1.2 (0.6–2.0) | – | 48/6882 | – | 0.7 (0.5–0.9) | – |
| Others | 41/6638 | 43/5380 | 0.6 (0.4–0.8) | 0.8 (0.6–1.1) | 46/9586 | 46/10979 | 0.5 (0.4–0.6) | 0.4 (0.3–0.6) |
| Mental and behavioural | 5/2514 | 9/1284 | 0.2 (0.1–0.5) | 0.7 (0.3–1.3) | 14/5040 | 22/11003 | 0.3 (0.2–0.4) | 0.2 (0.1–0.3) |
| Mood disorders | 3/857 | 8/566 | 0.4 (0.1–1.0) | 1.4 (0.6–2.8) | 9/365 | 21/519 | 2.5 (1.1–4.6) | 4.0 (2.5–6.1) |
| Other | 2/1657 | 1/718 | 0.1 (0.0–0.4) | 0.1 (0.0–0.8) | 5/4675 | 1/10484 | 0.1 (0.0–0.2) | 0.01 (0.0–0.01) |
| Nervous system | 32/1261 | 49/1157 | 2.5 (1.7–3.6) | 4.2 (3.1–5.6) | 33/5566 | 47/8771 | 0.6 (0.4–0.8) | 0.5 (0.4–0.7) |
| Motor neuron disease | 13/266 | 13/181 | 4.9 (2.6–8.2) | 7.2 (3.9–12.0) | 8/243 | 8/284 | 3.3 (1.4–6.4) | 2.8 (1.2–5.5) |
| Parkinson's disease | 4/87 | 1/51 | 4.6 (1.3–11.4) | 2.0 (0.0–10.4) | 10/1764 | 14/1569 | 0.6 (0.3–1.0) | 0.9 (0.5–1.5) |
| Multiple sclerosis | 6/150 | 27/290 | 4.0 (1.5–8.5) | 9.3 (6.2–13.3) | 1/77 | 5/228 | 1.3 (0.0–7.0) | 2.2 (0.7–5.0) |
| Other | 9/758 | 8/635 | 1.2 (0.5–2.2) | 1.3 (0.5–2.5) | 14/3482 | 20/6690 | 0.4 (0.2–0.7) | 0.3 (0.2–0.5) |
| Circulatory system | 4/12018 | 3/4176 | 0.03 (0.0–0.1) | 0.1 (0.0–0.2) | 44/48709 | 62/70065 | 0.1 (0.1–0.1) | 0.1 (0.1–0.1) |
| Musculoskeletal | 2/192 | 8/209 | 1.0 (0.1–3.7) | 3.8 (1.7–7.4) | 8/691 | 54/1964 | 1.2 (0.5–2.3) | 2.7 (2.1–3.6) |
| Other | 27/9740 | 31/5230 | 0.3 (0.2–0.4) | 0.6 (0.4–0.8) | 56/26342 | 75/32633 | 0.2 (0.2–0.3) | 0.2 (0.2–0.3) |
| All causes | 169/45758 | 224/27379 | 0.4 (0.3–0.5) | 0.9 (0.8–1.0) | 301/118408 | 399/151139 | 0.3 (0.3–0.3) | 0.3 (0.3–0.4) |

[a]Analysis is based on all deaths except external causes (ICD-10 codes S00-T98, V01-X59, X85-Y98). The first underlying cause is shown.

*Analysis of statistics and studies*

Considering this, the higher incidence of the female gender within assisted suicide statistics could imply that women are disproportionately affected by physician-assisted suicide. This can be inferred through reading the Swiss law, as there are no specific national laws about assisted suicide although it is legal. The Terminally Ill Adults Bill implements safeguards against coercion similarly to the directives published by the SAMS, which could imply that women in the UK could be similarly disadvantaged by assisted death. In order to ensure that female populations are at higher risk of an assisted death law, gender-specific safeguards should be put in place.

# Case study: Oregon

*Introduction and so on*

The Oregon Death with Dignity Act (1997) allows eligible adults suffering from terminal illnesses to voluntarily make a written request for lethal medication. In Oregon, the eligibility criteria to make such a request would mean the patient is an individual older than 18, who in the opinion of a court or physician can communicate health care decisions to providers, and has an incurable, terminal illness that will, within reasonable medical judgement, produce death within 6 months. The attending physicians are responsible for determining eligibility, ensuring that the patient has full information and to counsel the patient on how the medication should be taken. Safeguards in the legislation pertain to ensuring the patient has full information, but does not explicitly include protections for vulnerable populations.

Oregon is an appropriate case study to use since the definition of PAD used in the UK and Oregon is almost identical, with the only exception being the fact that a physician is not required to be present at the time the patient self-administers the lethal medication.

*Statistics*

Although men make up a slightly higher proportion of total assisted deaths (Oregon Health Authority, Public Health Division, Center for Health Statistics, 2025), a study by Canetto and McIntosh (2022) makes the analysis of how within general suicide statistics in older women, physician-assisted death is significantly more likely to used as a method of suicide compared to non-assisted. The opposite is observed in older male statistics. This supports the argument that women avoid self-initiated deaths and have a preference for more structured methods of death (Meier et al., 1998). Combining this with the lack of appropriate safeguarding for vulnerable populations in the Oregon Bill and the finding that 46% of all assisted suicides provided feeling like a burden as a reason for request (Regnard, Worthington and Finlay, 2023), these statistics could imply a higher likelihood of female vulnerability in assisted dying that would need to be addressed in the UK Bill.

*Analysis of statistics and studies*

However, it has been pointed out that there are gaps in data when it comes to preliminary evaluation and psychological examination of patients in Oregon, with individuals suffering from treatable depression receiving approvals of PAD requests (Regnard, Worthington and Finlay, 2023). This must be considered within the UK legislation with compulsory and thorough evaluation being a necessary eligibility criterion for PAD to safeguard against approval of PAD in cases where the motivation stems from the patient feeling like a “burden” (Regnard, Worthington and Finlay, 2023), which is more likely to happen to female patients (Grant et al., 2024). The requirement to collect data on motivations behind PAD must be a part of the UK Bill, with cases where the patient feels as if they “burden” their family becoming ineligible, in the way it is done in New Zealand (Casey and Macleod, 2021).

# CONTEXTUALISING A GENDERED SOLUTION: NEW ZEALAND VS SWITZERLAND

Assisted death in New Zealand refers to both the practitioner and patient administration of a lethal dose of medication to relieve the suffering of an eligible patient. In New Zealand, the distinction is not made between euthanasia and physician-assisted death (End of Life Choice Act 2019, Part 1.4) unlike the UK, which is why statistics drawn from New Zealand are not used as a primary source of support for a medical gender bias, but rather in support of safeguards that could be added to the UK bill.

**Safeguards in New Zealand legislation:**

- Primary and secondary practitioners must be satisfied that the patient is making their own decision and is not being coerced. This can be done by talking to other health care professionals who have treated the patient or by talking to the patient's family if the patient approves it.
- A psychiatrist may be consulted if the practitioners have concerns about the capacity of the patient to consent.
- Some patients, in the event of an illness that inhibits the patient's ability to communicate their own wishes, can place an advance directive communicating a request for PAD or can appoint someone using the enduring power of attorney to make decisions for them. However, an advance directive is not binding, and the patient's enduring power of attorney cannot make the decision to use PAD for the patient.
- A patient cannot request PAD for the sole reason of being elderly, they must fulfil all other criteria as well.
- The practitioner cannot initiate the discussion for assisted dying.

Data on the gender proportions of assisted suicide cases suggests that women are sufficiently safeguarded by legislation in New Zealand. In the Assisted Dying Service, Annual Service Report 2024, (Table 3 below, cited from Table 2, p. 8), the total proportion for applicants for PAD were 50.2% female since assisted death came into effect in 2021. Approved cases are also relatively equal in gender proportions – fluctuating between 45% to 55% female between 2021 to 2024 annually.

**Table 3:** Demographic summary of applications for assisted suicide by sex and age.

| Demographic summary: New applications (N=2,482) 7 November 2021 – 30 September 2024 | | Number of people[3] | % of applications |
|---|---|---|---|
| Sex | Female/wāhine | 1250 | 50.20 |
| | Male/tāne | 1232 | 49.80 |
| | Gender diverse | 0 | 0.00 |
| Age group | 18-44 | 50 | 1.99 |
| | 45-64 | 479 | 19.21 |
| | 65-84 | 1434 | 58.03 |
| | 85+ | 519 | 20.77 |

As explained earlier, there aren't many explicit safeguards in Switzerland apart from the necessity of the assisted suicide being carried out by only the individual. From 1999 to 2022, Switzerland has also maintained a female bias of 58% female patients (Güth et al, 2024, p. 1227).

This raises the point of whether illegalising euthanasia serves a significant safeguarding purpose. In the Public Committee Debate Session 2024-2025, Our Duty of Care highlights the risk of expansion to euthanasia as needing greater consideration. However, if we consider the cases of New Zealand and Switzerland, where they respectively do not and do outlaw euthanasia, we can see New Zealand has a balanced gender proportion of patients and Switzerland has a consistent unbalanced gender proportions.

In New Zealand, of 978 successful assisted deaths since 2021, 906 of those were administered by the physician through lethal injection (Review of the Choice of Life Act 2019, p.37) - implying that the preference for euthanasia is ungendered.

Additionally, another paper by Canetto & Hollenshead – analysing Dr Kevorkian's unauthorised euthanasia study, it was found that women were most likely to opt for lethal injection administered by the doctor, and men were most likely to opt for carbon monoxide poisoning (Canetto & Hollenshead, 1999, p.168).

The fact that both sets of data contradict each other in whether gendered biases and a safeguarding concern exists between euthanasia/PAD should instead signify that arbitrary distinctions between PAD and euthanasia are unimportant and that strict, clear rules around assisted death and safeguarding should instead be highly prioritised.

# RECOMMENDATIONS

## Medical training & awareness

01 **Train doctors to detect coercion which includes mentored clinical experience (Our Duty of Care, 2025).**

02 **Manuals outlining what forms controlling behaviour may take and how to spot it should be distributed to the patients and their family members.**

## Explicit procedures

03 **Collect data on motivations behind physician-assisted dying to avoid approving the procedure for patients who feel like "burdens" to their family or have been coerced into requesting PAD. For this a separate council should be established to collect and analyse such data, echoing the practice implemented in New Zealand.**

04 **Set a minimum doctor-patient relationship length to minimise the risk of "doctor-shopping" observed in Oregon (Houghton, 2019).**

05 **Set a mandatory waiting period before doctors may act on the assisted-dying request.**

# Regulation of practitioner-patient relationship

06 **Ensure medical practitioners do not initiate discussions of assisted dying to avoid coercion "by the process" (The Other Half, 2019), where the patient would choose to opt for PAD to please their doctor.**

07 **In the event a patient expresses a wish for an assisted death, ensure patients are fully informed about all the treatment and care options available to them beyond assisted dying, including the potential risks and benefits associated with any particular option. It is essential that assisted dying is not portrayed as the only viable option, yet patients should feel free to consider it without fear of judgment.**

08 **Introduce optional discussions with caregivers or family members in the presence of a mediator to assess the relationship.**

# DISCUSSION OF RECOMMENDATIONS

The implementation of the Recommendations above is necessary to minimise negative impacts of assisted dying practice on female patients and minimise risks of approving PAD for reasons other than informed and autonomous consent of the patient. As a rule, medical practitioners should foster a culture of trust and respect at all times, to build rapport and facilitate open and honest communication with the patient so as to understand and be able to assess their motivations behind the end of life decision.

As for Recommendation 1, a voluntary assisted dying awareness module available to healthcare workers in the Australian state of New South Wales and taking around 30 minutes to complete (NSW Health, 2023) may be used as a starting point for the UK healthcare system to develop and implement similar online training modules. Online learning platforms, such as BMJ Learning and the NHS Learning Hub, can be used to ensure quick and easy access to the training modules.
Training to identify signs of coercion should be prioritised for medical practitioners working with vulnerable groups, but it should also be made widely available for other specialisms to access, to account for the high workload of doctors today.

Recommendation 3 would involve additional costs, as government funding would be required to establish a council and employ data analysts able to analyse the data collected and draw meaningful conclusions. Some of the process could be automated with patients or their carers filling in digital questionnaires detailing their journey to the decision regarding PAD and linked to a digital database.
Alternatively, the government may consider establishing a fund or subsidising general practitioners, researchers, to collect and analyse data on assisted dying, as well as working through the data currently available in archives to provide a better picture of the PAD decision-making process in the past.

With regards to Recommendations 4 and 5, the requirement to introduce a minimum doctor-patient relationship length and mandatory waiting period acts as an ethical safeguard for the doctor to ensure that the approval of the dying request is based solely on facts rather than motivated by feelings of compassion resulting from the patient's circumstances. While concerns may be raised about the patient having to suffer while waiting to fulfil the bureaucratic requirements, the waiting period should be reasonable given the six-month prognosis and should not exceed a month.

The practice described in Recommendation 6 has generated significant discourse in countries where assisted dying has been legalised. While a comprehensive assessment of all disadvantages lies beyond the scope of this paper, the main concerns with this safeguard are, firstly, that it may be seen as a violation of service users' rights under Regulation 9 (sub-paragraphs c and g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (UK Government, 2014), in that patients may not receive a full explanation of all available treatment options available to them; and secondly, that it may create barriers for individuals from less privileged backgrounds or with lower levels of education—and therefore reduced access to information—who may remain unaware of this option (Casey and Macleod 2021, p. 115).

For these reasons, it may be proposed that medical practitioners be prohibited from initiating discussions about physician-assisted dying unless the patient expresses a consistent and recurring desire to end their life or alleviate suffering prematurely. However, recognising the sensitivity of this, it may be beneficial to initiate a broader discussion involving field experts, medical professionals, legal practitioners, and relevant government bodies.

The practice outlined in Recommendation 8 should remain optional in order to protect the patient's privacy in cases where they do not want information about their illness or assisted dying request to be shared with their family members, following the precedent set in New Zealand (Health New Zealand, 2024). With this ethical aspect taken into account, the practice may serve to increase the likelihood of the PAD request being approved in cases where coercion is suspected.

We recommend that an annual report is published after the implementation of the Bill, with the possible revision of the publishing guidelines should concerns about the costs of annual assessment arise. The Report should contain statistics on:

- Age;
- Gender;
- Ethnicity;
- Socioeconomic status;
- Family status;
- Area;
- Illness type;
- Time taken from beginning to end of treatment (including doctor-patient relationship length);
- Motivations for both unsuccessful and successful applicants;
- Detailed instances of suspicion of coercion.

The Recommendations require a revision of the assisted-dying procedure to allow the safeguards discussed to be implemented. These should not be neglected since they help minimise risk of coercion, emphasise the patient's autonomy, and ensure that the patient's eligibility is thoroughly analysed.

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