Research report August 2025

Assisted dying in practice

International experiences and implications for health and social care

Sarah Scobie, Rachel Hutchings, Miranda Davies,
Stephanie Kumpunen and Sarah Reed

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1 Introduction

Purpose of this research

This report reviews evidence from countries where assisted dying has been legalised, to understand the implications of a change in the law for the health and social care system in the UK. We focus on the challenges the health and care system might face if assisted dying is legalised, and what we can learn from experience elsewhere.

At the time of writing, the Westminster parliament is considering a bill to legalise assisted dying for terminally ill adults in England and Wales:[1] the bill will be debated in the House of Lords during autumn 2025. In Scotland, the Scottish parliament is reviewing a similar, but not identical, bill.[2]

No operational or funding decisions have yet been made about provision for assisted dying, should it become legal. Although international experience is often referenced in debates about assisted dying,[3] there is a lack of systematic research examining evidence from other countries and how it can inform policy in the UK. Building on our first report on assisted dying,[3] which describes differences in how assisted dying has been implemented internationally, this report starts to address that gap. While much of the current debate has focused on the legal and ethical issues associated with legalising assisted dying, less has been focused on the wide range of systemic, operational and practical issues that health systems have encountered – and how these affect people who wish to die, their families and carers, staff and volunteers working with people at the end of life, and the organisations that provide care.

We restrict our research to lessons from 15 jurisdictions in nine high-income countries with populations of more than three million people where assisted dying is legal (see Chapter 2 for details of our methodology), and focus on evidence of the effects of assisted dying on health and care systems. Impacts on the legal system or the political or social drivers that led to initial legislation are out of scope of this report; however, we do discuss changes to legislation and the implications for practice.

Boxes 1 and 2 set out our organisational position on assisted dying and definitions/terminology respectively.

Box 1: Our organisational position on assisted dying

The Nuffield Trust is an independent health think tank. We aim to improve the quality of health and social care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The Nuffield Trust retains a neutral position on the ethics of whether or not assisted dying should be legalised, for whom, and in what circumstances. But we are committed to identifying evidence to support decision-makers in understanding the effects that the legalisation of assisted dying may have. The focus of this report is not on the question of whether or not assisted dying should be legalised, but on the potential implications of a change in legislation for health and social care services, for non-statutory providers such as hospices and their workforce, as well as for individuals and families.

The Nuffield Trust is well suited to take on this challenging topic, given our independence and our experience of drawing system-level lessons from international settings.

Box 2: Definitions and terminology

Assisted dying

A wide range of terminology[4] related to assisted dying is in use and definitions vary.[5] In this study we follow the approach of the Nuffield Council on Bioethics and use the term 'assisted dying' as an umbrella term for a range of situations 'involving health care professionals in providing lethal drugs intended to end a patient's life at their voluntary request, subject to a set of conditions'.[6] This includes the following:

- self-administration of the lethal drug required to die, following prescription by a clinician at an individual's request – sometimes referred to as 'assisted suicide'
- clinician administration of the lethal drug, following a voluntary request from the individual – sometimes referred to as '(voluntary) euthanasia'.

End of life care

End of life care is the treatment and care provided to people likely to die within a year.[7] It is intended to enable people to live as well as possible until they die, and to die with dignity. For some people, and some health conditions, it can be clear well in advance that they are approaching the end of life, but for others they may only know months or weeks before death.

Euthanasia

Euthanasia is defined as the act of deliberately ending a person's life to relieve suffering.[8] For example, it could be considered euthanasia if a doctor deliberately gave a patient with a terminal illness a drug they do not otherwise need, such as an overdose of sedatives or muscle relaxant, with the sole aim of ending their life.

Palliative care

Palliative care[9] aims to make the dying individual as comfortable as possible, relieve pain and other distressing symptoms, provide psychological, social and spiritual care and give support to families, carers and others who are close to the person. Depending on the individual's care needs, a range of medications can be considered to manage symptoms at the end of life.[10]

Structure of this report

In the remainder of this introductory chapter we describe the current arrangements for end of life care in the UK, in order to understand the context within which assisted dying would be implemented if it is legalised.

In Chapter 2 we explain our methods and data sources and the limitations of the research to bear in mind.

In Chapter 3 we set the scene by describing the core components of assisted dying pathways in other countries, and summarise what we know from international evidence about who receives assisted dying and in what circumstances.

In Chapter 4 we examine what other jurisdictions have done to deliver assisted dying – describing the wide range of systems and services that have been established, what they do, variation in approaches between countries and common challenges that have arisen from which the UK can learn. We then look at what is known about the impacts of assisted dying on individuals and families, including on broader end of life care, and finally we review evidence about how staff and organisations are affected, including considering training for staff.

In Chapter 5 we consider implications in the UK context, and recommendations for UK policy makers.

End of life care provision in the UK

The divergent approaches taken to implementing assisted dying in other countries highlight the importance of considering the context within which assisted dying is implemented, including how the health and care system is organised, as well as wider societal factors.[3] In this section we identify some of the important considerations for the UK.

Health and social care are devolved to the governments of the four UK countries.

Health and social care in Scotland and Wales are devolved to their respective parliaments, and in Northern Ireland to the Northern Ireland executive. Justice is not devolved in Wales. While the health systems in each individual country of the UK share many common features, there are also differences that impact on how end of life care operates in each one,[11] for example the extent to which health and social care are integrated.

The landscape for the provision of end of life care in the UK is fragmented across the NHS, private and voluntary sectors, all of which play a critical role.

More than half of people die in home or community settings, with more than a fifth of people in the UK dying in care homes, and a further 29% dying at home, with support from home care services, primary care, community and hospice services, and family carers. However, the most common place of death is in hospital (accounting for 43% of deaths).[12]

While NHS care is generally free at the point of use across the UK, this is not the case for social care.

Access to social care varies widely across the UK, shaped by different policies, funding mechanisms and eligibility criteria.[13] Social care is provided by a combination of private, voluntary sector and local authority run services. A higher proportion of social care services is privately provided in England than in Scotland, Wales and Northern Ireland.[11]

Specialist palliative care and end of life care (see Box 2) are distinctive because of the role that independent hospices, operating largely outside the NHS, play in delivering these services.

While there is a spectrum across the UK in how specialist services are delivered, the majority of hospice inpatient beds are in voluntary or charity organisations, with some being NHS run. Either the NHS or the voluntary sector can deliver specialist liaison palliative care services in hospitals and the community. Under half of the funding for services that independent hospices run is from the public purse (44% in 2022), with the remainder coming from charitable funds.[11] Many hospices also have links to faith organisations and may be more likely to have an organisational position opposed to assisted dying – we discuss institutional objection further in Chapter 4.

Services in the UK are under considerable pressure, as funding and resources have struggled to keep pace with demographic and technological change.

Although the UK is not unique in this respect, relatively lower funding during the decade before the Covid-19 pandemic resulted in the NHS having less resilience than similar health systems, and more challenges in recovering afterwards. The NHS budget has not grown as quickly in recent years as the long-term spending trend, and there are substantial unfunded spending pressures.[14]

Inequalities in end of life care persist – and interact with understanding of end of life care.

Health inequalities and diversity are important factors to consider in end of life care, in relation to the cultural norms, preferences and resources of people who are dying, and also in relation to diversity in the health and social care workforce. People in more deprived areas are more likely to die in hospital, and spend more time in hospital in the last year of life, than people from less deprived areas.[15] Enabling individuals to die in their place of choice is an established goal of end of life care services, but preferences can change with proximity to death,[16] and vary between social, religious and ethnic groups in the UK.

A reluctance to talk about death and dying impacts on public understanding of options for care at the end of life.[17] People from minority ethnic groups report lower levels of trust that NHS services will provide them with the care they need, and already often have particular concerns about the role of palliative care services.[18]

There are diverse views about assisted dying across the UK, including across the health and care workforce.

Recent survey data found that while there is overall support for legalising assisted dying, support is lower among people with a minority ethnic background (58% are in favour compared with 83% of people from a white background).[19] Religious beliefs are an important factor in opposition to assisted dying, and minority ethnic groups in England and Wales are most likely to identify as having a religion.[20,21]

There are diverse views among key clinical groups likely to be involved in assisted dying in the UK, with general practitioners (GPs), palliative care specialists and psychiatrists among those who are least supportive.[22]

The NHS and social care workforce are more ethnically diverse than the general population, and a significant proportion of staff trained overseas. The diverse composition of the workforce is likely to influence the views and attitudes of staff to assisted dying.[23] For example, it could increase the number of staff with a conscientious objection to assisted dying (opting out of a practice they regard as morally wrong).[24]

2 How we carried out this research

Research questions and scope

For this research we conducted a mixed-methods study between October 2024 and July 2025, examining assisted dying implementation across nine high-income countries of the Organisation for Economic Co-operation and Development (OECD), guided by the following questions:

1. How has assisted dying been implemented and what approaches are in use where it is legal?
2. What systemic, operational and practical issues have countries faced in implementation?
3. What effects have the legalisation of assisted dying had on individuals/patients/service users and their families, staff and the broader health and social care system?

We focused on countries where assisted dying has been legalised at the province or state level and we used those jurisdictions as the unit of analysis for Australia and the United States (US). We included 15 jurisdictions in our study:

- Australia (Queensland, Victoria and Western Australia)
- Austria
- Belgium
- Canada
- the Netherlands
- New Zealand
- Spain
- Switzerland
- the US (California, Colorado, New Jersey, Oregon and Washington).

We limited the study to high-income OECD countries or jurisdictions with populations of more than three million people where assisted dying was legalised as of 2023. This excludes some systems where assisted dying is legal (for example, Colombia, Luxembourg and some Australian and US states). We also excluded countries where legislation had yet to be implemented (Portugal) or where legal frameworks remained ambiguous (Germany and Italy) at the time of writing.

Study design

Our research approach combined the insights gained from official data sources related to assisted dying, official government policy documents and reports, academic literature covering each jurisdiction, our project advisory group and patient and public involvement.

Analysis of official data sources

To support our understanding of international evidence on assisted dying, we used hand searching to identify official sources of data on assisted dying activity, focusing primarily on 2023 or the closest data period. We were able to identify governmental annual reports including data from all included jurisdictions except Austria, where no official data are published, and Switzerland, where we used data that DIGNITAS has published. DIGNITAS is a Swiss not-for-profit membership organisation which can arrange assisted deaths under certain conditions. The Appendix provides a summary of the different types of formal data reported across the jurisdictions. This includes:

- numbers requesting and accessing an assisted death
- individual demographic characteristics
- wider experiences of health and care, such as access to palliative care services
- information regarding the nature of the assisted death.

The findings from the data sources were embedded with the findings from the official policy documents and peer-reviewed documents during the overall analysis and writing-up phases of work, allowing for the triangulation and confirmation of findings across the different sources.

Review of official policy documents

Policy documents were primarily identified through hand searching of government websites, where we sought out government-authored and government-commissioned policy reports. We also held stakeholder scoping discussions, working with the European Observatory's Health Systems and Policy Monitor network and OECD country-level experts. In addition to gaining insights about their approach to assisted dying, we requested key policy documents and data sources from their countries.

Our policy document analysis included non-English sources, which were translated using DeepL translator. Translations were cross-checked against English-language literature to support accuracy and consistency where possible. Data were extracted from policy documents using a data extraction table, covering descriptions of legislation and models of assisted dying (for example, eligibility, the workforce involved, regulation and safeguarding, and patient consent), and relevant implications for patients, staff and systems were also drawn out. Our analysis of the policy documents (69 in total) also allowed for comparison of key features of jurisdictions, which we published as a long read on the Nuffield Trust website.[3]

Review of peer-reviewed articles

To identify peer-reviewed articles published in academic journals, we worked with a subject librarian (Rachel Posaner at the HSMC Knowledge and Evidence Service at the Health Services Management Centre, based at the University of Birmingham) to develop search terms incorporating terminology used in relation to assisted dying in different countries. The search strategy was applied in three databases – Embase, MEDLINE and the Social Sciences Citation Index (SSCI) – and sought English-language peer-reviewed texts published between 2019 and 2025. We excluded conference presentations, book chapters, legislation and policy documents – as we wanted to examine the breadth of views from researchers, rather than governments.

The review of peer-reviewed articles employed artificial intelligence (AI) assisted screening using Rayyan software, to screen 1,364 articles. Multiple reviewers undertook screening in two stages: first for titles and abstracts, and then as full texts. At least two team members screened each peer-reviewed article. During screening, we excluded articles that were strictly opinion pieces or media reports rather than primary research, and certain research formats such as conference abstracts and book chapters. Data from peer-reviewed sources were extracted from the academic literature using a data extraction table, covering key themes linked to our research questions:

- impacts on individuals (for example, access and experience)
- staff (for example, practitioner involvement, experiences, skills and competencies)
- organisations (for example, capacity and institutional objection)
- the health and care system (for example, safeguarding, capacity and the positioning of assisted dying relative to end of life care).

Each team member was responsible for a small number of jurisdictions during the analysis and then they were assigned whole report sections during the writing-up stage. Quality assurance was carried out throughout the analysis and report drafting.

The final sample consisted of 258 evidence sources – 189 peer-reviewed articles and 69 policy documents – covering all jurisdictions (see Table 1). Canada and Australia had the highest number of evidence sources, while Austria, Spain and Switzerland had the least. Twenty-three were international reviews, where information was extracted from the review rather than the primary papers.

Table 1: Summary of evidence reviewed

Jurisdiction	Data source		
	Academic journal articles	Official policy documents	Jurisdiction total
Australia	40	12	52
Austria	3	2	5
Belgium	17	11	28
Canada	48	13	61
The Netherlands	13	7	20
New Zealand	9	4	13
Spain	3	8	11
Switzerland	12	1	13
The US	21	11	32
International reviews	23	NA	23
Total	**189**	**69**	**258**

Advisory group and patient and public involvement

We established a project advisory group that met twice during the research project to provide ethical guidance, narrow the research scope and review project outputs. Patient and public involvement included eight representatives with end of life care experience who participated in a feedback session to contextualise our findings and reflect on inequalities. We worked with existing charity partners to recruit participants, who were compensated according to guidelines from the National Institute for Health and Care Research (NIHR).

Limitations of this research

Substantial variations in how assisted dying has been legislated and implemented across the 15 jurisdictions we studied limit the generalisability of our findings to the UK. Countries differ significantly in terms of their:

- eligibility criteria
- assessment processes
- administration methods (self-administered versus professionally administered)
- health care system integration
- regulatory frameworks.

Additionally, the diverse health care contexts, cultural attitudes, existing end of life care infrastructures and overall system pressures and challenges across the jurisdictions means that implementation experiences and outcomes are highly context-dependent. These differences in legal frameworks, operational approaches and health care environments constrained our ability to draw universal conclusions about assisted dying implementation that would be directly transferable to other settings, including the UK context.

Furthermore, we did not conduct formal risk of bias assessments for the academic literature included in our scoping review, which may have affected the reliability and quality of evidence synthesised, particularly regarding reported outcomes and the effectiveness of different implementation approaches.

3 What does the implementation of assisted dying look like in practice?

Core components of assisted dying pathways

There is wide variation in how assisted dying is organised across systems. However, almost all countries have processes for assessing eligibility for and delivering assisted dying, even though the numbers of steps and requirements for safeguards and procedures differ, and have changed over time in several countries.[3] Table 2 summarises common features of the pathway that individuals typically follow for assisted dying, outlining what happens at each stage and the roles and responsibilities of individuals and organisations who might be involved.

Table 2: Common features of assisted dying pathways and who might be involved

Stage	What this might involve	Who might be involved (as well as the individual)
Before a request	Conversations with professionals about prognosis and exploring care options and end of life care wishes Engaging in a patient-initiated conversation about wishing to die	• Usual end of life care services – GP, hospital doctors, nurses, palliative and end of life care services • May also involve family/carers
	Conversations with the individual and family/carers	• Family/carers
Information request	Conversations specifically about assisted dying as an option Request for more information about assisted dying	• Usual end of life care services – for example, GP, hospital specialists, nurses, palliative and end of life care services • Advice service or assisted dying specialist if usual end of life care professional not involved in assisted dying or has limited experience
Request	A formal request by the individual or by a professional on behalf of the individual	• Authorised or registered clinician, clinician with expertise in assisted dying or usual clinical team
First assessment	Review of medical history, prognosis and wishes Aims to conclude whether the individual meets core eligibility criteria (for example, age and prognosis) A set time between first assessment and second assessment may be required to allow for the individual to consider the decision	• Assessor – usually authorised or registered clinician or clinician with expertise in assisted dying

Stage	What this might involve	Who might be involved (as well as the individual)
Second assessment	Discussion of the assisted dying application with a second clinician (for example, intention, safeguarding and capacity)	• Second clinical assessor – may be required to have expertise in palliative care or the patient's underlying diagnosis
Additional information gathering	Further information gathering or assessments may be required, including consulting with other clinicians	• Additional clinical input or assessment, for example about mental health or capacity
Final request	Written submission from the individual to demonstrate that the request is enduring and persistent	• Independent witness
Final review process	Final sign-off required in some jurisdictions (not all)	• Review committee or registrar
Individual not eligible	Outcome of assessment, review and approval processes	• Usual end of life care services
Approval	Request approved A period between final approval and action may be required to allow for the individual to consider the decision	• Regulatory organisation
Prescription and substance issued	Prescription issued Where self-administered, substance may be dispensed	• Prescriber – authorised or registered clinician or clinician with expertise in assisted dying • Designated pharmacist
Request to administer	Where administered by a clinician (or in the presence of a clinician): • a date and place for administration are agreed • final confirmation is received from the individual • the substance is dispensed from a pharmacist	• Assisted dying practitioner – authorised or registered clinician or clinician with expertise in assisted dying • Designated pharmacist or pharmacies

Stage	What this might involve	Who might be involved (as well as the individual)
Administration	Individual self-administers (usually but not always in the presence of a clinician) or a clinician administers it	• Assisted dying practitioner – authorised or registered clinician or clinician with expertise in assisted dying
Registration	Required information about the assisted dying prescription and/or death is recorded and submitted to relevant organisations	• Assisted dying practitioner – authorised or registered clinician or clinician with expertise in assisted dying • Family • Regulatory organisation
Individual dies before administration	Individual may withdraw or may die of underlying condition before administration Relevant organisations need to be informed Unused medication needs to be returned by the individual/family/ care organisation	• Assisted dying practitioner – authorised or registered clinician or clinician with expertise in assisted dying • Family • Regulatory organisation
Retrospective review and learning	Committee or panel appointed by regulatory body reviews cases retrospectively to identify good/poor practice and recommend changes to approach	• Review panel/committee or other regulatory function
Bereavement	Support for bereaved families and carers	• Usual care services for bereaved families (for a discussion of gaps in bereavement services see the subsection 'Bereavement and grief, and support for carers' in Chapter 4)

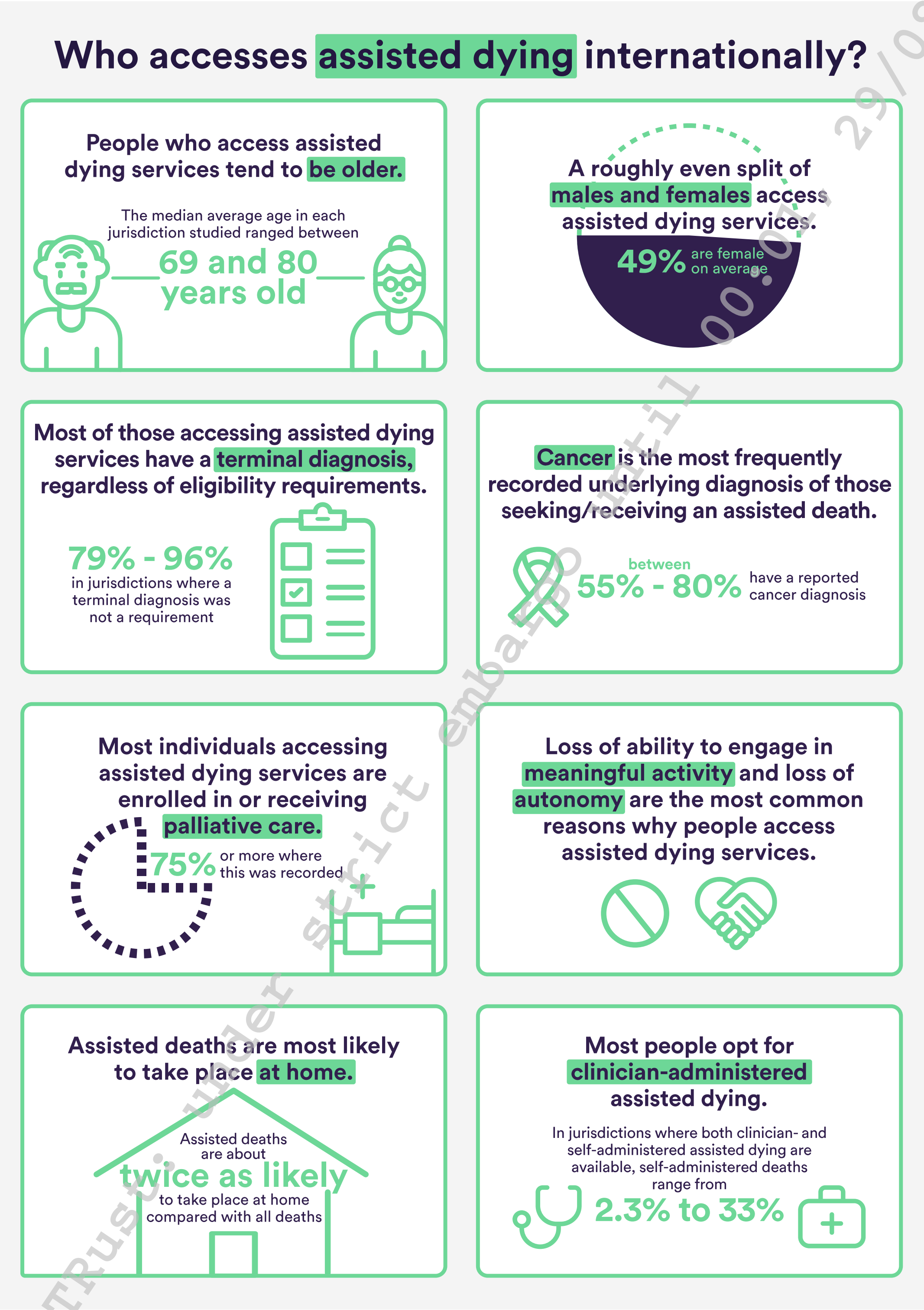
Note: As outlined in our long read on assisted dying in other countries, published earlier this year,[3] there are a range of requirements across countries and individual countries have different steps or may have fewer regulated steps, for example as in Switzerland.

While many steps in the pathway require activities and roles that are prescribed in regulations or guidance, the pathway also interacts with usual end of life care services. In the UK this could include the individual's GP, community nurses, hospice and palliative care services, social care teams – in care homes or home care providers – and clinical specialists for the individual's underlying condition, for example oncology or neurology. We discuss the different roles involved in assisted dying in the subsection 'Practitioners directly involved in assisted dying' and discuss the interaction with end of life care services in the subsection 'Impact on end of life care', both in Chapter 4.

What do we know from international evidence about people who access assisted dying?

In this section we consider what we can learn from formal data that different jurisdictions have reported about who is requesting and accessing assisted dying. Although the number of assisted deaths varies widely between jurisdictions,[3] there are broad similarities between countries in terms of who tends to seek an assisted death. People who access assisted dying services tend to be of an older age range and have a terminal prognosis (even when this is not an eligibility criteria), commonly associated with a cancer diagnosis (see the Appendix for demographic and other patient characteristics by jurisdiction). Jurisdictions vary in what data they collect and report regarding assisted deaths, and in the subsection 'Data collection, monitoring and reporting' subsection in Chapter 4 we discuss differences in the scope and scale of data reporting and implications for monitoring and oversight.

Who accesses **assisted dying** internationally?



People who access assisted dying services tend to **be older.**

The median average age in each jurisdiction studied ranged between

69 and 80 years old

A roughly even split of **males and females** access assisted dying services.

49% are female on average

Most of those accessing assisted dying services have a **terminal diagnosis,** regardless of eligibility requirements.

79% - 96%

in jurisdictions where a terminal diagnosis was not a requirement

Cancer is the most frequently recorded underlying diagnosis of those seeking/receiving an assisted death.

between **55% - 80%** have a reported cancer diagnosis

Most individuals accessing assisted dying services are enrolled in or receiving **palliative care.**

75% or more where this was recorded

Loss of ability to engage in **meaningful activity** and loss of **autonomy** are the most common reasons why people access assisted dying services.

Assisted deaths are most likely to take place **at home.**

Assisted deaths are about **twice as likely** to take place at home compared with all deaths

Most people opt for **clinician-administered** assisted dying.

In jurisdictions where both clinician- and self-administered assisted dying are available, self-administered deaths range from

2.3% to 33%

Note: Links to underlying data and further information regarding the demographic and other characteristics of individuals who request or access an assisted death, by jurisdiction, can be found in the Appendix.

4 Learning from international experience: implications for implementation within the health and care system

Legalising assisted dying in the UK would have wide-ranging implications for health and care systems, demanding careful planning and coordination. In this chapter we analyse international evidence on how health systems in other countries deliver assisted dying and we identify learning and implications for the UK.

The first section describes changes at the health system level and the supportive infrastructure – such as oversight committees, data systems and training resources – that other health systems have established to operationalise assisted dying. The second section explores the implications for individuals, families and carers, drawing on evidence about their experiences. And the third section examines the engagement and experience of staff and organisations involved in assisted dying.

Systems and supportive infrastructure developed to implement assisted dying

The delivery of assisted dying has required many countries to make changes to existing services or develop new forms of system infrastructure to deliver assisted dying services – to uphold safeguards, ensure legal and clinical compliance, and support access once legalised.

We use the term ‘infrastructure’ to reflect that these are changes that have been introduced at a health system level with the aim of enabling safe and effective assisted dying, which meets the needs of individuals and families, and supports the staff and organisations involved. In some cases, infrastructure needs have been anticipated and developed before assisted dying has come into operation, while in other cases, it has developed after initial implementation, in response to the experience of implementing assisted dying and to address issues and challenges for individuals, families, staff or organisations, discussed in the other two main sections of this chapter.

We group infrastructure into:

- assisted dying oversight functions – such as regulation and governance
- data collection, monitoring and reporting systems
- new roles, responsibilities and services
- information, training and support for the public and practitioners.

For each aspect, we:

- describe the new systems or services that had to be created
- set out key differences across the countries we studied
- detail the system challenges and implications that have been encountered.

In the final part of this section, we consider the broader implications for health system capacity and resources.

Assisted dying oversight functions

Key points

- Most systems have established oversight functions – in the form of committees, designated roles or boards – to monitor and assure compliance with assisted dying legislation. But their roles, composition and positioning within governance structures vary widely across jurisdictions. These bodies may operate independently or within government, and can have national scope or operate at a state or regional level.

- Oversight functions have an important assurance role in assisted dying.

They typically handle tasks such as:

- data collection and monitoring
- reviewing cases for compliance
- public consultation
- evaluating laws to inform recommendations.

- Some also play a direct role in approving or rejecting assisted dying applications, as in New Zealand and Spain, while others only review cases retrospectively. Membership on these bodies generally includes medical and legal professionals at a minimum, with additional roles – such as ethicists or lay members – varying across countries.

- Some countries have identified limited committee/board capacity – in terms of both staffing and administrative support – as a barrier to sustaining assisted dying services, which can hinder case management, data collection and overall system responsiveness.

Many systems have established national or regional boards or committees to provide oversight of and assurance to assisted dying decisions, although there are differences in how these bodies function and at what stage they fit into the process.[3]

These boards or committees often have wide-ranging responsibilities, including collecting data to monitor compliance with legislation and understand the effects of the law (see the subsection 'Data collection, monitoring and reporting systems' later in this chapter) and reporting any issues or violations identified to relevant bodies (that is, the state coroner, health regulators or the criminal justice system).

In some systems, these boards/committees also have an active role in the education and training of providers, including promoting continuous improvement through clinical symposiums or establishing standardised best-practice criteria.[25,26] Many also conduct regular assessments of the operation of the law to inform improvements to policy and processes and recommend legal amendments where necessary to government. In some jurisdictions, such as Australian states, boards also have an explicit duty to engage and consult with members of the public and providers of assisted dying, to identify potential improvements and recommendations.[27,28]

However, how boards/committees function varies significantly across jurisdictions, which also differ in size, membership and the policies and procedures that guide their operation. While many operate as independent oversight bodies, in some systems this function is embedded within government structures – for example, through the Department of Health, as in New Zealand. Systems also vary in whether boards/committees have national oversight, as in Belgium, or are delivered regionally (as in Canada and Spain, where each state or province has its own committee). Most countries require that boards/committees include medical and legal professionals, although other membership roles differ. For example:

- Spain requires that the panel is interdisciplinary, with nursing perspectives required.
- The Netherlands mandates that each regional review committee includes ethicists.
- Some Australian states have appointed lay members/service users with relevant skills, experience or knowledge.
- New Zealand has included GPs and nurses as part of its panel.

Another key distinction is whether boards/committees are responsible for approving or refusing applications for assisted dying, or only make assessments retrospectively. In cases of the former, committee review acts as another formal step in the approval process for assisted dying (as in New Zealand and Spain). Some systems also have strict confidentiality criteria, so that all cases must be reviewed anonymously as part of both retrospective and prospective review, unless details are needed to ensure the legal or clinical compliance of a case (as in Spain).

The examples given in Table 3 show the diverse ways in which these functions can be structured and governed.

Table 3: Comparison of assisted dying review processes and procedures in three jurisdictions

Country	Scope	Process	Composition	Evaluation
The Netherlands[29,30]	Retrospective review only	1. A physician who has performed an assisted death notifies the municipal pathologist, who examines the deceased, verifies documentation and gathers supplementary information (for example, clinical notes and specialist letters) before submitting the case to a regional review committee. 2. A committee secretariat conducts a preliminary assessment to determine whether the case is straightforward (and suitable for digital review) or requires in-person deliberation. Every case is reviewed. 3. The committee assesses whether the physician complied with all legal and clinical criteria. Additional information may be requested if details are incomplete or raise concerns, and complex cases may involve written follow-up or physician interview. Between 2017 and 2022, 0.1% of cases (n=44) were determined to not fulfil the due care criteria. 4. The physician is notified of the ruling within six weeks, extended to another six if needed. Cases of non-compliance are referred for potential legal or criminal proceedings, but formal action is rare, with just one disciplinary action between 2017 and 2022.	The Netherlands has five independent regional euthanasia review committees, which assess whether a physician who has performed an assisted death complied with legal criteria and exercised due medical care in line with established clinical guidelines for assisted dying. Each regional committee consists of a physician, an ethicist and a lawyer (who is also chair). A secretariat (a lawyer) assists each committee and attends meetings in an advisory capacity.	Separate from regional committees, the Regulatory Evaluation Committee conducts regular evaluations of assisted dying – drawing on evidence and data from regional committee reports – to assess the law, how it is working in practice, and key evolutions.

Country	Scope	Process	Composition	Evaluation
Belgium[31]	Retrospective review only	1. A physician must submit a registration form to the Federal Commission for the Control and Evaluation of Euthanasia within four working days of an assisted death. 2. Commission members receive and individually review each case before monthly meetings, flagging potential issues, and requesting further information from the physician if necessary. 3. At the meeting, cases are reviewed to ensure legal compliance. Only cases with potential issues are discussed. Physicians may be asked to provide additional information or attend an interview. 4. If two-thirds of the commission find a case to be non-compliant, it is referred to the Public Prosecutor. No cases were referred to the Public Prosecutor between 2022 and 2024.[31] Only one case has been referred since euthanasia was legalised in Belgium in 2002.	The commission has 16 full members and 16 alternates. Eight members are medical doctors – at least two of whom must be professors or lecturers. Four members are academics (professors or lecturers) or lawyers. Four members work or have expertise in areas related to an untreatable illness. Members are appointed by Royal Decree for a four-year term.	The commission produces a biennial report that is forwarded to government and includes, where appropriate, recommendations or other measures to refine the law.

Country	Scope	Process	Composition	Evaluation
Spain[26]	Prospective and retrospective review	**Prospective review** 1. The President of the Guarantee and Evaluation Commission designates a physician and lawyer from among its members to verify each request for assisted dying for legal compliance. 2. The lawyer has seven days from receiving the request to prepare a report outlining the decision. 3. The President verifies the decision and notifies the physician and applicant of the outcome. 4. If the physician and lawyer cannot agree, the case is taken to the whole commission for resolution, which must make a decision within 20 days. **Retrospective review** 1. Within five days of completing assisted dying procedures, the physician must submit documentation of all health and physician information to the commission, outlining the details of the case. 2. Within two months, the commission must determine whether the assisted death was legally compliant.	Each state of Spain organises its own Guarantee and Evaluation Commission. Membership must be multidisciplinary in nature and include at least seven members, including medical, nursing and legal representatives. The Ministry of Health convenes the presidents of each state commission to homogenise criteria and exchange good practices.	Each state commission produces an annual evaluation report on the implementation of the law. The Ministry of Health combines this joint data into one annual report, which is publicly available.

Ensuring sufficient resources

A key challenge that systems have had in establishing assisted dying oversight bodies is ensuring they are properly resourced to meet operational demands and support continuous improvement – essential for effectively monitoring the impacts of assisted dying.

In Belgium, the Federal Commission for the Control and Evaluation of Euthanasia has consistently reported insufficient funding and administrative support to fulfil its responsibilities.[31] Most commission members are unpaid and carry out duties on a voluntary basis, which can be extensive – including detailed file reviews, ongoing clinician communication and responding to external inquiries. Just two secretariat staff support the commission and they are also responsible for a range of activities, including coordinating meetings, maintaining records, liaising with external agencies and government departments, and handling referrals in cases of non-compliance.

This contrasts with the Netherlands, which has a dedicated 25-person secretariat supporting its regional euthanasia review committees, and is cited as a key enabler in ensuring timely decisions.[30] However, even there, rising case volumes have outpaced resources, raising concerns about consistency and delays in decision making.[32]

While the size and resourcing of oversight bodies will vary by legal framework, mandate and case volume, ensuring that they are adequately resourced is critical to enabling effective oversight of assisted dying, and avoid unnecessary delays. In systems that rely solely on retrospective review to ensure compliance, these delays can affect staff wellbeing, who may wait weeks for confirmation that their actions were compliant.[30] Equally, in systems that require pre-approval from committees before assisted dying can be provided, capacity issues have led to delays in access.[33] In addition, long timescales for the process can also reflect the rigorous process that individuals are required to go through to gain access, and the need to ensure that the appropriate safeguards are in place. In Spain, for example, completing all steps to be able to obtain approval for an assisted dying request usually takes between 30 and 40 days.[34] Almost 30% of applicants for assisted dying (n=152) in 2022 died before their request was approved, reflecting the significant chance that individuals may die during the process.[34]

Data collection, monitoring and reporting systems

Key points

- Jurisdictions adopt a variety of approaches for reporting data on assisted deaths, with differences in the scope and scale of data collected and published.

- Almost all jurisdictions produce formal assisted dying reports, usually annually. Other sources of information on assisted dying include case summaries, retrospective reviews and media reports. These can be important sources of information about the circumstances of assisted deaths that are not reported as part of routinely collected data.

- Demographic data about individuals enable countries to monitor access and identify service gaps, especially if information is collected along the pathway from the initial request for information about assisted dying to the assisted death.

- There are gaps in assisted dying data collection, and qualitative data may play an important role in increasing insights, particularly regarding the experiences of different groups. Insights from practitioners, families and carers about the assisted dying process can also form the basis of recommendations for service developments.

- It is important to consider how assisted dying data collection overlaps with other data systems, particularly death certification.

Nearly all jurisdictions studied in this research publish formal reports, usually annually, which include data summarising assisted dying activity. Switzerland is an exception, with minimal formal reporting. Table 4 provides an overview of the types of assisted dying data captured across jurisdictions, highlighting examples of data more and less commonly reported. In the Appendix we provide more detail on the data that each jurisdiction reports within these categories.

Table 4: Overview of data reported across jurisdictions where assisted dying is legal

Category	Subcategory	Key points to note
Numbers requesting/ accessing an assisted death	Numbers requesting an assisted death	Australian jurisdictions, as well as Canada, New Zealand and some US jurisdictions, report the number of applications for an assisted death, or the number of people requesting an assisted death. These figures can be different, as people may make more than one application in a year, and so there may be more requests than people.
	Number of assisted deaths as a proportion of all deaths	Data on the number of assisted deaths as a proportion of all deaths are available for nearly all jurisdictions in this research, but even counting the number of assisted deaths requires consideration of the impact of the legal framework upfront. For instance, in Colorado, the End-of-Life Options Act 2016 does not necessitate follow-up with physicians who prescribe aid-in-dying medication, patients or their families to obtain information about the use of medication, so an assisted death is not confirmed.[35]
	Place of death	Most jurisdictions report where assisted deaths take place, with a particular emphasis on the proportion of deaths at home or in a private residence, such as a relative's home. Categorisation of other places of death varies, but includes hospitals, nursing homes and hospices. Inconsistent reporting means it is challenging to compare where assisted deaths occur compared with all deaths.
Demographic characteristics	Age and sex	Age and sex are commonly reported but there is variation between jurisdictions in terms of whether demographic characteristics relate to those who apply for an assisted death, those who receive an assisted death or those who receive a prescription for an assisted death (some of whom will have died from other causes before the assisted death was scheduled to take place). While most jurisdictions report sex as either male or female, some provide a wider range of options – for instance, 'gender diverse' (New Zealand), 'self-described' (Victoria) and 'X or non-binary gender' (Queensland). These options were only selected a small number of times in 2023.

Category	Subcategory	Key points to note
Demographic characteristics (cont'd)	Ethnic group	Around half of all jurisdictions report information regarding the ethnic group of those who request or receive an assisted death. We could find no examples of annual reports that identify whether the percentage of people from different ethnic groups who request or receive an assisted death is representative of the population as a whole and is therefore what we might expect.
	Sociodemographic characteristics (for example, level of education)	Level of education is not recorded in either Canada or the European jurisdictions, but Australian and US jurisdictions report information regarding the highest level of education of those requesting or receiving an assisted death. In Queensland this is not a mandatory reporting field and was only recorded for 59% of people in 2023. Where information is recorded, in most jurisdictions more than 70% have at least some form of college education (See Appendix).
	Disability	While several annual assisted dying reports reference disability – for instance in terms of barriers to accessing services – it is less common to see such data reported. New Zealand and Canada are exceptions. Canada is of note as it provides a detailed breakdown of the prevalence of disability among people whose death is assisted, split by demographic characteristics, in addition to reporting the type of disability and medical conditions of those who self-report a disability.
Underlying diagnosis	For example, the percentage of people with cancer	The disease/pathology of the individual receiving an assisted death is reported as the underlying cause of death. This means not all health reasons for applying for an assisted death can be directly specified as an underlying cause of death. Specific International Classification of Diseases (ICD) codes for an assisted death – including the classification of circumstances such as multi-morbidity or chronic pain – would provide a more accurate reflection of assisted dying practice.[36]
Reasons for applying for an assisted death		Some jurisdictions provide data that point to the reasons why people request an assisted death, although this is captured in a variety of contexts. Canada reports sources of suffering related to a medical condition. Oregon and Washington provide self-reported data on the 'end of life concerns' of individuals who receive an assisted death. And Western Australia reports reasons for accessing assisted dying services.

In some instances, jurisdictions' reports on assisted dying also include **key points of learning** about how assisted dying services could be improved. For instance, Western Australia's Voluntary Assisted Dying Board publishes insights drawn from practitioners, families and carers about what worked well and less well as part of the assisted dying process, which are used to inform the development of recommendations to improve assisted dying practice. The most recent report noted an increase in feedback on the barriers to accessing voluntary assisted dying at the end of life.[37] In Queensland, communities of practice have been established to proactively learn from the families and loved ones of people who have accessed assisted dying, to understand their experiences and how services could be improved.[38,39] In the Netherlands, each of the five regional euthanasia review committees publishes examples of summary judgements of euthanasia cases.[40] These have been used to explore euthanasia in different circumstances, such as where individuals have dementia.[41]

It takes **time and resources** to establish effective mechanisms to capture assisted dying data. Early preparation is needed to determine what data need to be collected and the systems required to do so, and there are implications for long-term monitoring where data reporting requirements are subsequently altered. For instance, in 2019, Washington expanded the criterion used to count individuals who participated in its assisted dying programme to take account of more sources of information captured as part of compliance with the Death with Dignity Act 2008.[42]

Infrastructure should also enable the collection of data to monitor markers of **underuse or overuse of assisted dying services** by groups at risk. For a complete picture, there is value in data collection on those who attempt to access assisted dying services as well as those who ultimately receive an assisted death, but this is not done routinely. In Australia, where this information is recorded, the number of requests is around double the number of deaths (see Appendix). Such data can provide evidence on the challenges facing certain groups, such as those with a psychiatric illness. In the Netherlands, evidence drawn from the wider literature review shows that, in 2015, 45% of requests for assisted dying did not result in an assisted death, but for people with dementia or psychiatric illness, figures were higher at 57% and 58% respectively.[43] Data enable an assessment to be made about whether assisted dying services are being used appropriately.

Consistency of data collection is also an important consideration where assisted dying operates across multiple jurisdictions within one country. Governments in Australia and New Zealand have recognised the need for national minimum datasets, and ensuring collaboration across services to collect health data through surveys and develop data protocols.[50,44]

The infrastructure required to collect assisted dying data may also need to interact with **other data collection systems**, such as death certification. Some jurisdictions, such as those in the US, note that assisted dying data are collated from death certificates as well as data recorded as part of the formal assisted dying application process, but the extent to which data collection systems overlap and the degree to which data collected from different systems can be compared are not always clear. Canada notes that assisted dying data are not directly comparable with vital statistics.[45] Discrepancies between different sources of data on assisted dying highlight important data-quality considerations. Survey estimates of euthanasia in the Netherlands are reported to be higher than estimates in committee reports, which is attributed to incorrect classification of other activities (such as continuous deep sedation) as euthanasia.[46]

There are common **gaps in data collection** across jurisdictions in terms of the needs of particular groups in the population. For instance, there are limited international data on the number of prisoners requesting and receiving an assisted death. However, case studies have been reported to explore the ethics of access to assisted dying in a prison context and some of the challenges.[47,48]

It is important to consider the role of data in highlighting **safeguarding concerns** such as individuals at risk of coercion, or specific groups' use of assisted dying services. A systematic review highlighted insufficient reporting in cases of assisted deaths for patients with psychiatric conditions, specifically those with an eating disorder, limiting the ability to provide effective oversight and ensure that correct procedures were being followed.[49]

A key tension in relation to the reporting of assisted dying data is getting the balance right between **privacy and transparency**. Countries limit the types of data that can be collected and shared, given the sensitivities surrounding assisted dying, but this has created challenges in some systems in terms of getting that balance right. In New Zealand, a review of the End of Life Choice Act 2019, noted that reporting restrictions limited transparency.[50]

New roles, responsibilities and services

Assisted dying has necessitated the development of new roles, responsibilities and services within some systems to ensure assisted dying services are safe and accessible once legalised. In this subsection we discuss notable developments in: pharmacy and medication management; digital administrative infrastructure and processes; and care navigation and support.

Key points

- The legalisation of assisted dying requires new pharmacy protocols, especially for medication access, safety and disposal. In systems such as Australia and New Zealand, pharmacists have played an essential role in the delivery of assisted dying, with state-run pharmacies assuming responsibilities for providing education, guidance and support, and overseeing the retrieval of unused medications. Capacity issues and geographic barriers – particularly in rural areas – can delay access.

- Assisted dying introduces significant administrative complexity, often requiring new digital portals for staff to upload evidence and data, and multiple forms to record details of a person's eligibility and that all criteria have been met. Efficient platforms that meet clinical needs are essential for reducing delays and staff burden.

- Some systems have established new care navigation services to help individuals access assisted dying. While vital for improving understanding of the process, these services have also faced capacity challenges, especially when dealing with complex cases. How these roles function within systems has also varied locally, underscoring the need for standardisation or minimum requirements to ensure equity.

- Establishing comprehensive training for practitioners is essential to ensure they fully understand the legislation surrounding assisted dying, as well as their legal rights and professional responsibilities, thereby promoting safe, ethical and consistent care.

- Systems have needed to create new education and public information infrastructure – such as guidance documents and public education tools – to help individuals understand their options and rights. These should be culturally sensitive to different communities, and regularly updated.

Pharmacy and medication management

The use of lethal medications for assisted dying introduces a new complexity for health and care services, which in some jurisdictions has expanded the role of pharmacists. To support pharmacies, systems have had to develop **new protocols** for determining the most appropriate agents, route of administration and mode of access, and guidance for prescribers on active ingredients. They have also had to develop new protocols for the safe collection, storage and disposal of any unused medication, particularly where clinician-administered assisted dying is not available.

For instance, some Australian states and New Zealand have appointed dedicated state-run pharmacies for dispensing and retrieving substances. In these systems, individuals typically nominate a family member or other contact person who is responsible for returning any unused or remaining medication within a certain timeframe (failing to do so can incur a steep penalty, including prison for the nominated person). In these jurisdictions, it is the pharmacist's responsibility to provide comprehensive education and support to individuals and their families about the safe administration and storage of medications, including requirements for their return and safe disposal. In some cases, this may require a pharmacist to proactively follow up when substances have not been used within a certain timeframe, to provide refresher education, check the expiry date of the substance and assess the suitability of the method.[25]

Australian studies highlight the **essential role of pharmacies** in assisted dying services in terms of providing empathetic care and comprehensive education and guidance.[27,51] However, studies have also highlighted pharmacy capacity as an issue, which can lead to delays in accessing medication – this emphasises the need to ensure pharmacy resources can meet growing demand.[52,53] In some Australian states, reliance on a centralised, state-run pharmacy model has been challenged due to increasing case volumes and geographic barriers – particularly in rural areas where pharmacists must travel long distances to ensure timely delivery.[25] In other systems, the lack of a centralised model of pharmacy delivery may make it harder for individuals to identify pharmacists who would be willing to dispense a lethal drug, which has been the case in Oregon and Washington in the US.[54,55]

Digital administrative infrastructure and processes

Another major infrastructure and systemic change that assisted dying has prompted is the need for **administrative processes and digital systems** to manage requests and collect data. Clinicians must typically complete multiple forms to confirm each step of the assisted dying assessment process and demonstrate eligibility. For example, Queensland's process involves 17 separate forms before medication can be accessed.[25] To support this, jurisdictions have developed online platforms for submitting and storing information. For example, Austria has developed an electronic database to hold records of informative discussions and advance directives for assisted dying,* which is used for the analysis and oversight of assisted dying. In addition to having authorised groups of people with access to this database (for example, notaries, pharmacists and coroners), individuals can access their own assisted dying applications using portals with PIN codes and a form of electronic ID (for example, a citizen card or a mobile phone signature).[56]

The importance of effective digital systems for assisted dying cannot be overstated. Poorly designed platforms can delay access for seriously ill individuals and place unnecessary strain on already stretched clinical and administrative staff.[51] A qualitative study of 32 doctors in Victoria, Australia who were involved in providing assisted dying in the first year of operation found online systems to be 'clunky' and 'frustrating' and that they created unnecessary delays for individuals.[57] The government has since led a digital upgrade project in relation to the online platform, partly in response to a high proportion of rejected applications due to common errors (such as missing signatures, inconsistent patient information, incorrect spelling of medication and dosing).[28] In the Netherlands, 20% of physicians surveyed for a government evaluation of assisted dying legislation said they found the administration processes involved to be burdensome or time-consuming.[30] In Belgium, a key issue has been the lack of digitalisation in the assisted process altogether, with key forms still primarily paper-based, which has contributed to administrative errors and increased the workload of its review committee.[31]

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* In Austria, individuals must create an advance directive or 'dying will', outlining their request for assisted dying, which is valid for up to a year. These can only be drawn up after an individual has their first consultation with a physician to ensure their eligibility. Source: Federal Ministry of Social Affairs, Care, and Consumer Protection. Practical Guidelines. www.sozialministerium.gv.at/Themen/Gesundheit/Medizin-und-Gesundheitsberufe/Medizin/Sterbeverf%C3%BCgung.html

Protecting the **confidentiality** of individuals accessing and clinicians providing assisted dying is a critical concern in many countries, and may make it hard to share important information across different members of an interdisciplinary team, or with care navigation services. However, it is important to balance such a concern against regards for patient safety and continuity of care. This has prompted some systems to develop specific guidance about how to share information, coordinate care and manage handovers across interdisciplinary teams when an individual is requesting assisted dying.[58]

Care navigation and support

To support the implementation of assisted dying, some governments have introduced care navigation services to help individuals understand their rights and how to access the service.

For instance, in Australian states and some provinces in Canada, care navigators:

- provide information on assisted dying and how to access the service
- connect people with eligible clinicians
- offer support to families, carers and health professionals.

Nurses and allied health professionals tend to lead these services, but it varies by system. In some jurisdictions, care navigators may also provide education, training and practical and emotional support to health care practitioners delivering assisted dying, as in Victoria and Queensland in Australia.[25,28]

Research highlights the vital role these services play in improving access to and understanding of assisted dying,[59] but concerns have also been raised about **limited capacity**. For example, the Western Australia Voluntary Assisted Dying Board noted how staff shortages and rising caseloads make it difficult to sustain care navigation services.[60] This is a particular challenge when dealing with complex cases, for example individuals receiving care in faith-based institutions who struggle to identify a willing provider, or who have psychosocial challenges, requiring multiple interactions with care navigators before they can achieve a first assessment. These challenges highlight the need for sustained investment in new support services to ensure equitable access to assisted dying services once legalised.

In systems without a dedicated care navigation service, concerns have been raised about the absence of comprehensive **care and bereavement support** for families and communities during and after an assisted death. This is the case in New Zealand, but the government has opted not to create a specific navigator or bereavement role, preferring support to come from existing bereavement and mental health services to avoid separating assisted dying from other forms of death.[50] However, even where care navigation systems exist, such support can be inconsistent. In some Australian states, care navigators explicitly offer bereavement and grief support as part of their role, but this is not universal. Issues have been raised generally about the variability in how care coordinator roles are defined across jurisdictions – such as in Canada, where services are province-led – highlighting the need in some systems for greater standardisation of practice to ensure equitable access.[61,62]

Information, training and support for the public and practitioners

In addition to care navigation services, governments have developed resources to educate the public and help them understand their options when it comes to assisted dying (although it is important to note that some jurisdictions also place restrictions on what information on assisted dying can be provided). This includes establishing new public guidance and information sheets explaining the process involved and how to access services. For example, in Western Australia, (in addition to the state-wide care navigator service) the End-of-Life Care Program team has provided a range of information resources, including information sheets for patients and families, in addition to signposting them to information about considerations at the end of life more broadly.[37] This includes a booklet containing information about assisted dying, such as eligibility criteria, the stages of the process and where to go for additional support.[63] It has been noted that it would be beneficial for public information on assisted dying to be integrated into broader information about end of life care so that people can be informed of the range of options available to them.[64]

Country evaluations highlight the need for **clear, accessible and culturally sensitive information**. In the Netherlands, for example, evaluations have recommended that information needs to be provided for patients of different backgrounds.[30] This includes people whose faith may conflict with assisted dying – it was still felt important for them to be provided with accurate information on their options.[30]

Likewise, studies of patients and carers in Australia and Canada have found that public information could be strengthened by incorporating lived experiences and highlighting the emotional and personal aspects of assisted dying, to help counter misinformation and reduce stigma.[65] Establishing and maintaining these resources can be a significant undertaking, which is why some countries – such as Belgium – have emphasised the importance of having a designated government department responsible for creating, hosting and updating assisted dying resources to ensure timely information and support access.[31] Learning from other countries also highlights the importance of providing information to practitioners, so that they can accurately respond to people who ask about assisted dying. In the Netherlands, evaluation reports have highlighted the importance of practitioners having accurate information about assisted dying, to prevent them from discussing it with patients for whom it might not be an option.[30]

In addition to government initiatives, some community-based organisations and networks have taken steps to address specific barriers to gaining access to assisted dying or to improve public information and awareness. Examples of activities to improve awareness of assisted dying are summarised in Box 3.

Box 3: Examples of actions taken to improve awareness and information around assisted dying

Requiring organisations to publish policies. Health care providers in California must publish their assisted dying policies on their website, although there is significant variation in content, scope and detail.[66]

Government information materials. A Belgian federal review report noted that public awareness could be improved and recommended the government produce an information brochure for the public covering euthanasia law, patient rights and palliative care.[67]

Targeted information for diverse populations. An evaluation in the Netherlands recommended that information should be provided for citizens of different backgrounds to facilitate appropriate end of life care choices.[30]

Community engagement and education. Queensland's Voluntary Assisted Dying Board recommended further community and stakeholder engagement, leading to new publications, community knowledge surveys and stakeholder engagement.[25]

Ongoing engagement with vulnerable populations. A Canadian independent review recommended continuous engagement with vulnerable populations, including indigenous peoples, children and young people (under 18 years of age) with terminal illness, disabled people and those in the welfare system.[68]

Legalising assisted dying also requires careful planning to ensure staff are properly trained and supported to navigate the legal, ethical and emotional complexities of assisted dying. In jurisdictions that have legalised assisted dying, this has at times involved developing new infrastructure and resources – including clinical guidance, training programmes and support mechanisms – to ensure professionals understand their rights and responsibilities, and can deliver care safely and ethically.

Approaches and gaps in training are explored in more detail in the subsection 'Training and support for practitioners' later in this chapter), but it is worth noting that this is an important area, which requires careful planning and resourcing.

Delivering the infrastructure for assisted dying: developing and maintaining capacity and resources

Taken together, all of the infrastructure requirements that we have described in this section need capacity and funding to develop and maintain assisted dying processes and services. In this subsection we draw together themes on how countries have managed capacity and resource challenges.

Key points

- It takes time to establish the capacity to deliver assisted dying services. The scope of the infrastructure required will depend on the legislative framework, but almost all of the countries we looked at for this research have needed to establish new systems, processes and roles to operationalise assisted dying safely and effectively.

- Capacity needs to account for more people requesting an assisted death than those who ultimately have one. Further, requirements grow over time as case numbers increase and new needs emerge. Any country introducing assisted dying needs to plan for ongoing investment rather than treating infrastructure development as a one-time implementation cost.

- The scope and requirements of legislation and regulations can have direct impacts on the service requirements for assisted dying.

- Delivering assisted dying involves both new specialist roles (such as care navigators) and existing health care professionals (particularly GPs). Ensuring adequate training, support and reimbursement mechanisms is crucial for building and maintaining workforce capacity.

- Countries have taken different approaches to funding and reimbursement for assisted dying services – each with their advantages and disadvantages – resulting in implications for sustainability and access.

- Estimating the cost of assisted dying needs to take account of the wider infrastructure changes needed, not just direct delivery costs.

Setting up, developing and maintaining infrastructure

Literature and policy documents show that countries have recognised that careful preparation is essential before assisted dying laws become operational.

The complexity of establishing new systems, training staff and ensuring compliance with legal requirements necessitates **substantial lead-time**. Australian states exemplify this approach, with intensive 18-month implementation periods during which departments of health, and care organisations, prepared for the introduction of assisted dying.[91] In Victoria, the Assisted Dying Review Board commenced its duties a full year before the law on assisted dying came into effect, ensuring that necessary systems and processes were in place. The Victorian state government also developed an implementation framework, which identified the need for greater centralised and consistent information to ensure access before the law went live, leading to the creation of the state care navigator service. Austria is distinct for allowing a relatively short period between legalising assisted dying and the law coming into effect (12 months). Some studies indicate that some roles felt unprepared and in need of more training and guidance to be able to deliver assisted dying, highlighting the importance of allowing time to develop clear information and support structures as part of implementation.[69]

Experience of implementation in other countries also highlights a challenge to identify **what should be specified in law**, or defined in regulation, and what can be left to policy or guidance (which can have benefits as well as lead to inconsistency). A review of the assisted dying legislation in New Zealand found the level of operational prescription in its law to be unnecessary in primary legislation, and that it could have unintended impacts on how assisted dying is provided over time. Examples include the requirement to specify the date and method of administration and method after a person has been found eligible.[50] Detail within legislation can result in specific service requirements, which can in some cases result in become barriers to access (see the 'New roles, responsibilities and services' subsection earlier in this chapter).

Across all jurisdictions that have legalised assisted dying, the number of cases has increased over time (even when eligibility criteria have not changed), creating **ongoing pressure on service capacity**[70] This growth pattern necessitates dynamic capacity planning over time. It is important to account for the fact that the number of people who request an assisted death is much higher than the number who ultimately receive it. While there are a range of reasons for this, there is evidence from multiple jurisdictions of insufficient capacity to meet demand for assisted dying services, and thus service capacity must accommodate the full assessment process, not just completed cases: where data is collected, the number of requests is around double the number of deaths (see Appendix for more details). In Western Australia, the Voluntary Assisted Dying Board recommended that there needed to be more practitioners to meet demand for an assisted death, and in particular that the number of practitioners who complete the necessary training needed to be increased.[71] In Canada, because of initial low levels of engagement with assisted dying after it was legislated, to spread the management of cases across available providers, provinces created care coordination services[72] – and this practice has continued as the numbers of cases have increased.

Box 4 gives some examples of challenges in setting up, developing and maintaining infrastructure.

Box 4: Examples of particular capacity challenges

Ensuring sufficient capacity can be a particular challenge in rural areas. In Washington in the US, two physicians were required to confirm that an individual meets the criteria of a terminal diagnosis, but there were reportedly difficulties accessing a second doctor in rural areas; a change of law was therefore agreed in 2023 to allow physician assistants and advanced registered nurse practitioners to be involved.[73] In Western Australia, regional provision of services was reported to be beneficial to address specific capacity challenges in rural areas – a regional setting for assisted dying provision can make the best of pre-existing relationships with patients and within professional networks.[74]

Specialist capacity represents another persistent challenge, particularly for accessing professionals with expertise in palliative care or specific medical conditions relevant to the individual's case. In New Zealand, a review of the End of Life Choice Act 2019[50] highlighted that a lack of psychiatrists was a challenge, and recommended allowing other practitioners authorised to undertake capacity assessments to take on additional capacity review responsibilities.

Managing situations where clinicians are unable to provide care from the start to finish of the **assisted dying pathway** presents both practical and legal challenges. Some jurisdictions have recommended easing legal requirements in order to facilitate transfer responsibilities if a coordinating or assessing physician becomes unavailable, to ensure that the individual does not have to start the assisted dying process all over again. In New Zealand, operational practice has been to appoint a replacement practitioner in situations where a clinician can no longer provide a service,[50] but greater clarity is needed to manage these circumstances while ensuring safety and accountability.

Funding and sustainability

Funding and sustainability issues compound these capacity challenges.

Approaches to managing funding and payment mechanisms for assisted dying are interdependent with payment mechanisms for health care in each system. However, several jurisdictions have encountered challenges with funding for health care professionals participating in assisted dying services, given the significant workload involved (which we discuss in more detail in the section 'Impacts on staff and organisations' engagement and experiences' later in this chapter):

- In Australia, there is no standard remuneration for voluntary assisted dying practitioners, even though state-wide services may receive government funding.[75] There are recommendations to introduce fee-for-service arrangements, with examples of providers having to work outside normal working hours such as at weekends, or even after retiring, to meet demand.

- Queensland recommended dedicated funding for assisted dying services on the basis that, initially, services were absorbed within existing hospital and health service budgets, which led to variations in service delivery and was threatening sustained capacity.[38]

- New Zealand has identified the need for specific payment mechanisms for providers working outside their regular contracts,[76] and that resourcing staff training and support is essential.[77]

Beyond initial set-up and workforce capacity challenges, assisted dying infrastructure requires **ongoing maintenance and adaptation**. This includes maintaining governance infrastructure, as discussed earlier, and keeping digital systems updated and user-friendly. It also includes ensuring adequate supplies of medications; however, drug shortages have been reported in Belgium,[67] requiring the importation of Thiopental, which has resulted in additional administrative burden for physicians and pharmacists.[31]

Within the scope of this research we have not been able to quantify how much funding has been required to establish assisted dying infrastructure (given the time span for implementation, multiple changes in requirements and broad a range of impacts). However, experience from other countries indicates that infrastructure requirements for assisted dying represent a **significant but necessary investment** in ensuring that where assisted dying is legal, it can be delivered safely, equitably and sustainably. Countries' experiences demonstrate that successful implementation requires not only careful initial planning but also commitment to ongoing capacity development and system refinement. In the next section, we cover individuals', families' and carers' experiences of assisted dying.

Impacts on individuals, families and carers

In this second section of Chapter 4, we draw on the evidence of individuals', families' and carers' experiences of assisted dying in other countries to examine potential implications for the UK. We also examine monitoring data on the use of services and describe access to assisted dying in the jurisdictions we studied, along with barriers to access. When we talk about barriers to access to assisted dying we are not referring to people excluded by the specific eligibility criteria in the relevant jurisdiction, but rather the experiences of people navigating or accessing assisted dying in the relevant jurisdiction.

Key points

- We identified limited evidence of the experiences of people who access (or seek) assisted dying. The small amount of evidence that there was suggested that people can find the process reassuring and that it can give them a sense of control, even if they do not go on to have an assisted death.

- Uptake of assisted dying tends to be higher in countries where clinician-administered assisted dying is allowed – in these countries, a minority of people choose to self-administer lethal drugs. Self-administered assisted dying can place more responsibilities on families and carers than clinician-administered assisted dying.

- Barriers to accessing assisted dying exist at individual, organisational and system levels and include factors such as:

  - geography (particularly for people in rural or remote areas)
  - health literacy

  - socioeconomic factors (particularly if accessing assisted dying incurs a cost)
  - illness or disability.

Features of how assisted dying has been implemented (such as workforce requirements, or preventing the use of telehealth in assisted dying conversations) can also create barriers or delays. Balancing having the right safeguards with enabling access for eligible individuals who want to seek assisted dying is an ongoing issue for jurisdictions that have legalised assisted dying.

- While most people who access assisted dying are also receiving palliative care, we identified a small amount of evidence showing that the impact of assisted dying on broader end of life care experiences is mixed.

- Assisted dying can entail additional roles for carers or family members, depending on how it is implemented, such as navigating the process, providing ongoing support to the individual requesting assisted dying and preparing for the assisted death itself.

- Family and carer experience was variable, and included both positive and negative emotions. While there are some similarities with other end of life experiences, assisted dying can be viewed as unique due to the opportunity to prepare and plan for the death. Positive aspects of assisted dying for carers included feeling that they were relieving suffering, supporting the person's wishes and helping them to plan and prepare for the death. But assisted dying can also cause carers to feel guilt, trauma or stigma. Carers' experience of assisted dying can be influenced by their own views of assisted dying and the person's decision to pursue it, their involvement in the process and their experience of the assisted death itself.

- Bereavement and grief support for families should take account of the unique aspects of assisted dying. But access to such support is variable and several jurisdictions have identified this as an area requiring further action.

The experiences of individuals who access or seek assisted dying

We identified **limited evidence** that reported on the experiences of assisted dying from the perspective of individuals who seek or access it. However, where these were reported, it appears that the option of assisted dying can have positive effects, giving individuals a greater sense of control and peace of mind at the end of life. For example, in one study from the Netherlands, individuals reported feeling reassured by knowing how to access medication, and some even delayed obtaining it because having the option was sufficient to give them control and independence, and renewed energy to continue living.[78] A study from Canada of people with chronic conditions showed that the assessment process for assisted dying validated individuals' suffering, which similarly led some to delaying assisted dying.[79] Another study from Canada found that individuals valued personal agency, with their decision to seek assisted dying bringing about a sense of control, relief and an ability to avoid a distressing death.[80]

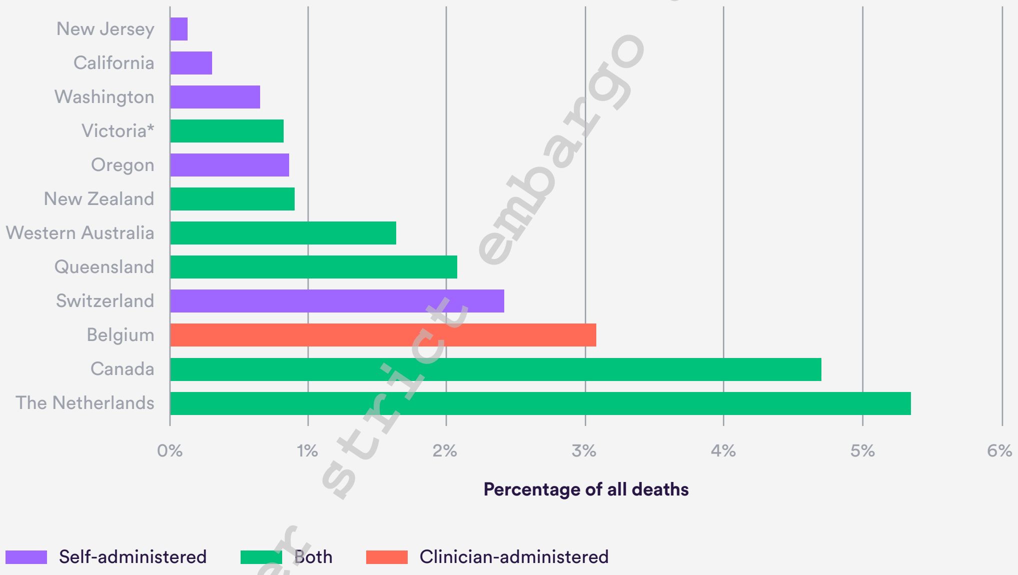
However, individuals could also feel anxiety around the process, reinforcing the need for support and guidance for individuals – particularly if the medication is self-administered. The same study from the Netherlands described above found that some individuals had concerns about the practicalities associated with assisted dying, such as storing and preserving the medication, and concerns that family members who were not supportive of their decision might take it away.[78] Other negative experiences reported in the literature primarily related to delays in or barriers to accessing assisted dying in the first place – described in more detail in the next subsection. In addition, the literature highlights the importance of managing expectations about the assisted dying process, in terms of eligibility criteria, the steps involved and the time it might take, emphasising the importance of clear and accessible information and communication for individuals, families and carers.[81,82]

The extent to which the practical challenges of self-administered assisted dying has an impact on the numbers of people who undertake this is unclear, relative to other factors such as social norms and individual choice. However, we found that where self-administration is a requirement, there tends to be fewer assisted deaths, as a proportion of all deaths, than where clinician administration is an option (see Figure 1). In jurisdictions that allow only self-administered dying, assisted deaths make up less than 1% of all deaths.

The exception is Switzerland where self-administered assisted deaths represent 2.4% of all deaths, but here there are well-established voluntary organisations supporting individuals through the process (see Table 6).

Further, in jurisdictions that allow both self-administered and clinician-administered assisted dying, clinician administration is far more common: the percentage of self-administered assisted deaths where both are available ranged from less than 1% in Canada to 32.9% in Queensland in 2023 (see the Appendix).

Figure 1: Assisted deaths as a percentage of all deaths in 2023, comparing where self-administered or clinician-administered assisted dying is available or where both are available



Notes: Figures reflect the number of assisted deaths as a percentage of all deaths by jurisdiction, drawing on routinely collected data on assisted deaths and annual or monthly mortality statistics in each jurisdiction. Where there are discrepancies between figures reported by year, we have used those that are most up to date. Care should be taken when comparing data by jurisdiction. For instance, some areas report assisted deaths by calendar year, whereas others run mid-year to mid-year.

* While Victoria does offer both self-administered and clinician-administered assisted deaths, clinician administration is only available if the person is physically incapable of self-administration.

Barriers to accessing assisted dying

In jurisdictions where assisted dying is legal, individuals have experienced a range of barriers when attempting to access it. Examples of the types of barriers identified in the literature are summarised in Table 5. Balancing having the right safeguards with enabling access for individuals who want to seek assisted dying is an ongoing issue for jurisdictions that have legalised assisted dying.

Barriers exist at individual, organisational and system levels and can be the result of specific decisions around implementation (such as mandating workforce requirements). Other barriers include a lack of understanding or awareness of the option of assisted dying or the process, financial barriers (depending on how the assisted dying is funded) and individual factors such as health literacy. Some studies also suggest that challenges in accessing broader health care services including end of life care may be reflected in access to assisted dying.[83] This was considered to be particularly the case for vulnerable groups with chronic illness or disability who may experience social disadvantage.[84]

Table 5: Examples of barriers to assisted dying

Type of barrier	Examples
Impact of implementation or design of the model	• Provisions around institutional objection[85] (see the subsection 'Institutional objection' later in this chapter for detail) • Prohibition on telehealth to carry out assessments (as in Australia) • Eligibility to publicly funded assisted dying linked to residency requirements • Workforce requirements (for example, requiring health care practitioners to have specific skills, expertise or training, which may limit the pool of willing and qualified health care professionals, particularly for people living in rural or remote areas) or not providing remuneration for practitioners undertaking assisted dying services • How information about the assisted dying service is communicated, for example whether public advertising of assisted dying is permitted • Whether there are limits on what health care practitioners can do with regards to informing patients about assisted dying (for example, in Victoria, Australia and New Zealand, health care practitioners are prohibited from raising assisted dying in conversations with patients
Public information, awareness and availability of assisted dying services	• Whether a service is transparent about offering assisted dying and the extent to which this information is publicly available[86] • A lack of contactable services and a failure to comply with transparency regulations around assisted dying policies[87] • Whether the person has a pre-existing relationship with health care practitioners (who understands their wishes)[74] • Understanding of assisted dying among health care practitioners (risk of misconceptions and incorrect information)[50] • Whether individuals or their families have connections to the health care system such as insider information or links to professionals or organisations with a history of supporting assisted dying[80]
Financial factors (cost to individuals, health care practitioners and the system)	• How assisted dying (and associated care) is funded (for example, limitations on whether assisted dying can be covered by health insurance).[55] • Cost of medication (or other aspects of the assisted dying process, such as needing to pay for consultations)[92] • Increasing numbers of practitioners electing to charge private fees for voluntary assisted dying care[37]

Type of barrier	Examples
Individual factors	• Health literacy, beliefs and knowledge about assisted dying, including reasons for seeking it, and eligibility criteria[52] • English as a second language or people who are not internet literate[52] • Level of education, health or legal training, or not being well informed about assisted dying[52] • People with socioeconomic vulnerabilities, such as lower income and education levels, who have less knowledge about end of life care options, including assisted dying[88]
Practical barriers	• Issues to do with physical mobility, schedule flexibility and knowledge of who can provide the service[89] • Having to travel to different facilities, which is likely to impact vulnerable groups disproportionately[89] • Difficulties generating the documentation required for assessing eligibility, in particular proof of residency[90] • Uncertainty about how to navigate the assisted dying request process, sometimes requiring multiple attempts and delays[91] • Having enough time to complete the process[50]

Impact on end of life care

We identified limited evidence of the impact that legalising assisted dying has on individuals' broader experiences of end of life care. In most jurisdictions we looked at, health care practitioners are required to give information about palliative care and other treatment options before a person can access assisted dying – it is part of assessing that the person has come to an informed decision based on all the options available, such as in Austria, Spain,[26] some US states (for example, Oregon[92]) and Canada.[93]

The extent to which assisted dying services are integrated with broader end of life care has been a source of debate in several of the systems we analysed. Tensions have surfaced in some jurisdictions due to **unclear policies** on the responsibilities that care facilities or hospices have in relation to assisted dying, and a strong feeling among some stakeholders that it should remain a separate and distinct services from hospice, palliative and other end of life services (see the subsection 'Institutional objection' later in this chapter). A review of New Zealand's assisted dying legislation found that unclear guidance discouraged some individuals from being open about seeking assisted dying, out of fear it might jeopardise their access to palliative care.[50]

In legalising assisted dying, the Canadian government recognised the need to also strengthen palliative and broader end of life services more generally. It committed to developing a palliative and end of life care strategy to improve quality and access, in part to ensure that no one chooses assisted dying due to a lack of other support. But even though a framework and strategies on palliative and end of life care have been developed, Canadian studies have cited that there is a lack of clear policies or guidelines on how these services should be integrated or relate to one another.[94] Belgium has attempted to reform palliative care at the same time as assisted dying, and assisted dying and palliative care are considered to co-exist: assisted dying is considered as one element of an array of options and palliative care is viewed as accessible for all, with assisted dying being part of the 'tool box' for end of life care practitioners.[95,96]

Monitoring reports indicate that the majority of people who access assisted dying are also in receipt of **palliative care**. Across the jurisdictions we studied that reported use of palliative care services, 75% or more people accessing assisted dying were reported to be receiving palliative care in 2023 (see the Appendix). We identified a small amount of evidence that being on the assisted dying pathway or requesting assisted dying may have negative impacts on end of life care, mostly as a result of provisions on institutional objection (see the later subsection on this). Some studies also reported on the impact that assisted dying can have on broader conversations about end of life care planning: a scoping review on assisted dying in Canada found that assisted dying caused discomfort for clinicians in discussing palliative care and end of life issues with patients, potentially perpetuating stigma about choosing assisted dying.[97]

Legalising assisted dying has the potential to improve practice around end of life care. A study from Australia found that health care practitioners who had been involved in the assisted dying process viewed it as a 'catalyst' for having broader conversations about goals at the end of life and advance care planning with patients.[98] Similarly, a scoping review of health care practitioner and family experiences of assisted dying found that most studies conducted on physicians indicated that legalised assisted dying had improved their ability to provide better end of life care to patients who did not request assisted dying.[99,102]

There can also be consequences for individuals who are **found ineligible** for assisted dying, despite meeting some of the criteria. A review of the legislation in New Zealand highlighted the risk that people who have been declined assisted dying may be at higher risk of suicide and recommended that operational guidance and training should be 'strengthened' – to enable a response tailored to the person's circumstances and encourage practitioners to refer a person back to their regular health provider or ensure that they are aware of resources available in their area for support.[50]

Family and carer roles and experiences

Family and carer roles

Legalising assisted dying impacts not only individuals seeking assisted dying, but also their families and carers too, potentially requiring them to undertake additional tasks on top of their familial/caring role. Roles of families and carers can include supporting the individual, navigating the process, retrieving medication and assisting in the preparation or administration of medication (that is, being involved in the assisted death itself).[100] However, specific roles vary depending on the model in place, highlighting how decisions about implementation and regulation have an impact on people's experiences:

- Models where lethal drugs are self-administered are considered to leave more tasks and responsibilities to family members compared with clinician-administered assisted dying.[101] This may be a factor in the lower rates of assisted dying where this is self-administered (see Figure 1 earlier in this chapter).

- In systems where assisted dying is legally and openly available, family members rely more on health care professionals compared with systems where it is only decriminalised.[101]

- If a health care professional is required to be present at an assisted death, this may reduce the role of family carers who otherwise have additional responsibilities such as preparing medication and assisting with ingestion.[102] For example, in Victoria in Australia, assisted dying medication is self-administered by the person and a health professional is not required to be present, meaning family members are felt to play a more central, active role in organising and managing the death.[103]

Family and carer experiences

Given the many roles that families and carers may be required to undertake and the impact on them of their loved one choosing assisted dying, understanding their experiences is crucial when implementing assisted dying. Learning from other jurisdictions demonstrates that despite this, carers do not always receive consistent support, either during or after an assisted death.

While some elements of assisted dying are considered consistent with other experiences at the end of life, there are **some distinguishing factors**, such as advanced knowledge of the time, place and manner of the death and an opportunity for preparation, which impact carers' experiences and the support they may require.[103]

Key motivators for family carers in agreeing with the person's assisted dying decision are witnessing suffering and a respect of mutual values.[101] However, while requests for assisted dying are often not surprising to family members, those who are **opposed to assisted dying** for moral or religious reasons, or who disagree with the person's decision, find it challenging to discuss things.[102] In addition, a Canadian study found that while being able to have an assisted death means relief for most patients, for families and for friends, feelings could include loss, betrayal, decline in hope and conflict, particularly as some individuals may not have told others about their decision.[80]

How assisted dying is implemented has an impact on the role of families and carers and the support available to them. The following factors have been found to be important to family members and need to be considered as part of the implementation of assisted dying:

- **Carers' involvement in the assisted dying process**
  - Involvement can give families more control and the ability to prepare for the death in a meaningful way, which can have positive impacts on their experience.[104] Compared with other end of life experiences, carers involved in situations of hastened death less commonly report burden or physical exhaustion.[105]
  - Facilitating an assisted death requires considerable work from the carer, such as fulfilling the person's wishes about the process itself or how they wanted to be remembered. It can also generate a range

of sometimes conflicting emotions – such as unease and distress at participating in the assisted death, relief and gratitude – and challenges if family members disagree with the decision or there was a desire to keep the assisted death a secret.[103]
  - Families may have to manage disclosure and potential negative reactions from others,[106] particularly as there are still issues with stigma in relation to assisted dying, which means the individual may not inform their wider network.[101,107]
  - Carers can also experience guilt, trauma and secrecy and many family members do not feel prepared for the process.[108]
  - Regardless of the quality of the dying experience, accessing assisted dying can add extra strain on carers during the dying process, with the process highlighted as highly challenging and emotionally taxing, with the mandatory reflection period (10 days in Canada in this example) causing particular anxiety.[109]

- **Carers' experience of assisted death itself**
  - If the assisted death itself does not go according to plan, it can lead to feelings of loss of control, exclusion, regret and disappointment.[103]
  - Relatives may have other support needs such as managing rituals and activities, their emotions and resolving conflicts.[110]
  - Adverse events at the assisted death can result in strain for family members.[102]

- **Carers' knowledge and information about assisted dying and the process**
  - Carers may need more information and preparation around the clinical aspects of the procedure (delays or unclear communication can result in additional distress).[111]

Bereavement and grief, and support for carers

In addition to experiences during the assisted dying process, studies highlight that it is important to recognise the nature of grief following assisted dying and provide appropriate support. There is evidence from other countries of both positive and negative experiences, which again several factors influence. While an assisted death often shares characteristics with other forms of bereavement,[112] it also has distinct features. These include a sense of meaning for family members from fulfilling a loved one's wishes, and the ability to plan and prepare. These factors can foster emotional preparedness, facilitate acceptance and improve overall end of life experience for families, with some studies reporting a sense of peace and closure.[102] Grief is eased when there is agreement with the decision, opportunities to say goodbye and avoidance of prolonged suffering.[113] However, studies have also identified negative experiences, such as conflict over the person's decision to pursue assisted dying, anxiety over scheduling the assisted death itself, and stigma.[113]

Despite this, bereavement care in some jurisdictions appears **inconsistent**.[101] As highlighted above, several jurisdictions have identified the need for greater bereavement and grief support, including Australia, which has developed bereavement guides, care navigators and liaison nurses to support families and individuals throughout the process.[114] Other initiatives identified, which could provide support to carers, include counselling, support groups and assisted dying coaches.[109] However, gaps remain: studies in Canada and Australia have found that families can lack access to formal aftercare, and can find the experience difficult to talk about.[71,115] International learning demonstrates the importance of structured support and bereavement services – both during and after the process – which take account of the unique aspects of assisted dying. This is often part of the system infrastructure and changes that jurisdictions have had to put in place on legalising assisted dying, described in the first section of this chapter.

These country experiences highlight the importance of embedding bereavement support into assisted dying services, and ensuring that support is timely, accessible and culturally sensitive for a diverse range of groups – including children.

Impacts on staff and organisations' engagement and experiences

The implementation of assisted dying legislation requires careful consideration of health care practitioners' roles, responsibilities, training and experiences. Individual practitioners face complex decisions about their involvement in assisted dying, navigating tensions between institutional positions, individual conscience, rights and patient access needs. In this final section of this chapter we look at these matters in more detail.

Key points

- A range of health care practitioners are involved in assisted dying, with roles and responsibilities varying significantly by jurisdiction, although GPs typically represent the largest group of participating professionals.

- Effective provision of assisted dying typically requires coordinated multidisciplinary teams rather than isolated providers, with specialised teams helping to manage capacity and streamline service delivery. Roles and responsibilities need to be individually defined, but the legislation should recognise the importance of the multidisciplinary approach – especially in rural and underserviced areas.

- A pre-existing relationship between clinician and the individual can make the assisted dying process easier to navigate for both. But this may not be feasible in practice because a relatively small number of clinicians are involved in a high proportion of assisted deaths, according to the available data on this. Assisted dying policy should recognise the value of established doctor–patient relationships but also consider the need for centralised services where needed.

- Most health care practitioner training on assisted dying focuses on the legal aspects, including eligibility criteria and conducting assessments – with universal gaps in practical training such as how to communicate about end of life options, provide information and offer emotional support. Nonetheless, training for all is encouraged as all staff could encounter information requests. Studies show that practitioners may not engage in assisted dying due to a lack of knowledge. This has implications for system capacity, but training can provide support.

- The experiences of health care practitioners in relation to assisted dying are mixed. While most involved in assisted dying report no negative mental health effects and find the work professionally rewarding, they experience administrative burden and require adequate support systems.

- Practitioners' and provider organisations' right to object to participating in assisted dying protects them from moral distress, but can create access barriers for individuals. Assisted deaths are most likely to take place at the individual's home.

- Both individual and institutional attitudes towards assisted dying can change over time through education, experience and relationship-building, with some opposition softening as the process becomes more familiar and accepted.

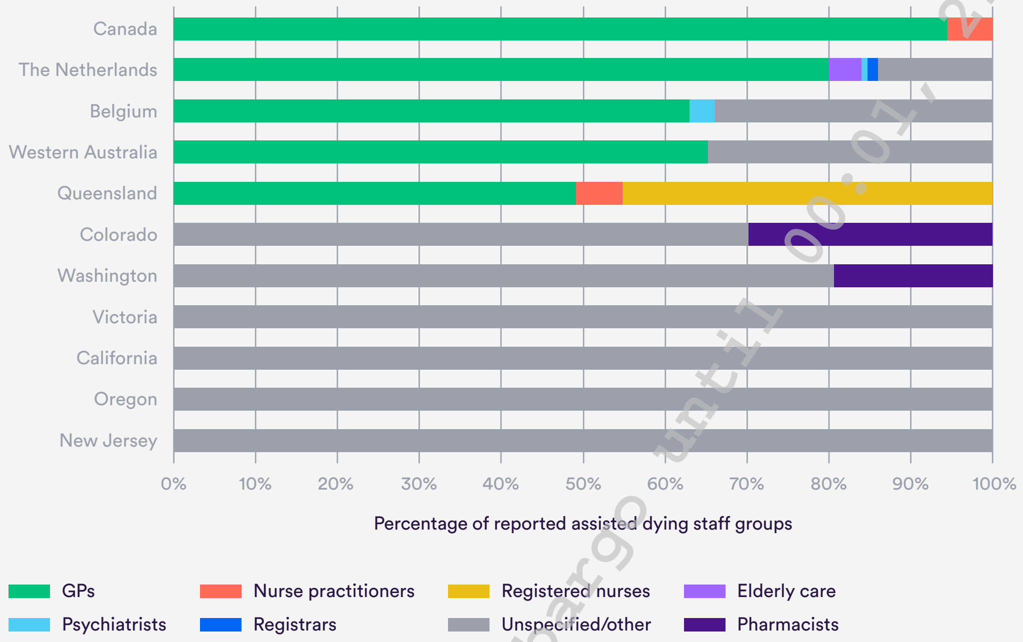
Practitioners directly involved in assisted dying

Physicians play a central role in the assessment and delivery of assisted dying in most countries, with GPs often serving as the key professional in many jurisdictions, such as Australian states, Belgium, Canada and the Netherlands (see Figure 2). Pharmacists typically dispense the medications used in assisted dying procedures, and in some systems they support individuals and their families to safely administer medications.[104] Participating professionals also include:

- nurses
- psychologists
- pastoral counsellors
- social workers
- staff at centres that provide euthanasia
- palliative care specialists
- volunteers at right-to-die organisations.[116,117]

The high proportion of people in 'unspecified/other' staff groups in some jurisdictions in Figure 2 reflects that staff groups are not always specified even if overall staff counts are provided. Some jurisdictions such as California and Colorado refer purely to broad groupings such as 'physician', and others report staff by their assisted dying job role rather than their underlying job role. For instance, New Jersey specifies the number of attending physicians/prescribers.

Figure 2: Proportion of reported staff involved in assisted dying, by staff group and jurisdiction, 2023



Notes: There are large differences in the number of staff underlying the proportions reported, with the total number of staff reported ranging from 11 in New Jersey to 9,068 in the Netherlands. New Zealand is excluded as it only reports specific job roles registered on the Support and Consultation for End of Life in New Zealand (SCENZ) list, which is not a requirement to participate in assisted dying and therefore does not inform understanding of the full involvement of different staff groups. 'Unspecified/other' includes instances where staff numbers are provided under a generic grouping (such as 'physicians' or 'medical providers') but specific staff groups are not named. Links to underlying source data can be found in the Appendix.

Many jurisdictions rely on a multidisciplinary approach, with specialised teams playing a pivotal role. In Canada, multidisciplinary teams have developed significant expertise in assisted dying services,[118] and in the Netherlands, multidisciplinary teams are assembled to address particularly challenging situations.[119] In Belgium, the model extends further to include expert advisors specifically focused on end of life decisions, offering vital support to practitioners.[120] These team-based frameworks:

- ensure seamless service delivery
- provide essential support to patients and families
- manage emotional and logistical complexities
- alleviate burden on individual providers.

This team-based structure appears to be essential, but is not always captured in legislation, which often defines individual practitioners' roles and responsibilities rather than focusing on the contributions of a team.

Requirements for health care practitioners

Requirements for health care practitioners wanting to participate in the assisted dying process vary across jurisdictions. In addition to training requirements (explored in detail in the subsection 'Training and support for practitioners' later in this chapter), some countries have introduced a minimum number of years of experience in a professional role or require areas of expertise.

In Victoria, Australia, in addition to completing mandatory training, coordinating and consulting practitioners must hold specialist registration, or general registration and have practised for at least 10 years. The administering practitioner may be the coordinating practitioner, or another who must hold specialist registration or general registration and have practised for at least five years, or be an overseas-trained specialist who holds limited registration or provisional registration or be a nurse practitioner.

On the other hand, in New Zealand, there are no specific requirements for the person acting as the attending practitioner (who may also administer), beyond being registered with the Medical Council of New Zealand as a practitioner of the profession of medicine with a current practising certificate. However, the independent practitioner (who makes the second assessment) must have held their practising certificate for at least five years.

Requirements also exist in some places with regards to **areas of expertise**. For example, in Austria, one of the assessing physicians must be specialised in palliative medicine.[121] In Victoria in Australia, if the person has a neurodegenerative condition, there is a requirement for one of the doctors involved to have expertise in the person's condition. Additional requirements exist if the person has a mental disorder – for example in Austria, practitioners must refer the individual to a psychiatrist for an additional assessment if they have a mental disorder.

Requiring health care practitioners to meet **certain criteria** has been identified as a barrier to assisted dying, particularly for people living in rural or remote areas or whose condition is rare (see Box 4, page 44). However, a lack of requirements may also cause issues. A review of the New Zealand End of Life Choice Act 2019 highlighted that the lack of requirements has raised concern that practitioners who are not sufficiently skilled and experienced to provide these services may still seek to provide them – this is particularly so given the absence of a professional college with responsibility for assisted dying, or other mechanisms to manage and regulate the workforce.[50] As noted earlier, this is another area where balancing safeguards with enabling access is key.

Responsibilities of health care practitioners in assisted dying

While there are specific responsibilities for each professional group (see Table 6), several overarching responsibilities apply to all practitioners involved in assisted dying.

All practitioners must balance patient autonomy with professional judgement and choose whether or not to participate in assisted dying, or facilitate access to a provider who can support the individual's assessment and request. Effective communication about end of life choices and clinician–patient relationship management are paramount – requiring sensitive conversations, respect for cultural and spiritual needs, maintenance of confidentiality and coordinated care to build trust. Professional development is essential through:

- ongoing training on laws and procedures
- participation in peer support and debriefing sessions
- seeking supervision for complex cases
- contributing to quality improvement.

Additionally, meticulous documentation and legal compliance are required, including detailed record-keeping, mandatory reporting, participation in oversight processes and adherence to jurisdictional safeguards. But administrative requirements can have an impact on practitioners' willingness to be involved in assisted dying.

With so many potentially overlapping roles and responsibilities in delivering assisted dying, policy and guidance need to clearly define roles and responsibilities of practice, and ensure that these are framed within the context of multidisciplinary approaches.

Table 6: Responsibilities of practitioners

Professional group	New or additional responsibilities associated with assisted dying
Physicians and nurse practitioners*	**Primary assessment and decision making** • Explain palliative and end of life care services. • Assess patient eligibility for assisted dying according to legal criteria in the jurisdiction. • Evaluate whether suffering is unbearable and cannot be relieved through other means (in jurisdictions where this is relevant, such as the Netherlands[122]). • Determine decision-making capacity and ensure voluntary, informed consent – even among those with dementia.[123] • Assess the quality of past treatments and review the patient's medical history. • Prescribe lethal medications for assisted dying procedures. • Provide or oversee the administration of assisted dying (in most jurisdictions except Switzerland. **Relationship and communication responsibilities** • Engage in reciprocal communication with patients about end of life wishes. • Maintain the doctor–patient relationship ('*colloque singulier*' in Belgium) as the foundation for decision making.[116] • Consider family bereavement and manage family dynamics during the process – taking care of patients and often their families as well. **Procedural and legal obligations** • Engage in discussions around end of life and assisted dying (note that it is illegal for professionals to initiate this conversation in New Zealand and parts of Australia). • Inform patients within seven days if refusing a request for assisted dying (Belgium) and provide referral to an alternative service. • Consult with independent physicians or trained consultants for second opinions (see specialist descriptions later in this table). • Complete detailed record-keeping and documentation requirements – including reporting required data to relevant authorities for monitoring. • Participate in post-death investigations and legal reporting processes. • Ensure compliance with safeguards and regulatory requirements.
Pharmacists	**Medication management and supply** • Serve as a 'central checkpoint' for supplying assisted dying medications (for example, Australia[124]). • Dispense lethal substances according to strict protocols and security measures – including ensuring proper handling of unused medications. • Record and report data to relevant authorities for monitoring. **Patient interaction and support** • Familiarise oneself with patients if they are not previously known to you. • Provide private counselling sessions, answering questions about the medication and process, and offering emotional support.

Professional group	New or additional responsibilities associated with assisted dying
Nurses	**Direct patient care and support** • Serve as a first contact for patients expressing wishes to end their life (for example, Austria[125]). • Provide practical support by coordinating care and emotional support during procedures (for example, in Canada).[104] • Coordinate care between different health care providers and services. • Assist with medication preparation and intravenous line establishment (where legally permitted). • Provide comfort care and symptom management alongside assisted dying services – often alongside palliative care professionals (see more on this later in this table). **Communication and advocacy roles** • Engage in conversations about the individual's motivations and care concerns. • Educate patients and families about the assisted dying process and alternatives – thus, navigating complex conversations about end of life options while avoiding 'counselling to die'. • Support other staff members and provide guidance to colleagues. • Notify physicians or nurse practitioners when patients request information about assisted dying.
Social workers	**Psychosocial assessment and support** • Assess family dynamics and provide support throughout the process (for example, Quebec[126]). • Help with social determinants that may influence assisted dying requests (for example, Canada). • Provide counselling and emotional support to patients and families. • Facilitate communication between patients, families and medical teams. **Case management and coordination** • Navigate complex social situations and address barriers to care. • Connect patients with resources and support services. • Document psychosocial factors relevant to eligibility assessments. • Collaborate with practitioners or interdisciplinary teams carrying out assisted dying.

Professional group	New or additional responsibilities associated with assisted dying
Volunteers	**Witnessing and documentation** • Serve as independent witnesses for medical assistance in dying (MAiD) request signatures and documentation (for example, Canada[127]). • Provide companionship and emotional support during the process. • Guide individuals through procedures (particularly in Swiss right-to-die organisations[116]). **Information and support services** • Provide information about assisted dying options and processes. • Offer non-medical companionship during difficult decisions. • Support families during and after the assisted dying process. • Navigate organisational procedures for right-to-die organisations.
Palliative care specialists	**Specialised end of life care** • Mediate family dynamics and tensions around end of life and assisted dying decisions. • Organise external assessors in conscientiously objecting institutions and facilitate transfers to non-objecting institutions when needed. • Coordinate comprehensive end of life care alongside assisted dying services. **Professional integration** • Balance palliative care principles with the provision of assisted dying – and provide emotional support regardless of personal views on assisted dying. • Clarify the individual's goals within broader socio-relational contexts. • Support families through decision-making processes.
Specialists and subspecialists (disease-specific specialists such as cancer specialists, or medical specialists such as psychiatrists)	**Expertise requirements** • Provide disease-specific expertise for complex cases. • Assess treatment options within your specialty area. • Evaluate the prognosis and trajectory of conditions. • Participate in multidisciplinary consultations for complex cases.

Notes: * Nurse practitioners are authorised a role in assisted dying in certain jurisdictions, including Canada, Colorado (US), Washington (US), Australia (administration only in the state of Western Australia) and New Zealand (final administration only). We did not examine the roles of judges, witnesses or legal representatives on panels, as this was out of scope for this project.

Clinicians report that having a **pre-existing relationship** with the individual enables them to assess the individual's needs, because they understand their wishes and values.[128,129] Doctors report being more likely to agree to being involved in assisted dying for an individual they already have a clinical relationship with, because they are more confident.[84] For individuals seeking assisted dying, an existing relationship with the clinician can make it easier to raise the topic (a factor that is particularly important where clinicians are not allowed to raise it first, such as in Victoria, Australia).[130]

However, in practice, often there may not be an existing relationship between the individual and the clinician: monitoring reports from several countries indicate that a high proportion of assisted dying cases involve a small number of clinicians. In Victoria, 10 physicians either coordinated or consulted on 55% of all cases in 2023–24, and four were involved in 50 applications each.[131] In Western Australia, five practitioners completed 43% of all first assessments.[37] Centralised coordination services, as developed in Canada to provide assisted dying across a wide, remote geography, can mean that clinicians will not have direct knowledge of the individual.[84] In the Netherlands, it was previously a standard that assisted dying required a pre-existing treatment relationship between the physician and the individual – brief but extending beyond the assisted dying act itself – to meet the duty of care. This has since evolved with the establishment of the Euthanasia Expertise Centre, which enables more limited relationships by introducing additional safeguards.[30]

We can learn from this subsection on the responsibilities of health care practitioners that overly restrictive requirements, such as years of experience or specialty credentials, can create access barriers, especially in rural areas and for rare conditions. Flexibility is also required in terms of eligible practitioner types over time, as experience with assisted dying grows, yet without clear professional oversight bodies, there a risk of inadequately skilled practitioners taking part.

Training and support for practitioners

Content of training

Across the systems we looked at, training largely focuses on the procedural aspects of assisted dying, such as eligibility criteria, permitted drugs and how to comply with processes for documentation and monitoring. This training is mostly directed at practitioners who are or wish to be directly involved in the assisted dying process. Some countries also provide training for staff not directly involved, but who may encounter requests for information and therefore need to be prepared and understand their roles and responsibilities. In New Zealand, for example, all health care practitioners are encouraged to complete e-learning modules on assisted dying, even if they do not plan to be involved in the service. This is important, as many people may be approached for information about assisted dying, even if they are not directly part of the process. In fact, in Belgium, monitoring reports have recommended that assisted dying is included in all university medical training.[132] To ensure consistent application of the law and high-quality, culturally sensitive care in Canada, national reviews of assisted dying have suggested that assessors and providers should receive training in capacity assessment, trauma-informed care, and cultural safety – as biases related to ethnicity, race, gender, disability, and religion can compromise care quality and create structural barriers.[133]

Approaches to requirements for training

Jurisdictions have adopted a wide variety of approaches to whether or not training is standardised, or mandatory. Table 7 provides some illustrative examples of the range of approaches in the jurisdictions studied. This includes states in Australia where training is mandatory before practitioners can be involved in assisted dying, to states in the US where training is neither standardised nor mandatory and instead has developed organically among health care practitioner groups and organisations.

Table 7: Overview of training approaches in the jurisdictions studied

Training approach	Example	Content of training
Training is mandatory before health care practitioners can be involved in assisted dying but it is not standardised	**Australia** Each state's legislation requires that practitioners wishing to be involved in assisted dying must undertake training, but the content varies between states.	**Victoria, Australia** Online training covering: • conversations, a first request, and deciding whether to participate in voluntary assisted dying • roles, qualifications and expertise of medical practitioners • eligibility assessments and permits • prescribing or administering medications, and actions following the individual's death • protections and oversight • self-care for medical practitioners.[134]

Training approach	Example	Content of training
Standardised training is available but it is not mandatory for health care practitioners	**Canada** The federal government funded the Canadian Association of MAiD Assessors and Providers (CAMAP) to develop a national curriculum for assisted dying, to provide practitioners with training and ensure consistency when implementing legislation.[45] All licensed medical and nursing practitioners can register whether or not they have medical assistance in dying (MAiD) experience (but not trainees or non-medical practitioners).[84] There is guidance for practitioners and to help regulatory authorities ensure public protection in complex MAiD cases.[45]	**Canada** 13 online self-study hours and 14 hours for facilitated sessions. Topics include: • foundations of MAiD in Canada, including federal and provincial processes, eligibility criteria, safeguards and ethics • clinical conversations about end of life, which include MAiD as an option • how to do a MAiD assessment • assessing capacity and vulnerability • best practice in providing MAiD • navigating complex cases • MAiD for people with mental disorders • resilience.[135]
	New Zealand There is no requirement in the legislation for practitioners to undertake training before providing assisted dying but it is a prerequisite for health care practitioners receiving reimbursement for assisted dying activities (note that this has been highlighted as unsatisfactory, as practitioners can provide assisted dying without seeking funding from Health New Zealand for their services).[50] However, all health professionals, regardless of their involvement in assisted dying, are encouraged to complete training.	**New Zealand – training required for reimbursement**[136] Five e-learning modules for medical and nurse practitioners who plan to provide assisted dying services: • the assessment process • preparations for an assisted death • assisted death and after-care • practitioner safety and wellbeing • a module to review learning. **New Zealand – optional training for health care practitioners**[136] Three e-learning modules: • an overview of the End of Life Choice Act 2019, including roles of health care practitioners • the assisted dying pathway, including best-practice communication skills • how to respond to requests for assisted dying. There are also online factsheets and webinars.

Training approach	Example	Content of training
Training is neither standardised nor mandatory	**The US** There are no mandatory training requirements for practitioners, although guidance is available from organisations such as the Coalition for Compassionate Care of California.[137] In addition, Compassion & Choices convened the Physician Aid-in-Dying Clinical Criteria Committee, in July 2012, to create clinical criteria for physicians who are willing to provide aid in dying to patients who request it.	**The US – clinical criteria for physician aid in dying** This covers: • how to respond to an individual's inquiry about assisted dying, including discussing end of life options • how to assess decision-making capacity • prescribing and medication procedure.[138]
	Belgium Belgium has a combination of training sources from university courses[139] and training from professional networks, for example the Life End Information Forum (LEIF).	**Belgium – LEIF training** Assisted dying, other medical practices at the end of life and quality criteria for consultation in assessing assisted dying requests. Taught in person by experts in palliative care and assisted dying, in modules covering: • medical end of life decisions • assisted dying legislation • legislation on patient rights and access to palliative care • organisation and functioning of LEIF • legal context for advance directives and advance care planning • ethics and the concept of mental capacity in palliative care • assisted dying in practice and research • physician communication with patients, relatives and other professional carers. Physicians obtain LEIF consultant/physician qualifications when they have completed the first two modules (core curriculum) as a minimum standard, but they are encouraged to complete all modules.[120]

One of the main challenges with assisted dying training is that it often focuses on the procedural aspects. But health care staff have identified a range of additional areas where more training or support would be beneficial. For example, there are gaps in training around navigating some of the practical complexities associated with delivering assisted dying, responding to initial requests, or simply engaging in broader conversations about end of life care (see Box 5).

Box 5: Areas identified where further training would be beneficial

- How to recognise when a person is initiating a request.[140]
- How to respond to requests about assisted dying.[141]
- Communication skills.[69]
- For pharmacists, the optimal dose of the medicine and its effects, and information around counselling for patients, how to develop emotional strategies and the legislative requirements involved.[124]
- Procedural and clinical aspects of assisted dying, including required forms and medication[142] and inserting cannulas.[143]
- Managing structured communication with patients and family.[101]
- How palliative and end of life care exists alongside assisted dying.[69]
- Support with basic palliative care skills, resilience training and dealing with the emotional and spiritual aspects of assisted dying.[140]
- Managing potential conflict or relationships with individuals, families and carers or with other professionals in the team.[144]
- Managing the situation if a person's request for assisted dying is unsuccessful.[50]
- Knowledge gaps around assessing capacity and the potential for undue influence.[145]
- Assessing aspects of eligibility criteria, for example in relation to unbearable mental suffering.[146]

Beyond formal training, studies highlight the broader set of skills needed in practice, including:

- compassionate and open communication
- technical competencies (for example, inserting cannulas and medication preparation)
- governance (for example, checking physician actions, paperwork, finding witnesses, and supporting and organising the assisted dying process).[102]

Training needs may also evolve over time, particularly if there are changes to legal frameworks. This means that systems and infrastructure need to be adaptive and have ways of systematically identifying how training needs may need to change in line with practice. For example, in Belgium, practitioners identified the need for greater training on how to handle assisted dying for individuals with psychiatric conditions, following amendments to the law that allowed for assisted dying for individuals with non-terminal conditions.[95]

Gaps in training by professional role

Training tends to focus on the assisted dying roles outlined in legislation (for example, coordinating or assessing practitioners). But assisted dying potentially affects many other staff groups. Several studies from different countries reflected on the needs of different groups of staff such as nurses,[147,148] social workers[118] and pharmacists,[124] who are often overlooked by training programmes. In Canada, for example, one study reported that nurses – despite being formally part of assisted dying services – felt ‘relatively invisible’ in training policies and guidance.[149] However, this did vary between provinces – in one region, registered nurses were required to achieve 80% on a competency exam specific to assisted dying, to assist with medical assistance in dying (MAiD) provision within their scope of practice.[149]

These training gaps also apply to new roles that assisted dying legislation has created (see the ‘New roles, responsibilities and services’ subsection earlier in this chapter). For example, in Canada, Simpson-Tirone and colleagues[61] noted that there are no specific qualifications, training or credentials for the care coordinator role, despite it being a key part of the assisted dying process (although, as outlined earlier, some jurisdictions have introduced requirements for other roles). They identified a need to define standards of practice due to the lack of formal regulation, the vulnerability of patients seeking assisted dying and the consequences if the legal requirements are not met.

Additional support

As well as formal training, additional support and networks exist to help health care practitioners involved in assisted dying. These perform a variety of roles, such as additional training or guidelines, peer support and mentoring (see Table 8). In some places they have been formally established, recognising the importance of providing ongoing support for practitioners involved in assisted dying. For example, in Western Australia, communities of practice were established for all participating practitioners before implementation.

Table 8: Overview of examples of additional support

Medical association guidelines and support	• **The US.** In 2020, the American Clinicians Academy on Medical Aid in Dying was organised as a non-membership organisation to support clinicians caring for patients considering or completing aid in dying.[150] • **Switzerland.** Practitioners have drawn on institutional policy, senior colleagues, Swiss Academy of Medical Sciences (SAMS) policy guidelines and perceptions of best practice.[151]
Professional networks and communities of practice	• **Australia.** In Western Australia, a community of practice for all participating practitioners who had completed training and navigator/pharmacy service was established before the Voluntary Assisted Dying Act 2021 came into force.[74] In Victoria, separate groups were established after the Act came into force. • **Belgium.** The Life End Information Forum (LEIF) was founded in Belgium to inform and educate patients and professionals. Physicians can register themselves as LEIF physicians with a prerequisite to comply with ongoing education and be consulted as independent physicians.[152] • **The Netherlands.** The Royal Dutch Medical Association has established regional networks of independent, expert physicians known as SCEN physicians (SCEN: Support and Consultation on Euthanasia in the Netherlands), who have been specially trained and certified to assess a person's eligibility for assisted dying.[152] • **The Netherlands.** The Euthanasia Expertise Centre (founded as the End-of-Life Clinic in 2012 by the Dutch Right to Die Society) is a network of health care practitioners, which provides information, ongoing training and education to clinicians to ensure that cases fulfil legal requirements.[152]

Even when formal training exists, this is a dynamic space and learning from other jurisdictions suggests that health care practitioners adapt and develop skills through personal experience over time. In the absence of more formal training, US research reported a 'steep learning curve' for physicians in the US, who made decisions on medication based on what patients could afford, their insurance coverage and their ability to swallow.[102] In Canada many nurses developed an impressive degree of comfort and skill around navigating nuances within a rapidly evolving legislative context.[81] An international review of nurses found that most based their approach on institutional policies, senior colleagues or perceptions of best practice, demonstrating the importance of peer support, networks and best-practice sharing.[141]

These findings have important implications for the UK regarding training, as a wide range of both health and social care staff may encounter requests for assisted dying and so would benefit from access to training. Training would need to cover existing ‘invisible roles’ such as nurses, social workers and care workers, and new roles such as care coordinators. To offer the best support to practitioners, any training should go beyond legal and procedural aspects to cover communication skills as well as technical skills. Furthermore, our evidence review suggests benefits to ongoing training through mentoring and peer support.

Experience of health care practitioners

Health care practitioners’ experiences with assisted dying reveal a complex landscape of both positive and challenging aspects (see Table 9). While a range of professionals will have participated in research on assisted dying, these research participants may have been biased towards those involved in this (rather than those who objected to participation), and those who might have had more polarised reactions.

As set out in Table 9, while many practitioners report positive outcomes – including professional fulfilment and emotional rewards from honouring patient autonomy – and no mental health effects, significant challenges persist. Practitioners consistently face substantial workload burdens with administrative requirements and time investments, which are often uncompensated or poorly compensated. Training gaps emerge as another consistent concern, with practitioners reporting feeling underprepared for the emotional intensity and ethical complexity of assisted dying even when formal training programmes exist. The evidence suggests that while many practitioners find meaning in engaging in assisted dying, systemic improvements are needed to support their wellbeing and professional sustainability.

Table 9: Practitioner experiences of participating in assisted dying by theme – showing positive experiences and negative experiences/challenges

Theme	Positive experiences	Negative experiences/challenges
Wellbeing and mental health	• 81% of Austrian nurses reported no mental health influence from assisted suicide legislation.[153] • Some Canadian providers found assisted dying 'life-changing' in positive ways.[154]	• 14.5% of Austrian nurses experienced mental health deterioration.[69] • Canadian rural providers faced elevated emotional costs and social ostracisation risks.[84,159] • Dutch physicians experienced long-term psychological consequences from crossing personal boundaries.[123]
Professional satisfaction	• 75% of Colorado physicians found recent assisted dying cases emotionally fulfilling and professionally rewarding.[155] • 71% of Californian medical residents found assisted dying work more rewarding than other clinical responsibilities.[156] • Canadian nurses and social workers found assisted dying professionally fulfilling.[118] • There is an opportunity to honour patient autonomy and provide relief from suffering.[54]	• Canadian pharmacists tended to minimise their role as just part of routine work.[118]
Workload and administration	• The care coordinator role emerged to alleviate administrative pressures.[61]	• Dutch GPs found euthanasia requests required more time than regular care.[119] • Australian practitioners were frustrated with overly technical, burdensome online portals – a primary barrier to participation.[51] • Coordinating applications requires around 60 hours of working time.[157] • Assessments where natural death is not foreseeable demand significant time for complex histories (Government of Canada, 2021–2024). • Additional workload was often unremunerated or poorly compensated.[54,76,157] • Refusing participation necessitates work to meet onward referral requirements and non-abandonment rules (having an impact on the capacity of practitioners even if they do not provide assisted dying).[149]

Theme	Positive experiences	Negative experiences/challenges
Emotional impact and coping	• Emotions reported included intrinsic reward for some nurses (for honouring patients' wishes).[148]	• 85.5% of Canadian social workers experienced medium to high emotional charge and 62.4% required processing breaks.[126] • Nurses described sadness and despair; some adopted task-based approaches for protection.[148] • New Zealand providers required days off for self-care and reflection[158] • Some were unprepared for emotional intensity when patients appeared cheerful.[84]
Professional support and isolation	• Time and education allowed trust-building when safeguards respected everyone's beliefs.[159] • Belgian workers appreciated regulatory clarity with necessary boundaries.[139]	• Canadian providers described work as 'difficult', 'isolating', feeling 'not valued', with 'disrespectful' colleague interactions.[94] • Health care providers working alone lacked support and felt isolated.[128] • Formal emotional support was often unavailable, especially in isolated locations.[51] • There were strong opposition units where providers could not express opinions or have productive conversations.[104]
Moral and ethical challenges		• Canadian providers experienced moral burden balancing early death counselling with preventing assisted dying ineligibility.[128] • Nurses had to reframe concepts of intolerable suffering when patients appeared well.[160] • Dutch physicians felt pressure: 25% from patients, 33% from next of kin.[30] • People experienced moral and ethical distress, particularly regarding disclosure of assisted dying involvement.[159] • Requests where natural death is not foreseeable created distinct moral distress in balancing autonomy with best interests.[161]

Theme	Positive experiences	Negative experiences/challenges
Training and preparation	- Physicians without terminal illness experience became more comfortable over time with increasing experience.[102] - Palliative care nurses in Australia had better knowledge and could articulate principles.[162] - Oncologists in Colorado felt significantly more prepared to provide services.[163] - In New Zealand, where training is not mandatory but encouraged, both the e-learning and webinars showed increased odds of understanding the End of Life Choice Act 2019, although the e-learning module had a stronger association.[164] - In a study from Victoria, Australia, following training, participants were generally confident (69%) or very confident (24%) in their knowledge of legislation, and generally confident (66%) or very confident (22%) in their ability to apply the Act.[142] - A review of a residency curriculum in assisted dying at a centre in California found a high level of assisted dying training uptake among the residents, concluding that the training may be effective at producing physicians willing to take part in assisted dying processes.[156]	- Canadian early-adopting physicians first undertook assisted dying without formal training, relying on protocols/online resources.[165] - Providers felt surprised and unprepared when patients raised assisted dying topics.[166] - Austrian nurses expressed a strong desire for additional training despite existing education.[153] - Medical assessors requested further training, particularly on psychiatric aspects.[167] - In Australia, the biggest deterrents to undertaking training were the lack of remuneration, time and practical clinical guidance,[157] a difficult-to-navigate online system and a lack of professional development points.[75] - In a survey of social workers in Canada, of those who reported having been involved in the assisted dying process, 36.4% had not been trained on assisted dying and 22.1% did not know that they could refuse to be involved.[126]

Theme	Positive experiences	Negative experiences/challenges
Professional relationships and stigma		- Australian practitioners anticipated conflict with colleagues, patients and families.[168] - There is potential for professional stigma and threats to wellbeing from collegial relationships.[86] - Spanish clinicians rejected assisted dying due to stigma concerns, work overload and a lack of institutional support.[169]
System-level impacts	- Swiss palliative care physicians saw requests as requiring information rather than direct engagement.[151]	- Conscientiously objecting nurses who were granted time off created provider capacity challenges.[84] - In Australia, there were under-resourced systems and a lack of government appreciation for clinical staff support.[51] - Canadian centralised services created challenges in assessing unfamiliar patients in brief timeframes.[84]

Choosing whether or not to participate in assisted dying – factors and implications for practitioners

Laws and policies are in place in many countries allowing practitioners not to participate in assisted dying, to protect their wellbeing, in recognition of the moral distress experienced when compelled to act against their values. However, there may be many reasons why a practitioner chooses not to participate in assisted dying, unrelated to moral objection, such as a lack of resources or time. Nonetheless, protection from obligations to participate covers a range of tasks in the assisted dying pathway – for example, initial engagement in the process, supporting patient decision making, assessments and initiating administration procedures – and practitioners can refuse to take part at any of these stages in the pathway.[84] However, not all clinicians are aware of their rights, especially those without clear roles in assisted dying legislation, such as social workers, where legal grounds and training routes are less clear.[126]

Multiple factors influence clinicians' willingness to participate – it does not represent a binary choice. For example:

- Health care providers struggle when personal morals or religious beliefs are misaligned with assisted dying[151] or when navigating dual professional and personal roles in rural communities.[159,27]

- Participation becomes more difficult when clinicians feel that health care services such as palliative care or mental health care are not available and accessible.[81]

- Communication barriers also present challenges, particularly when patients' verbal communication is impaired, preventing the two-way conversation that many clinicians consider essential for informed decision making.[123]

- The strength and duration of professional–patient relationships significantly influence willingness, with clinicians feeling more comfortable when they have good relationships with patients and families, while requests 'out of the blue' or those coordinated through centralised services without prior patient knowledge can be particularly challenging.[84,129]

- Some clinicians in Canada were unwilling to provide assisted dying when it became legal for people without a foreseeable natural death, experiencing moral distress in trying to balance patient autonomy with what they felt was in the patient's best interests.[161]

Individual attitudes demonstrate capacity for change, with about a quarter of Austrian nurses reporting attitude changes during the first year after assisted dying was legalised there, with shifts occurring in both directions.[153] Learning one's moral positioning often evolves over time – with experience and within collegial communities of practice.[84] Time and education have allowed trust to be built when safeguards were implemented that respected everyone's beliefs.[159] However, as eligibility criteria expand over time, clinicians report the need for continual reassessment of their moral positions, with some advocates worrying that accessibility may become increasingly difficult as more practitioners struggle with expanded parameters in jurisdictions such as Canada.[84]

Institutional objection

Health care organisations have adopted varying positions towards assisted dying. Evidence from Australia indicates that while some faith-based institutions allow full participation, others restrict access.[59] And some organisations have evolved towards more supportive positions over time.[139] Jurisdictions face challenges with limited providers willing or able to deliver assisted dying services, creating potential access barriers, particularly in rural areas.[28]

Systems vary significantly in how they address institutional objection – some lack specific provisions while others have developed prescriptive approaches.[50] Belgian law prohibits institutions from preventing doctors from providing assisted dying on site,[139] while Canadian studies note that objecting institutions may still need to provide effective referrals and abide by non-abandonment principles.[149] Studies suggest that opposition can soften over time through advocacy by employed health care practitioners and family members, policy-making by local health authorities, education and relationship building.[85]

Impacts of individual and institutional objection

When individual practitioners or institutions refuse participation in assisted dying, significant challenges arise for patients (see Table 10). It may limit or disrupt their care, require them to move to a different provider or travel a significant distance, and ultimately may block access to assisted dying.

Table 10: Challenges associated with institutional objection

Themes	Examples from the literature
Forced transfers of patients	• Patients have been transferred to various locations – including other health care institutions, cafes, public parks, funeral homes or their own home to receive assessments or the assisted dying procedure itself.[85] • These transfers can be particularly burdensome for patients with limited mobility or severe symptoms. • Semi-structured interviews with assisted dying assessors and providers in Canada highlighted that forced transfers could be physically painful for those in very poor health, but also sometimes resulted in feelings of stigma and shame that they were doing something wrong by wanting an assisted death.[85]
Disruptions to ongoing care	• Forced transfers of care can disrupt other types of ongoing care.[59]
Constrained choice of care provider	• Some hospice providers explicitly inform patients during admission interviews that if they are considering assisted dying, they will not be allowed to enter.[85] This forces patients to choose between accessing palliative care in a hospice setting and pursuing assisted dying, creating a dichotomy between these two end of life options.[91] • Alternatively, a lack of transparency about institutional positions complicates informed choice.[85]
Blocked access to assisted dying	• In some cases, institutional objection completely blocks patient access to assisted dying. The persistence required to obtain an assessment or even have a conversation about assisted dying in objecting institutions (particularly Catholic ones) can be overwhelming for patients who are already dealing with serious illness.[85] • Many patients find it too difficult to pursue assisted dying in the context of institutional objection, and abandon their attempts.
Requirements to travel	• If the only institution in a remote or rural region objects to assisted dying, patients may need to travel long distances to access services.[57,74] • The use of telehealth has been identified as a potential solution, but legal restrictions on using telehealth for assisted dying in some jurisdictions significantly impede access, particularly for rural communities.[131]
Stigmatisation and emotional distress	• Patients seeking assisted dying report feeling judged or marginalised for their end of life choices, adding additional psychological burden during an already difficult time.[85]

This section of the report has offered insights into how assisted dying implementation involves diverse health care practitioners working primarily in multidisciplinary teams, with GPs typically forming the largest professional group. While practitioners have profession-specific responsibilities, all share overarching obligations around ethics, communication, documentation and legal compliance. Practitioner experiences are mixed – most find the work rewarding but face administrative burdens and require adequate support systems. Conscientious objection rights protect individual practitioners but can create access barriers, with multiple evolving factors influencing their willingness to participate, including personal values, relationships and system supports. Both individual and institutional positions can change over time, although institutional objection creates significant challenges for patient access, particularly in rural areas and faith-based institutions.

5 Implications and recommendations for the UK

Our study draws on policy documents, monitoring reports and research literature from 15 jurisdictions in 9 countries where assisted dying has been implemented. Throughout the report we have summarised key findings from international experience.

Our neutral position on the ethical question of assisted dying does not preclude us from offering a view on how to implement and integrate assisted dying with existing health and social care services if the legislation does pass. If assisted dying is to be made available in practice, understanding the implementation challenges and planning accordingly will be crucial.

In this section we discuss the implications of international learning and recommendations for policy in the UK, in the context of Bills currently being considered by the UK and Scottish Parliaments which would legalise this procedure under particular conditions. We draw on the international evidence and our wider knowledge of UK health care systems.

Regulation and infrastructure for assisted dying

Regardless of differences in implementation and legal frameworks being applied, most countries have established new infrastructure and services to support assisted dying. Services and systems needed range from establishing new regulation and oversight functions, administrative and data collection systems, through to staff training and public education services, and new pharmacy functions for the safe handling of medications used in assisted dying. Establishing these new systems and processes takes careful planning and design, and they need sufficient resources to develop and maintain.

Across the health systems we looked at, capacity to deliver assisted dying services was sometimes insufficient, with not enough staff trained and willing to support assisted dying services, or insufficient capacity to undertake eligibility and other assessments needed to support the process. Capacity planning needs to take account of more than just the number of people who may receive an assisted death. In some Australian jurisdictions, the number of requests for an assisted death was around double the number of deaths which were ultimately assisted. Staff are required to manage requests regardless of the outcome. Capacity requirements also extend beyond the initial service set up phase: numbers of assisted deaths have increased over time, and services have needed to adapt to respond to challenges which have arisen and to address gaps in services.

The Assisted Dying for Terminally Ill Adults Bill in Scotland currently does not set out mechanisms to oversee or review individual cases. There will be important decisions about whether Scotland does want these mechanisms, which are common elsewhere, and if so who defines and specifies them – whether MSPs, the Scottish Government, or a particular consultative process.

Experience from other countries shows how difficult it can be to decide what should be set out in law, what should be covered by regulation, and what can be left to policy or guidance. Specifying details in law can improve consistency but also result in over-prescription of operational aspects which may need to evolve over time. Examples include the requirement in New Zealand to specify the date of administration and method after a person has been found eligible.

The balance between national standardisation and local adaptation extends beyond legal and regulatory requirements: for example, different approaches have been taken to training curricula and requirements, how standardised these are, and whether there are any mandatory requirements.

In countries with more devolved or regional implementation (such as Spain and Canada), processes and systems have had to be established to ensure consistency across jurisdictions, spread best practice and key learning, and ensure standardisation of how laws are interpreted and applied. This is important for UK policymakers to consider depending on how assisted dying may be legalised or implemented – with its legal status potentially varying across the different countries of the UK. If legalised, there are also important considerations to be made about how much local variability or flexibility there might be in the assisted dying pathway, and what processes or approaches must be standardised.

Recommendations

- Policymakers in the UK should anticipate that if assisted dying is legalised, there will need to be a range of new infrastructure and services required, covering activities such as regulation, training, data management and funding systems.
- Policymakers need to take account of capacity for regulation and oversight functions on an ongoing basis, to allow for increasing numbers of people requesting assisted dying over time, and changes to requirements.
- Policymakers need to consider what should be specified in law or regulations, and what can be managed within policy and guidance, for example, in relation to training and staffing requirements, and steps in the process.

Funding and supporting change

The financial challenge of meeting demand for health care is not unique to the UK, but it is important to recognise that there is limited funding available for implementing a new service such as assisted dying. Estimates of funding within the government's impact assessment[170] for the TIA bill in England and Wales are limited to direct costs (for example for staff directly involved) – but international evidence demonstrates that wider costs need to be considered, including to develop the infrastructure to support implementation of assisted dying services. The financial memorandum supporting the Scottish Bill reflects some wider costs, such as for an annual report, but not for any oversight process, which is currently not spelt out in the Bill.

Depending on implementation decisions, costs may appear more cost-neutral in financial terms if no new staff are recruited to manage implementation, but it could still come with significant time and capacity costs as changes require coordination, oversight, and attention from people already managing competing priorities. In practice, this means there will have to be trade-offs: time spent on implementation in one area may come at the expense of progress elsewhere. No decisions have yet been made about funding mechanisms and reimbursement for assisted dying: addressing funding requirements will need to be an urgent priority if it becomes legal in the UK.

The system's capacity for transformation and service change is likely limited – let alone for something of this scale. And delivering this would have opportunity cost for other change too. In England, Integrated Care Boards, which might be expected to have a role at a local level, are to have a 50% headcount reduction. NHS England is undergoing a major restructure to become part of the Department of Health and Social Care, and Health Education England, which might be expected to lead on training requirements for assisted dying, has only recently been absorbed within NHS England. To add to this, the NHS in England is just embarking on a 10-year plan which includes an extensive list of new developments to deliver.[171] Finding both the funding and organisational capacity to implement assisted dying will be extremely challenging in these circumstances. Wales is also going through a change process following recommendations from its Ministerial Advisory Group.

The financial implications for provider organisations, including impacts on both funding and staffing, need to be fully understood. Specialist palliative care is not comprehensively funded in the UK, and assessment of the impact on non-NHS organisations needs to consider both direct costs related to providing assisted dying but also resources required to train and support staff, even if they are not directly involved. In the UK, palliative care is reliant on a patchwork of provision from organisations like hospices and social care providers, whose funding comes from voluntary, private and public sector sources. The willingness of providers to engage with assisted dying – by providing services or training staff – could present particular challenges, especially for faith-based and third-sector independent hospices and social care organisations.

In terms of professional groups, in many jurisdictions GPs and pharmacists are directly involved in delivering assisted dying. In the UK, general practice and pharmacy are largely funded through national contracts with practitioners, and these contracts may also need to be reviewed to take account of reimbursement for assisted dying. General practice is already facing a shortage of GPs and particular areas of the country are especially poorly served. This needs to be factored in if GPs take on additional responsibilities for assisted dying – or become involved either by virtue of being a gatekeeper to other services, or having a pre-existing relationship with the individual.

Recommendations

The government's impact assessment estimates direct costs and savings, but if assisted dying is passed, UK governments will need to establish new funding mechanisms, and consider wider costs.

- Policymakers will need sufficient funding to implement assisted dying, including regulation and data collection (see below), planning for training, redesigning services and developing new services.

- Careful preparation is essential before assisted dying laws become operational, and there must be a significant lead-in time after key policies are decided upon.

- Oversight functions need sustained funding. Experience from other countries shows that the Voluntary Assisted Dying Commissioner is a substantial and important role, and the Commissioner will require a secretariat, data and expertise which will require funding. Review panels will also need funding, as will any oversight mechanisms in Scotland.

- Policymakers will need to establish a system to pay providers to deliver assisted dying. This will need to be carefully designed where charities providing hospice care may be delivering other end of life care services for free. Expecting free provision would have a negative effect on their finances, but the government will want to ensure that there are not disproportionate rewards for providing assisted dying. Funding also needs to address the costs of training staff (whether these are employed in the NHS or elsewhere).

- Policymakers will need to consider the implications for contracts for GPs and pharmacists who can be expected to play a large role in assisted dying. They are typically reimbursed through national contracts in Wales, England and Scotland. Either these will require amendment, or particular contracts for assisted dying as an additional service will be needed.

Workforce issues

The assisted dying pathway intersects with end of life care delivery, and staff involved in end of life care are often those most likely to be delivering assisted dying services, with general practitioners most often directly involved. It could be one of any number of practitioners an individual talks to about their wishes and they all need to be equipped to at least start the conversation appropriately.

Willingness of individual clinicians to engage is not a binary issue, and depends on the circumstances. However, where data is available on numbers of staff involved it indicates that a relatively small number of clinicians are directly involved in delivering assisted dying: in Victoria, just 10 doctors co-ordinated or consulted on 55% of all cases. Training and support for staff is critical to ensure engagement, and greater familiarity with assisted dying has been found to increase willingness to participate in services. Clinicians may be more likely to engage in assisted dying if they have a pre-existing clinical relationship with the individual, but in practice this is often not feasible.

A frequent finding from other jurisdictions is that training requirements, guidance and regulation are often limited to professional groups with roles specified in legislation. Guidance and training for nursing staff, who have key roles in delivering end of life care, and pharmacists, who have a key role in assisted dying, is often not developed from the start. Social care providers and staff play a significant role in providing end of life care, but are largely missing from legislation, guidance, and research evidence. Staff report gaining experience over time and valuing colleague and mentor support – professional support networks can facilitate this learning.

Existing workforce pressures, while not unique to the NHS, present significant challenges for implementation. The impact on staffing extends beyond clinicians directly involved in assisted dying provision, as effective implementation requires team-based approaches rather than relying solely on individual practitioners. Implementation decisions have resulted in complex and time-consuming processes (often developed to ensure safeguards are in place).

Drawing on international experiences, several support strategies could help mitigate workforce challenges. In Canada, national reviews of assisted dying have suggested that assessors and providers should receive training in capacity assessment, trauma-informed care, and cultural safety – as biases related to ethnicity, race, gender, disability, and religion can compromise care quality and create structural barriers. Considering diversity is particularly important in the UK (and especially England), where health and social care staff represent diverse religious beliefs and cultural backgrounds from around the world, which will impact on willingness to be involved in assisted dying. This is an additional dimension to the already diverse views of assisted dying found across clinical groups in the UK. In other countries, communities of practice and networks exist to share learning and experiences and offer peer support, as well as develop pools of experts who can offer ongoing training and expertise, as well as creating a roster of practitioners trained and willing to provide assisted dying and who can provide independent assessments.

Experience from other jurisdictions suggests that the pathway for assisted dying must enable clinicians to step away from particular cases that cause them moral distress, otherwise they become reluctant to be involved in assisted dying at all. A balance needs to be achieved between individuals' rights to have an assisted death, and the rights of staff to not participate in assisted dying services if they object, either in general or in specific cases.

Recommendations

- Policymakers need to actively engage professional bodies during the implementation phase, alongside the provision of appropriate training and funding.

- Plans for training, awareness and providing support are needed for a wide range of staff, not just those directly involved in delivering assisted dying. Policymakers need to plan from the start to provide training and support for nurses, pharmacists and social care staff, not just doctors.

- Policymakers should consider how to support staff to become and stay involved in delivering assisted dying. Peer support networks have proven valuable to develop capacity for assisted dying in a number of countries.

- Policymakers should consider how to provide culturally appropriate support for staff, and consider strategies to engage with staff from across different communities and faith groups.

- Policymakers need to ensure that there is a clear and well-understood process for staff to decline involvement in assisted dying, including on a case-by-case basis, depending on individual and clinical circumstances.

Equity and access

Access to specialist palliative care in the UK is patchy, and in addition there are divergent experiences and expectations across different communities. People in more deprived areas are less likely to receive end of life care services at home, and minority ethnic groups are less likely to receive hospice care. The diverse nature of the UK population will necessitate a culturally sensitive approach that is more complex than in some other jurisdictions. This diversity may require localised implementation strategies to ensure equitable access and culturally appropriate care delivery.

Additional considerations include residency requirements and the management of care for individuals receiving health care treatment across UK boundaries, which could complicate eligibility and service provision. For example, patients commonly cross UK boundaries for specialist NHS treatment and services, and so information about eligibility for assisted dying may be required outside of the jurisdiction in which assisted dying is being requested. Assessing where a patient is resident will also add additional burden on clinicians.

Experience from family carers and people bereaved following an assisted death identifies additional burden on family carers to help individuals navigate the assisted dying process, especially in systems where the lethal drug is self-administered. Unmet needs for support in bereavement have also been identified in other countries. The existing lack of coordination in end of life care services already presents significant challenges for patients and their carers in the UK.

Recommendations

- Policymakers need to recognise the support needs of families and how these will be addressed. Experience in other countries suggests navigating complex processes and services can be a problem for staff and patients at a difficult time. This is already a significant problem in end of life care in the UK, and should be addressed as a priority as assisted dying is introduced.

- Given cultural diversity across the UK, implementation of assisted dying may require local strategies or assessments at ICB or health board level to reflect different population needs, and strategies required to support equitable access to assisted dying services.

- Policymakers should consider strategies used in other countries to manage workload and improve access, such as establishing dedicated care navigator roles to provide information on assisted dying and how to access the service, connect people with eligible clinicians, and offer support to families, carers, and health professionals. There is evidence that these improve access and understanding, and the UK government should consider creating a similar service.

- Managing residency requirements and differences in implementation of assisted dying across the UK will require additional consideration.

Data, monitoring and addressing evidence gaps

Effective monitoring and evaluation will be essential if assisted dying becomes law in the UK, to ensure safe, equitable and accountable service delivery. Three distinct areas will require particular attention: the collection of data and evidence at a system level; the provision of research to fill gaps in understanding around individuals' experiences of and participation in assisted dying; and evidence to inform a better understanding of particular issues to do with workforce and staffing.

These are explored more in turn below, with recommendations covering all three areas. The issues identified here are not an exhaustive list, and do not include topics which were not included within the scope of our research, for example, efficacy of drugs used in assisted dying.

Data collection

The evidence we have reviewed does not offer a clear way forward as to whether assisted dying data collection should be separate from or incorporated with routine statistical data collection and medical records. Routine reporting remains inconsistent across systems.

More generally, while several jurisdictions review whether individual cases are compliant with the law, countries vary in the extent to which policymakers are able to assess the overall impact of legislation. This extends to evidence on resource implications at a system or provider level: mechanisms to track costs of implementation and service delivery will provide valuable learning.

Individual and care pathway evidence gaps

Our international analysis also revealed notable gaps in the evidence concerning individual experiences and care pathways. The contemplation of assisted dying often begins long before individuals make formal requests, yet little research exists on this preliminary phase and its implications for care provision and support. In addition, the specific care and support needs of people who are assessed as ineligible for assisted dying have received minimal direct research and attention despite some studies – including those from New Zealand – highlighting gaps in support for this group. More broadly, there is limited evidence around the experiences of people who receive assisted dying services. Some systems, such as New Zealand, have directly engaged people with lived experiences in reviewing assisted dying services.

Workforce evidence gaps

Research on training effectiveness is limited, although some evidence suggests associations between training participation and improved understanding of the law, confidence in application, and willingness to participate in assisted dying services.

As highlighted above, we were unable to find research evidence about the social care workforce in relation to assisted dying, whether in legislation, guidance or research literature. Limited knowledge exists about volunteers across different systems, and little is known about how staff groups not covered in legislation exercise conscientious objection, or the experiences of those who choose not to act as providers of assisted dying.

Recommendations

Effective use of digital infrastructure will be essential for delivering assisted dying and monitoring the impact of the policy.

- Policymakers need to underpin new processes for assisted dying with digital infrastructure, to streamline administrative processes and improve data collection.
- Given the diversity of UK countries, and known inequalities in end of life care, assisted dying implementation should be carefully monitored by ethnic group, sex, region and other characteristics, to support improvements to address inequity.
- Policymakers in different UK jurisdictions need to ensure that data collection is comparable between jurisdictions, and that information relevant to individual cases can be accessed across country boundaries to support end of life care and assisted dying which may be delivered by different authorities.
- Data collection needs to enable resource implications at a system or provider level to be tracked, to support understanding of costs of implementation and future needs for funding, given anticipated increase in demand as the service becomes better understood.
- It will be critical for the UK to ensure that people directly impacted – including those going through the process, family, and people who were ineligible – are involved in any implementation in the UK.
- A research programme will need to be established to address evidence gaps which are important to UK stakeholders, drawing further on international experience, as well as learning from implementation in the UK.

Concluding remarks

The ongoing progress of legislation in the Westminster and Scottish parliaments demonstrates that assisted dying remains a contested issue. There will need to be continued engagement with supporters and opposers, and with a wide range of stakeholders, regardless of the outcome of current legislative processes.

The international evidence provides valuable lessons, but the UK's distinctive context requires tailored approaches that account for its diverse population, complex health care arrangements, and unique organisational structures. Successful implementation would require comprehensive planning, adequate resources, and ongoing evaluation to address the challenges and opportunities identified in this analysis.

The parliamentary debate on assisted dying in the UK highlighted the balance being sought between safeguards to prevent misuse of assisted dying legislation, such as banning advertising of assisted dying, and raising awareness of services to enable eligible people seeking an assisted death to achieve this. There is also a tension between establishing processes and procedures that are scrupulous enough to avoid harm, without preventing eligible people from timely access to assisted dying. This is a common challenge in other countries, and a reason why eligibility criteria and systems to support assisted dying have evolved over time, for example, eliminating waiting period requirements within the assisted dying pathway.

Moving forward, it is essential to balance individual needs, clinician perspectives, and wider health care system priorities. UK countries must determine what outcomes they wish to achieve through any assisted dying framework and establish appropriate measures for evaluation. The evidence gaps identified in this review highlight the need for continued research and monitoring to ensure that any implementation is evidence-based, equitable, and responsive to the needs of diverse populations.

Appendix: Reported data on assisted dying across the jurisdictions studied

Jurisdiction	Numbers requesting/accessing an assisted death				Demographic characteristics					Health and care				Nature of the assisted death				Nature of the assisted death		
														Place of death						
	Number of people requesting an assisted death	Number of assisted deaths	Assisted deaths as a percentage of all deaths	Assisted deaths as a percentage of people requesting an assisted death	Median age	Percentage female	Ethnic group	Education level	Percentage reporting a disability	Underlying diagnosis: percentage with cancer	Prognosis: percentage with a terminal diagnosis/ reasonably foreseeable death	Percentage receiving palliative care	Reasons for requesting an assisted death	Percentage at home (assisted deaths)	Percentage at home (all deaths)	Model of assisted deaths: clinician-administered, self-administered or both	Percentage of assisted deaths self-administered	Key reporting details	Do demographic characteristics relate to those who apply for an assisted death or those who receive an assisted death, or a mixture?	Links to source data
Belgium	Not reported	3,423	3.08	Cannot be calculated as number of people requesting an assisted death not reported.	Age distribution rather than median age reported – 71% of people (2,420) were aged 70+	51.5	Not reported	Not reported	Not reported	55.5	79.2	Not reported	Belgium has some information (see page XX of report) but it is not totally clear.	48.6	24	Clinician-assisted.	NA	Report covers a 2-year period, but figures reflect the 2023 calendar year. Belgium reports 'expected time of death', reflecting if death is or is not likely to be in the foreseeable future (terminal or non-terminal). Belgium does not report if people are in receipt of palliative care, but does report if the assisted death took place in the Hospital Palliative Service – this happened for 6.1% of people (209) in 2023. Data on 'Place of death: percentage at home (all deaths)' is from 2022.	Demographic data reflect people who received an assisted death.	fccee_pressrelease20250122-report_for_2022-2023.pdf https://statbel.fgov.be/en/open-data/number-deaths-month-place-death
Switzerland	Not reported	1,729	2.41	Cannot be calculated as number of people requesting an assisted death not reported.	80	59.9	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Self-administered.	NA	Data reflects calendar year 2023. Switzerland report limited data regarding assisted deaths.	Demographic data reflects people who received an assisted death.	www.dignitas.ch/images/stories/pdf/statistik-suizid-ftb-bevoelkerung-lebenserwartung-ch-e.pdf www.bfs.admin.ch/bfs/en/home/news/whats-new.gnpdetail.2024-0101.html
Netherlands	Not reported	9,068	5.35	Cannot be calculated as number of people requesting an assisted death not reported.	Age distribution rather than median age reported – 62% of people (5,582) were aged 70–90.	49.2	Not reported	Not reported	Not reported	56.3	Not reported	Not reported	Case study examples include descriptive information about the reason for requesting an assisted death.	78.9	Not reported	Both	2.3	Data reflect calendar year 2023.	Demographic data reflect people who received an assisted death.	https://english.euthanasiecommissie.nl/documents/annual-reports/2002/annual-reports/annual-reports www.cbs.nl/en-gb/news/2024/06/fewer-deaths-in-2023
Canada	Unique number of people not reported, but total number of requests for an assisted death is reported (which may include repeat applications) – 19,660 requests in 2023.	15,343	4.7	Cannot be calculated as number of people requesting an assisted death not reported.	78	48.8	95.8% white	Not reported	67% (10,581) provided information regarding disability – of those, 34% (3,633) self-reported a disability.	64.1	95.9	75	Reports the sources of suffering related to a person's medical condition – loss of ability to engage in meaningful activities was most commonly reported (95.5%).	37.8	Canada reports overall place of death as 'hospital', 'non-hospital' or 'unknown' – 43.3% of all deaths were 'non-hospital' in 2023.	Both	Fewer than five instances.	Data reflect calendar year 2023. Canada reports if assisted deaths are Track 1 (death is 'reasonably foreseeable') or Track 2 (death is not 'reasonably foreseeable'). Terminal deaths therefore reflect Track 1. 95.9% of deaths were Track 1 in 2023. Reports the racial, ethnic or cultural identity of recipients of an assisted death – 63% (9,619) provided information.	Demographic data reflect people who received an assisted death.	Fifth Annual Report on Medical Assistance in Dying in Canada, 2023 – Canada.ca www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071501

Jurisdiction		Numbers requesting/accessing an assisted death				Demographic characteristics					Health and care				Nature of the assisted death				Nature of the assisted death		
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		Number of people requesting an assisted death	Number of assisted deaths	Assisted deaths as a percentage of all deaths	Assisted deaths as a percentage of people requesting an assisted death	Median age	Percentage female	Ethnic group	Education level	Percentage reporting a disability	Underlying diagnosis: percentage with cancer	Prognosis: percentage with a terminal diagnosis/ reasonably foreseeable death	Percentage receiving palliative care	Reasons for requesting an assisted death	Percentage at home (assisted deaths)	Percentage at home (all deaths)	Model of assisted deaths: clinician-administered, self-administered or both	Percentage of assisted deaths self-administered	Key reporting details	Do demographic characteristics relate to those who apply for an assisted death or those who receive an assisted death, or a mixture?	Links to source data
New Zealand		Unique number of people not reported, but total number of requests for an assisted death is reported (which may include repeat applications) – 1,015 requests in 2023.	396	0.9	Cannot be calculated as number of people requesting an assisted death not reported.	Age distribution rather than median age reported – 79.2% of applicants were aged 65+.	48.5	82.3% of new applicants were NZ European/Pākehā.	Not reported	11.8	67.4	NA – terminal diagnosis is a requirement	75.3	Not reported	81.1	Not reported	Both.	Not reported	Reporting period is 7 November 2022 to 31 December 2023. 'Gender diverse' is a reporting option.	Demographic data reflect applicants for an assisted death. Report notes that repeat applications are included as unique instances.	Assisted Dying Service Yearly Report – November 2022 to December 2023 – Health New Zealand | Te Whatu Ora
Australia	Victoria	758	371	0.82	48.9	73	45	Not reported	Highest level of education not reported for 212 people (28%).	Not reported	80	NA – terminal diagnosis is a requirement	75	Not reported	Not reported	Not reported	Both, but clinician administration is only available if the person is physically incapable of self-administration.	81.1	Reporting period is 1 July 2023 to 30 June 2024. In Victoria, the applicant must be diagnosed with a disease, illness or medical condition that will cause death within 6 months (or 12 months for a neurodegenerative condition).	Demographic data reflect applicants for an assisted death.	Voluntary Assisted Dying Review Board Annual Report 2023–24 www.health.govt.nz/publications/registrar-assisted-dying-annual-report-june-2023
	Western Australia	759	292	1.63	38.5	75	42.7	Reports the number of first assessments where applicant is of Aboriginal and Torres Strait Islander origin – of the 593 first assessments, 589 responded 'no'.	Patients most commonly reported high school as their highest level of education (41.9%, n=220).	Not reported	71.4	NA – terminal diagnosis is a requirement	83.8	Reports reason for accessing assisted dying services – being less able to engage in activities making life enjoyable was the most commonly reported (65.3%) followed by losing autonomy (64.6%).	49.5	Not reported	Both.	5.1	Reporting period is 1 July 2023 to 30 June 2024. In Western Australia, the applicant must have been diagnosed with at least 1 disease, illness or medical condition that is advanced, progressive and will cause death within a period of 6 months (or 12 months for a neurodegenerative condition).	Demographics reflect eligible patients requesting access to assisted dying services.	Voluntary Assisted Dying Board Annual Report
	Queensland	1,560	793	2.07	50.8	74	42.5	Not reported	Highest level of education is not a mandatory reporting field and was recorded for 59% of people.	Not reported	75.5	NA – terminal diagnosis is a requirement	75.6	Not reported	Not reported	Not reported	Both.	32.9	Reporting period is 1 July 2023 to 30 June 2024. In Queensland, eligibility requires that the disease must be advanced, progressive and will cause death, expected within 12 months.	Demographics reflect patients who requested access to assisted dying services and received a first assessment.	2023–2024 Annual Report by the Voluntary Assisted Dying Review Board | Queensland Health

	Jurisdiction	Numbers requesting/accessing an assisted death				Demographic characteristics					Health and care				Nature of the assisted death				Nature of the assisted death		
															Place of death						
		Number of people requesting an assisted death	Number of assisted deaths	Assisted deaths as a percentage of all deaths	Assisted deaths as a percentage of people requesting an assisted death	Median age	Percentage female	Ethnic group	Education level	Percentage reporting a disability	Underlying diagnosis: percentage with cancer	Prognosis: percentage with a terminal diagnosis/ reasonably foreseeable death	Percentage receiving palliative care	Reasons for requesting an assisted death	Percentage at home (assisted deaths)	Percentage at home (all deaths)	Model of assisted deaths: clinician-administered, self-administered or both	Percentage of assisted deaths self-administered	Key reporting details	Do demographic characteristics relate to those who apply for an assisted death or those who receive an assisted death, or a mixture?	Links to source data
USA	Washington	Unique number of people not reported, but number of 'written request for medication to end my life' forms completed is reported – 510 in 2023.	427	0.65	Cannot be calculated as number of people requesting an assisted death not reported.	76	48	95% white	74% had at least some level of college education.	Not reported	70	NA – terminal diagnosis is a requirement.	86	Reports the end of life concerns of people whose death was assisted – being less able to engage in activities making life enjoyable and loss of autonomy were the most commonly reported.	88	37.4	Self-administered	NA	Data reflect calendar year 2023.	Demographic data reflect information from death certificates for people where assisted dying medication was dispensed (not all went on to die from ingesting the medication).	Death With Dignity Act Report 2023, DOH 422–109 https://wonder.cdc.gov
	Oregon	Not reported	367	0.86	Cannot be calculated as number of people requesting an assisted death not reported.	75	43.6	93.5% white	72% had at least some level of college education.	Not reported	65.9	NA – terminal diagnosis is a requirement.	86.6 enrolled in hospice care	Reports the end of life concerns of people whose death was assisted – loss of autonomy and being less able to engage in activities making life enjoyable were the most commonly reported.	87.7	42.2	Self-administered	NA	Data reflect calendar year 2023.	Demographic data reflect people who received an assisted death.	Oregon Death with Dignity Act: 2023 Data Summary https://wonder.cdc.gov
	California	1,272	884	0.3	69.5	78	49.9	85.4% white	77% had at least some level of college education.	Not reported	63.8	NA – terminal diagnosis is a requirement.	93.8	Not reported	87.8	38.7	Self-administered	NA	Data reflect calendar year 2023.	Demographic data reflect people who received an assisted death.	California End of Life Option Act Report 2022 Data Report https://wonder.cdc.gov
	New Jersey	Not reported	101	0.13	Cannot be calculated as number of people requesting an assisted death not reported.	69	57	95% white	71% had at least some level of college education.	Not reported	61	NA – terminal diagnosis is a requirement.	Not reported	Not reported	83	31.7	Self-administered	NA	Data reflect calendar year 2023.	Demographic data reflect people who received an assisted death.	NJMAiD-2023AnnualReport.pdf https://wonder.cdc.gov
	Colorado	Number of people requesting an assisted death not reported but 389 patients received prescriptions for medication.	Not reported	Cannot be calculated as number of assisted deaths not reported.	Cannot be calculated as number of assisted deaths not reported.	75	52.6	92.8 white, non-Hispanic	76% had at least some form of college education.	Not reported	55.3	NA – terminal diagnosis is a requirement.	83.2	Not reported	77.8	36.8	Self-administered	NA	Data reflect calendar year 2023. The Colorado End-of-Life Options Act 2016 does not require follow-up about the use of aid-in-dying medication that is prescribed and therefore the number of assisted deaths cannot be confirmed.	Demographic data reflect information from death certificates for people where assisted dying medication was dispensed (not all went on to die from ingesting the medication).	Colorado End of Life Options Act, 2023 data summary with 2017–2023 Trends and Totals.pdf – Google Drive https://wonder.cdc.gov

Notes:

Data reflect calendar year 2023 or the closest reporting period.

Data for Austria are not included as at the time of publication there was no routinely reported data source. Data for Spain are not included as data are not available for 2023.

Caution is needed when comparing assisted dying data by jurisdiction because of data-quality issues and differences in how key concepts are defined.

Data on 'Place of death: percentage at home (all deaths)' have been included for context alongside the proportion of assisted deaths that occur at home. The data year is highlighted in key reporting details.

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59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
www.nuffieldtrust.org.uk
Email: info@nuffieldtrust.org.uk

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