A TERMINAL TUSSLE: ASSISTED DYING ON THE PRECIPICE OF LEGALISATION FOR ENGLAND AND WALES BUT WILL THIS BRING SAFEGUARDING OVERREACH?

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The issue of assisted dying in the United Kingdom ('UK') has been a consistent feature of legal and political discourse for several decades. A series of court decisions in which it was decided that neither UK common law nor the Human Rights Act 1998 (UK) supported a change to the ban on assisted suicide in the criminal law stymied the introduction of voluntary assisted dying laws. While 2009 saw the UK Director of Public Prosecutions introduce a set of guidelines designed to inform the prosecution of assisted suicide, the argument for legal change to the substantive law has persisted. This has taken the form of private members' bills which have to date failed or lapsed at various stages of parliamentary consideration. In 2025, however, the Terminally Ill Adults (End of Life) Bill 2024 has passed both stages of the Commons and is on the precipice of being debated in the House of Lords. This short commentary assesses the key provisions of this proposed legislation, comparing it to the Western Australian Voluntary Assisted Dying legislation. It identifies key provisions in both pieces of legislation and questions whether the safeguards underlying the Bill[1] *will ultimately provide an obstacle for those seeking access to the statutory scheme.*

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[1] Labour MP Kim Leadbeater, who introduced the Bill into the House of Commons on 11 November 2024, has stated that '[t]his bill already contains the strongest safeguards anywhere in the world, but I promised to give close attention to the advice we have received on how the bill could be made even stronger, and that is what I have done': Harry Farley, 'Replacing judge with experts', *BBC News* (online, 11 February 2025) <https://www.bbc.com/news/articles/c2egl17pvldo>.

I INTRODUCTION

On 20 June 2025 the United Kingdom ('UK') House of Commons passed the Terminally Ill Adults (End of Life) Bill ('TIAB') by a margin of 23 votes (314–291).[2] The securing of the approval of the House of Lords remains the only hurdle to this assisted dying ('AD') legislation becoming law in England and Wales. The passage of the TIAB marks a turning point in the long history of the UK wrestling with the issue of AD.[3] Although a form of AD is found in many Western democracies,[4] there has been a stubborn resistance to legalising this in the UK despite the many efforts of advocates and politicians. This article will firstly plot out a short history of these efforts, focusing on the judicial aspect given the insights which these give to the relevant legal frameworks. It will then assess key aspects of the TIAB, comparing these to provisions in the *Voluntary Assisted Dying Act 2019* (WA) ('*WAVADA*'). The reason for the choice of this comparator lies in the *WAVADA* being

[2] 'UK parliament votes for assisted dying, paving way for historic law change', *ABC News* (online, 21 June 2025) <https://www.abc.net.au/news/2025-06-21/uk-parliament-votes-for-assisted-dying/ 105445246>.

[3] The term 'assisted dying' ('AD') will be used in this commentary to refer to all situations in which a person is voluntarily helped to die by administration of a lethal substance, whether self or other administered. The term euthanasia is deliberately avoided given its lack of consistent understanding and its emotional connotations, evident in the decision in *Airedale NHS Trust v Bland* [1993] AC 789 (HL) ('*Bland*') in which the English courts drew a sharp, if spurious distinction, between withdrawing life-sustaining treatment and the ending of life by a lethal injection: see Hoffmann LJ at 831.

[4] *Medical Assistance in Dying Act*, RSC 2016 c 7; *Death with Dignity Act,* ORS 2023, 800–995; *Death with Dignity Act of 2016*, DC Law 21-182; *Termination of Life on Request and Assisted Suicide (Reviews Procedures Act)* (the Netherlands); *End of Life Choice Act 2019* (NZ). AD legislation has now been passed in all Australian states and the Australian Capital Territory ('ACT'): *Voluntary Assisted Dying Act 2017* (Vic); *Voluntary Assisted Dying Act 2019* (WA); *Voluntary Assisted Dying Act* 2021 (Qld); *Voluntary Assisted Dying Act 2022* (NSW); *Voluntary Assisted Dying Act 2021* (SA); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas); *Voluntary Assisted Dying Act 2024* (ACT).

the second-longest regime in Australia, its proportionately high rates of uptake,[5] and the fact that access provisions have been considered by the State Administrative Tribunal ('SAT') on several occasions, providing the opportunity for the interpretation of its provisions.[6] It has been described in the Voluntary Assisted Dying Board Western Australia's 2023–2024 Annual Report as 'an established and enduring end of life choice'.[7] The comparison identifies key differences in the regulatory schemes, raising, it is argued, potential issues for accessing AD in England and Wales, should the TIAB be ultimately implemented in its current form.

II UK HISTORICAL BACKDROP

There has long been popular support for AD in the UK.[8] The National Centre for Social Research notes that a 2024 British Social Attitudes survey indicated that 79% of people expressed support for a doctor being able to end the life of a person with an incurable and painful terminal illness if the person requests it, similar to the result in 2016, when 78% expressed their support.[9] Leading up to the second reading of the TIAB, a number of opinion polls and surveys on public attitudes were published indicating that a majority of the population supported a change to the law to allow someone to help a person who is terminally ill to end their life if they have voluntarily requested it.[10]

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[5] Although note that AD was briefly legal in the Northern Territory — the *Rights of the Terminally Ill Act 1995* (NT) — before it was effectively annulled by the federal government in 1997. The Voluntary Assisted Dying Board Western Australia ('WA')'s Annual Report for 2023–2024 notes that deaths under the legislation account for 1.6% of the total deaths in WA: WA State Government, Department of Health, *Voluntary Assisted Dying Board Annual Report* (2023–24). While under the *Voluntary Assisted Dying Act 2021* (Qld) the 2023–2024 Annual Report reported that deaths under that scheme accounted for approximately 2% of deaths, it is suggested that this may be associated with the broader residential requirements under the legislation which contains a Queensland residency exemption.

[6] See the discussion in Aidan Ricciardo, 'Voluntary Assisted Dying and State Residence Requirements: A Western Australian Perspective' (2024) 51(2) *UWA Law Review* 146.

[7] WA State Government, Department of Health (n 5) Foreword.

[8] Note that this commentary does not purport to discuss developments on AD in Scotland and Northern Ireland which both have devolved Parliaments responsible for making laws on certain matters, notably health.

[9] 'Public support for assisted dying remains high and stable', *National Centre for Social Research* (Media Release, 18 March 2025) <https://natcen.ac.uk/news/public-support-assisted-dying-remains-high-and-stable#:~:text=Gillian%20Prior%2C%20Deputy%20Chief%20Executive, doctor%20%20for%20someone%20with%20an>. See also 'Two thirds of UK public continue to think assisted dying should be legal, provided certain conditions are met', *Ipsos* (Web Page, 14 October 2024) <https://www.ipsos.com/en-uk/two-thirds-uk-public-continue-think-assisted-dying-should-be-legal-provided-certain-conditions-are?_ >.

[10] See Sally Lipscombe et al, 'The Terminally Ill Adults (End of Life) Bill 2024-25' (Research Briefing, House of Commons Library, House of Commons, 22 November 2024) 32–3.

Despite evidence of this support, the numerous challenges to the existing illegality of AD have been unsuccessful to this point. The illegality is founded in the UK homicide laws, specifically murder and assisting suicide. In *Airedale NHS Trust v Bland* ('*Bland*'),[11] several members of the then House of Lords relied on the moral and legal difference between withdrawing or not administering life-sustaining or saving treatment and positively administering a lethal substance to hasten death. While these judges noted the artificiality of the deontological theory-based act/omission distinction,[12] they nonetheless identified the need for the law to draw a clear line as to legal and illegal conduct in this context.[13]

It is difficult to quantify the effect of *Bland* on the AD debate in England and Wales. Lord Goff's specific comment referencing 'the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia — actively causing his death to avoid or end his suffering'[14] has been often cited in the jurisprudence,[15] and is therefore perhaps an example of its effect. It can confidently be stated, however, that post *Bland*, the UK courts have consistently resisted endeavours to legalise AD through the judicial route.

The legal challenges have mostly centred on the *Suicide Act 1961* (UK) ('*Suicide Act*') which makes it an offence for a person to intentionally encourage or assist the suicide (or attempted suicide) of another.[16] The applicants in the three most significant cases considered by the UK courts asserted that this prohibition contravened the *Human Rights Act 1998* (UK) ('*HRA*') which incorporates the European Convention on Human Rights ('ECHR'), to which the UK is a signatory.[17] In the first of these cases, Dianne Pretty, a woman living with motor neurone disease, argued that the *Suicide Act* could potentially apply to someone who

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[11] *Bland* (n 3).
[12] Discussed in a wide range of articles: see, eg, Andrew McGee, 'Finding a Way Through the Ethical and Legal Maze: Withdrawal of Medical Treatment and Euthanasia' (2005) 13(3) *Medical Law Review* 357; John Keown, 'Medical Murder by Omission? The Law and Ethics of Withholding and Withdrawing Treatment and Tube Feeding' (2003) 3(5) *Clin Med (London)* 460.
[13] See *Bland* (n 3) 865, 885 and 887 (Lords Goff, Browne-Wilkinson and Mustill).
[14] *Bland* (n 3) cited in, eg, JM Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 *Law Quarterly Review* 329, 329.
[15] Colleen Davis, 'Merciful Acts and Cruel Omissions' (2013) 1(2) *Griffith Journal of Law and Human Dignity* 166, 166–89; John Keown, 'Restoring Moral and Intellectual Shape to the Law after Bland' in *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (online ed, Oxford Academic, 20 September 2012) ch 12 <https://doi.org/10.1093/acprof:oso/9780199589555.003.0012>; *Nicklinson & Ministry of Justice v DPP* [2012] EWHC 2381, [60] (Toulson LJ).
[16] *Suicide Act 1961* (UK) s 2(1).
[17] *Pretty v Director of Public Prosecutions and Secretary of State for the Home Department* [2002] 1 AC 800, [11] (Lord Bingham).

helped her to travel to Switzerland to access AD there, and was therefore in breach of several provisions of the ECHR.[18] The House of Lords rejected her claims that the *Suicide Act*, as it applied to a person living with a terminal illness resulting in profound suffering, was a violation of her right to respect for her private life (art 8 ECHR), her right to be free of inhumane treatment and torture (art 3 ECHR) and her right to equal treatment (art 14 ECHR).[19] Ms Pretty's appeal to the European Court of Human Rights ('ECtHR') was also unsuccessful,[20] with the ECtHR giving decisive weight to the margin of appreciation accorded to all States to the Convention.[21] It did, however, recognise that 'preventing the applicant from exercising her choice to avoid an undignified and distressing end to her life constituted an interference with her right to respect for private life' under art 8 of the ECHR.[22] This interpretation of art 8 is consistent with the established jurisprudence of the ECtHR and accords with interpretations of similar provisions in the United States Constitution and the Canadian Charter of Rights and Freedoms which regard the notion of 'private life' as encompassing the right to make decisions about matters affecting a person's bodily integrity and identity.[23]

Subsequently, in *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45, the House of Lords, accepting the ECtHR's interpretation of art 8 in the Pretty decision, ruled that the lack of certainty as to whether Mrs Purdy's husband would be prosecuted under the Act were he to assist her to travel to Switzerland to access AD, constituted an interference with her rights under this Article. It ultimately found, however, that this interference was justified in the

[18] In Switzerland the Dignitas Clinic provides assisted dying by virtue of the fact that under the Swiss Criminal Code it is only unlawful to assist a person's suicide if that is done for 'selfish' reasons: *Swiss Criminal Code* (1937) art 115.

[19] See the discussion in M Blake, 'Physician-Assisted Suicide: A Criminal Offence or a Patient's Right?' (1997) 5(Autumn) *Medical Law Review* 294 in which the relevance of these rights to AD are analysed.

[20] *Pretty v UK* [2002] ECHR 427.

[21] In a unanimous judgment the European Court of Human Rights ('ECtHR') found that while her application was admissible, the interference with her art 8 rights could be justified as 'necessary in a democratic society' for the protection of others. The margin of appreciation is discussed by the Council of Europe in 'The Margin of Appreciation' (Web Page) <https://www.coe.int/t/dghl/cooperation/lisbonnetwork/themis/echr/paper2_en.asp>.

[22] *Pretty v UK* (n 20) IV.

[23] See *State of Washington v Glucksberg et al* 138 L Ed 2d 777 (Wash, 1997); but see *Dobbs v Jackson Women's Health Organisation* 597 US 215 (2022); and in Canada, *Carter v Canada* [2015] 1 SCR 331.

public interest.[24] Notably, Lord Hope emphasised that the courts were not the appropriate avenue for legal change on AD:

> It must be emphasised at the outset that it is no part of our function to change the law in order to decriminalise assisted suicide. If changes are to be made, as to which I express no opinion, this must be a matter for Parliament.[25]

Consistent with this position of judicial reluctance, the House of Lords held that the Director of Public Prosecutions was required to develop a policy on the prosecution of assisted suicide cases. That policy was published by the then Director of Public Prosecutions Kier Starmer in 2010 in response to this ruling.[26]

In the third case of significance, *R (on the application of Nicklinson and another) v Ministry of Justice,*[27] the UK Supreme Court (the successor to the House of Lords) considered the *Suicide Act*'s compatibility with art 8 in circumstances where a person has made 'a voluntary, clear, settled and informed decision to commit suicide', but who cannot because of their physical incapacity. The case concerned three individuals living with permanent and severe disabilities, who could not end their lives except through the refusal of all nutrition and hydration. In the earlier Court of Appeal hearing,[28] the claimants had argued that the common law should provide a defence of necessity in euthanasia cases.[29] This argument sought to establish that actions which would otherwise constitute murder (because the person assisting had caused the death of the person intending to do so)[30] or assisted suicide, were exempted on the grounds that bringing about death was

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[24] The House of Lords therefore accepted the ECtHR ruling in the *Pretty* case as to the scope of the right to respect for private and family life.

[25] *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45, [26].

[26] Crown Prosecution Service ('CPS'), *Code for Crown Prosecutors* (26 October 2018). As published in 2010 the Code identified the involvement of a health professional in another's suicide as being a reason in favour of prosecution, although that was later clarified in 2014 amendments. The publication of the Code was associated with an increased level of prosecutorial discretion being introduced into s 2(4) of the *Suicide Act 1961* (UK). Data associated with the effect of the Code and its role in supporting access to AD in Switzerland is discussed in Alexandra Mullock and Jonathan Lewis, 'Assisted Dying, Vulnerability, and the Potential Value of Prospective Legal Authorisation' (2025) 33 *Medical Law Review* 1, 9.

[27] *R (on the application of Nicklinson and another) v Ministry of Justice* [2015] 1 AC 657.

[28] *R (Nicklinson) v A Primary Care Trust* [2013] EWCA Civ 961.

[29] The applicants relied on the earlier case of *Re A (Conjoined Twins: Surgical Separation*) [2000] 4 All ER 961. The case is discussed in Sally Sheldon and Stephen Wilkinson, 'On the Sharpest Horns of a Dilemma': Re A (Conjoined Twins)' (2001) 9(3) *Medical Law Review* 201.

[30] Note that in relation to assisting suicide the person providing the assistance is not necessarily regarded as having caused the death of the person: *AG v Able* [1984] QB 795. However, it is a requirement for murder that the person be the cause of the death. This is the common conduct element (or actus reus) for all homicide offences. See also *Criminal Code Compilation Act 1913* (WA) ss 268, 270.

necessary in the best interests of the patient in order to alleviate their suffering. Following the Court of Appeal's unanimous rejection of this argument it was subsequently abandoned in the Supreme Court proceedings which focused on the *Suicide Act* provisions and their compatibility with the *HRA*. While Lord Neuberger agreed that the Supreme Court had the institutional authority to make a declaration of incompatibility under the *HRA*:

> The interference with the Applicants' article 8 rights is grave, the arguments in favour of the current law are by no means overwhelming … no compelling reason has been made out for the court simply ceding any jurisdiction to Parliament.[31]

The Court ultimately concluded not to make such a declaration on the basis that this was the remit of Parliament.[32] Again, Lord Neuberger set out reasons as to why it was 'institutionally inappropriate at this juncture' for the court to intervene. He set out four reasons, the first, notably, that

> the question whether the provision of section 2 should be modified raises a difficult, controversial and sensitive issue, with moral and religious dimensions, which undoubtedly justifies a relatively cautious approach from the courts.[33]

Importantly, his third reason was that Parliament was due to shortly debate the issue; a reference to Labour MP Lord Falconer's Assisted Dying Bill 2014 which ultimately failed to progress due to a lack of time for debate associated with the 2015 General Election. This Bill was subsequently revamped in Labour MP Rob Marris's Assisted Dying (No 2) Bill (2015) (defeated at its Second Reading)[34] and Crossbencher Baroness Meacher's Assisted Dying Bill (2021) (which ultimately failed when parliamentary session time ran out while it was in the Committee stage).[35]

This snapshot of the historical consideration of legalising AD in the UK indicates the courts' persistent maintenance of the view that this was Parliament's

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[31] *R (on the application of Nicklinson and another) v Ministry of Justice* (n 27) [111].

[32] Although one of the consequences of the *Nicklinson* decision is that the DPP prosecutorial guidance was revisited to clarify the position of health professionals' involvement. The change is to the effect that health professionals are more likely to be prosecuted for an offence under the *Suicide Act* should there be a pre-existing relationship of care between the health professional and the deceased person: CPS (n 26) as amended in 2014.

[33] *R (on the application of Nicklinson and another) v Ministry of Justice* (n 27) at [116].

[34] There were 330 against and 118 in favour. See Rowena Mason, 'Assisted Dying Bill Overwhelmingly Rejected by MPs', *The Guardian* (online, 12 September 2015) <https://www.theguardian.com/ society/2015/sep/11/mps-begin-debate-assisted-dying-bill>.

[35] John Keown, 'Physician-Assisted Suicide: Improving the Quality of the Debate' (Report, Policy Exchange, 12 March 2023) 12.

responsibility. It was recently made clear that were this to happen, it would be through a private members' bill.[36] This of itself is a point worth noting, given the existence of the *HRA* (UK). Whereas the Supreme Court of Canada's role in the interpretation of the Canadian Charter of Rights and Freedoms was central to the introduction of the Medical Assistance in Dying ('MAID') laws,[37] the UK Supreme Court is of the view that judicial intervention, via a declaration of incompatibility, is not the appropriate way to proceed.

The fact that a legislative route to the legalisation of assisted dying has been carved out enables a timely comparison with the Western Australian legislation, which was passed in 2019 and came into force in 2021, following the successful passing of the Victorian legislation.[38] Realistically, Australian states were bound to Parliamentary intervention were assisted dying to be realised. While Victoria, the ACT and Queensland boast human rights legislation[39] — potentially providing 'legal hangers' for rights associated with AD — this legislation has not particularly featured in the AD discourse in those jurisdictions.[40] The remarkable legal landscape change in Australia – which has seen all States and the ACT legalise AD over a period of eight years[41] — was preceded by a plethora of private members' bills in most jurisdictions dating back many years.[42] The gamechanger appeared to be the then Victorian Premier's endorsement of the Victorian AD Bill in 2017,[43] a recognition of the importance of the support of one of the two major political

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[36] Now Prime Minister Sir Kier Starmer committed to making parliamentary time for a vote on changing the law in March 2024, and confirmed in July 2024 that this would happen 'by way of a private member's bill': Sam Francis, 'Starmer sticks by promise of assisted dying free vote', *BBC News* (online, 12 July 2024) <https://www.bbc.com/news/articles/cy0857z0v5no>.

[37] As a result of the decision in *Carter v Canada* (n 24), which overruled the 20-year-old decision in *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519.

[38] *Voluntary Assisted Dying Act 2017* (Vic) which came into force on 19 June 2019.

[39] *Charter of Human Rights and Responsibilities Act 2006* (Vic); *Human Rights Act 2019* (Qld); *Human Rights Act 2004* (ACT).

[40] Neither the Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End-of-Life Choices* (Parliamentary Paper No 174, June 2016) nor the Queensland Law Reform Commission, *A legal framework for voluntary assisted dying* (Report No 79, May 2021) references their jurisdiction's human rights legislation in any detail. Also note that WA was the second Australian jurisdiction to introduce AD legislation and there is no WA Human Rights Act.

[41] Victoria's Act was passed in 2017. Most recently the ACT passed AD legislation in 2024 following the Commonwealth's repealing of the ban on territories power to introduce laws legalising euthanasia and assisted suicide in 2022: *Restoring Territory Rights Act 2022* (Cth).

[42] For a review of the historical attempts to legalise AD in Australian jurisdictions see Lindy Willmott et al, '(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics' (2016) 39(1) *University of New South Wales Law Journal* 1.

[43] Melissa Davey, 'Daniel Andrews recounts harrowing deaths as MPs debate voluntary assisted dying', *The Guardian* (online, 17 October 2017) <https://www.theguardian.com/society/2017/oct/17/daniel-andrews-recounts-harrowing-deaths-as-mps-debate-voluntary-assisted-dying>.

parties in Australia.[44] While the private members' bills did not gain particular traction in the Australian jurisdictions, the commitment to this avenue in the UK has, on this occasion, proven successful in this instance, with Labour MP Kim Leadbeater presenting the TAIB to Parliament in 2024. Although there have been suggestions that it is unlikely that the House of Lords would overturn a decision of the House of Commons, particularly considering the clear and demonstrable public support for AD, scholars have expressed the view that the House of Lords may well make amendments to the TIAB which would then need to be approved by the House of Commons.[45]

This commentary now moves to consider several key provisions of the TIAB, essentially those associated with accessing the proposed AD scheme. It is in this regard that some useful comparisons can be drawn with the *WAVADA*, a jurisdiction which has now had a number of years to reflect upon, and collect data in connection with, its own scheme.

III KEY ACCESS PROVISIONS IN THE TIAB AND COMPARISONS WITH THE *WAVADA* SCHEME

This commentary identifies three core areas in connection with a person's ability to access the AD statutory schemes. These have been selected on the basis that they relate to statutory provisions which set out key preconditions and processes associated with the schemes. The commentary deliberately does not engage with other, very real, factors which are relevant to access such as a person's socio-economic status, whether they are living in urban as opposed to regional or rural areas, and the availability of resources (such as the drugs and appropriately qualified health care professionals). These are identified in the scholarship and grey literature as influential in accessing AD schemes.[46] It will also not be engaging with the decisional criteria associated with access, essentially those parts addressing decisional capacity, voluntariness and understanding. These

[44] See the discussion in Willmott et al (n 42).

[45] Mark Elliott, 'Would it be constitutionally improper for the House of Lords to block the Assisted Dying Bill?', *Public Law for Everyone* (Web Page, 20 June 2025) <https://publiclawforeveryone.com/2025/06/20/would-it-be-constitutionally-improper-for-the-house-of-lords-to-block-the-assisted-dying-bill/>.

[46] Eg Casey M Haining, Lindy Willmott and Ben P White, 'Accessing Voluntary Assisted Dying in Regional Western Australia: Early Reflections from Key Stakeholders' (2023) 23(4) *Rural and Remote Health* 8024. These impediments to access have been identified in the various Reports of the Voluntary Assisted Dying Boards in WA, Victoria and Queensland. For examples see Victoria State Government, Department of Health, *Voluntary Assisted Dying Board Report Annual Report July 2023 to June 2024* (Report, June 2024) 7; WA State Government, Department of Health (n 5) under 'Workforce Sustainability'.

aspects are common to the legality of health care decisions more broadly[47] and this commentary is not looking to engage with this more generalised debate, particularly the issue of coercion in relation to AD, which has been consistently identified in the political discourse as a matter of concern, the UK debates being evidence of this.[48]

A *Eligibility Criteria*

1 *Residency*

Section 1 of the TIAB provides that for a person to access the scheme the person must be ordinarily resident in England and Wales and has been resident for at least the last 12 months since the date of the first declaration under the TIAB. There is a further requirement that the person is registered with a general medical practice in England or Wales.[49]

Residency requirements are relatively common in AD schemes worldwide, and are certainly a common feature of the various Australian schemes (although the Queensland legislation is more relaxed on this point).[50] It is acknowledged that this is in order to constrain 'health tourism' — such as that associated with the Swiss Dignitas Clinic.[51] Health tourism has also been associated with surrogacy. While it is seen as problematic in this context because of particular ethical issues and legal challenges in relation to parentage,[52] these are not associated with AD — a point developed below. The requirement of registration with a practice is less

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[47] As noted by Ricciardo (n 6) 175. Also note the discussion in Mullock and Lewis (n 26).

[48] Colin Gavaghan, 'The assisted dying debate has been about safety not sanctity — here's why I think the bill passed the test', *The Conversation* (online, 21 June 2025) <https://theconversation.com/the-assisted-dying-debate-has-been-about-safety-not-sanctity-heres-why-i-think-the-bill-passed-the-test-259476>; and see discussion in Mullock and Lewis (n 26) in which the authors interrogate understandings of vulnerability in the literature and argue that this can co-exist with respect for autonomy.

[49] Terminally Ill Adults (End of Life) Bill (2025) (UK) s 1(1)(d) ('TIAB').

[50] *Voluntary Assisted Dying Act 2021* (Qld) s 10(1)(e).

[51] For example, data from 'Dignity in Dying' indicates that since the UK Prosecutorial Policy on AD was introduced several hundred UK citizens have been assisted to travel to Dignitas in Switzerland to access AD: 'Dignitas British membership at all-time high with 80% increase in last decade', *Dignity in Dying* (Web Page, 2 March 2023) <https://www.dignityindying.org.uk/news/dignitas-assisted-dying-switzerland/>.

[52] See Raywat Deonandan, 'Recent Trends in Reproductive Tourism and International Surrogacy: Ethical Considerations and Challenges for Policy' (2015) 8 *Risk Management and Healthcare Policy* 111; and discussion of the issue in Janelle Miles and Kate McKenna, 'Australia's complex patchwork of surrogacy laws is leaving some children in legal limbo', *ABC News* (online, 2 May 2025) <https://www.abc.net.au/news/2025-05-02/commercial-surrogacy-australia-international-legal-challenges/105238124>.

common and may well be associated with the status of UK's National Health Service as the main provider of medical services.[53]

AD legislation does, like other Australian schemes, contain a residency requirement. Section 16(1)(b)(ii) of the *WAVADA* requires that the applicant be regarded as ordinarily resident in Western Australia ('WA') for at least 12 months. There is a right of appeal in relation to the residency requirement which has been considered in, to date, three decisions of the WA State Administrative Tribunal ('WASAT').[54] In a recent publication considering these decisions, the author notes that the members of WASAT adopted a holistic approach to the question as to whether the applicants should be able to access the *WAVADA* scheme, notwithstanding their long absences from WA.[55] It will be argued later in this commentary that these decisions, and the article, give valuable insight into the underlying purpose of the *WAVADA*.

2 *Qualifying Health Conditions*

The TIAB requires that the applicant have a 'clear, settled and informed wish to end their own life'[56] and that the applicant must have been diagnosed with a terminal illness (an inevitably progressive illness or disease which cannot be reversed by treatment) and be expected to die within the next six months.[57]

Timeframes associated with death of those with terminal illness is a relatively common qualification for accessing AD schemes, although some schemes have expanded their qualifying criteria to include people who are not terminally ill. In the Netherlands and Belgium, this has been the case for some time, with the implication that persons enduring intolerable mental suffering not associated with terminal illness qualify for access to AD in those countries.[58]

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[53] It has been suggested that AD services under the TIAB (n 49) could be provided by the NHS; alternatively that there might be services provided by a separate provider but overseen by the NHS: Mason (n 34).
[54] *AB and CD* [2024] WASAT 6; *EF, GH AND IJ and KL* [2024] WASAT 18; *HM v Co-ordinating Practitioner, HM* [2024] WASAT 23.
[55] Ricciardo (n 6).
[56] TIAB (n 49) s 1(2)(a).
[57] Ibid s 2.
[58] *Termination of Life on Request and Assisted Suicide (Reviews Procedures Act)* (the Netherlands); *Wet betreffende de euthanasie* [*Belgian Euthanasia Act of 2002*] (Belgium).

As is the case in other Australian jurisdictions,[59] the *WAVADA* scheme sets out two timeframes for accessing AD. A person is eligible if they have a medical condition which is advanced and progressive and will, on the balance of probabilities result in death in six months, but this is extended to 12 months where the person has a neurodegenerative condition.[60] It is a further condition of eligibility that the disease, illness or medical condition is 'causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'.[61] This reference to the experiential suffering of the applicant is also a requirement of other AD laws globally.[62] The absence of this from the TIAB is, again, a point of difference which, in the author's view, suggests an approach to the legalisation of AD in England and Wales which is different to that in WA (and indeed other Australian jurisdictions), a point which will be expanded upon in Part IV.

Notably, both regimes specify that the fact that a person has a disability or has been diagnosed with a mental illness does not, itself, provide a basis for accessing the schemes.[63]

B *Process of Approval*

1 *First Stage*

The first stage of the process of approval merits particular consideration as a 'gateway' to accessibility. Under the TIAB the process of access commences with a 'first declaration' which must be witnessed.[64] The first assessment of eligibility is carried out by the first 'registered medical practitioner' (co-ordinating doctor — 'COD')[65] 'as soon as reasonably practicable' after the declaration. A report must then be completed and given to the assessed person detailing reasons as to why the eligibility criteria are or are not satisfied.[66] If satisfied, the COD must refer the assessed person to an independent doctor ('ID').[67] The first doctor with whom the applicant has the consultation is under no duty to raise the option of AD but

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[59] See Katherine Waller et al, 'Voluntary Assisted Dying in Australia: A Comparative & Critical Analysis of State Law' (2023) 46(4) *University of New South Wales Law Journal* 1421 for a comprehensive discussion of the differences between the various Australian state AD laws.
[60] *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(c) ('*WAVADA*').
[61] Ibid s 16(1)(c)(iii); TIAB (n 49) s 2(3).
[62] For example see Canadian Medical Assistance in Dying ('MAID') laws referring to 'suffering that cannot be alleviated under conditions the person considers acceptable': *Medical Assistance in Dying Act*, RSC 2016 c 7 (Canada). See also *End of Life Choice Act 2019* (NZ) s 5(1)(c).
[63] *WAVADA* (n 60) s 16(2).
[64] TIAB (n 49) s 7.
[65] Ibid s 8.
[66] Ibid s 9(5).
[67] Ibid s 9(3)(c)

can raise it if 'appropriate'.[68] If it is raised it must be done in conjunction with explaining all appropriate other options including palliative care.[69] If a medical practitioner is 'unwilling or unable' to conduct the initial discussions then that person 'must ensure' the applicant is directed to where they 'can obtain information and have the preliminary discussion.'[70]

Under the *WAVADA*, a 'clear and unambiguous' request made during a medical consultation is termed a 'first request'.[71] If that request is accepted, that practitioner becomes the coordinating practitioner and is required to make an assessment as to eligibility. In comparing the analogous provisions of the *WAVADA* a clear difference is that this permits medical professionals to administer the scheme by virtue of the reference to the Health Practitioner Regulation National Law (WA), which as a consequence includes both medical doctors and nurse practitioners.[72] This, it is argued later in this commentary, has implications for accessing the relevant schemes.

There are, however, similarities. For example, the *WAVADA*[73] states that the medical practitioner can discuss AD as long as the person is also informed about other 'treatment options'.[74] A further alignment includes the *WAVADA* provision which requires that where a medical practitioner does not want to engage with the request as a matter of conscientious objection, unavailability or 'some other reason',[75] they must provide the applicant information relating to accessing AD.[76]

2 *Subsequent Stages*

The TIAB requires an ID, once passed on a report by the COD, to carry out the second assessment 'as soon as reasonably practicable after the first period of reflection for the assessed person has ended (a period of seven days following the

[68] Ibid s 5(1), (2).
[69] Ibid s 5(2), (5).
[70] Ibid s 5(6).
[71] *WAVADA* (n 60) s 18.
[72] See ibid s 5 in which a 'medical practitioner' is defined as a 'person registered under the Health Practitioner Regulation National Law in the medical profession'.
[73] Ibid s 10(3).
[74] The ability of a practitioner to raise the possibility of AD was a point of contention in the political debates associated with the *WAVADA*: Western Australia, *Parliamentary Debates*, Legislative Council, 26 September – 5 December 2019. Under s 8 of the *Voluntary Assisted Dying Act 2017* (Vic) the practitioner is not permitted to raise this as a possible end of life choice. This was recognised in Victoria State Government, Department of Health (n 46) as a barrier to accessing VAD under that Act (at 39).
[75] *WAVADA* (n 60) s 20.
[76] Ibid s 20(4)(b).

day of the COD's Report).[77] The IC is required to make a report[78] and then supply the Report to the Voluntary Assisted Commissioner ('VAC')[79] after which the VAC must refer 'as soon as reasonably practicable' to the Assisted Dying Review Panel ('Panel') for the determination of the person's eligibility.[80] If the certificate of eligibility is granted there then ensues a 'second period for reflection' which lasts for 14 days unless the COD reasonably believes that the person's death is likely to occur within a month in which case the period of reflection is 48 hours.[81] If the Panel refuses to grant a certificate of eligibility, an appeal is possible although confined to narrow grounds, essentially procedural rather than substantive.[82] The appeal is heard by the Commissioner who must consider the appeal without a hearing.[83]

Under the *WAVADA*, if the coordinating practitioner assesses the patient as eligible then they are required to refer the patient to another medical practitioner for a second assessment of eligibility.[84] If the patient's eligibility at this second stage is confirmed, the patient may make a written request to access the scheme,[85] following which the patient can make a final request to the coordinating practitioner. Within two business days of receiving the request the coordinating practitioner must carry out a final review which involves notifying the Voluntary Assisted Dying Board of the final request and confirming the patient's eligibility and other details.[86]

Under both schemes there are three assessments of the patient's eligibility. The main difference is that under the *WAVADA* all the assessments are carried out by individual medical practitioners. Secondly the timeframes permit a rather quicker progression of the request; a final request for access to AD can be made at the end of the 'designated period' (which is nine days from when the patient made the first request),[87] although exceptions to this are built in where the person is likely

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[77] TIAB (n 49) s 10(1), (3). If the ID makes a report stating that they are not satisfied then they 'may, if requested to do so … refer that person to a different registered medical practitioner …': TIAB s 13(2).
[78] Ibid s 11(5).
[79] Established under s 4.
[80] Ibid s 16(2).
[81] Ibid s 19.
[82] Ibid s 18(2): the grounds are that the first panel's decision (a) contains an error of law; (b) is irrational; or (c) is procedurally unfair.
[83] Ibid s 18(3).
[84] *WAVADA* (n 60) s 30.
[85] Ibid s 42(1).
[86] Ibid divs 5, 6: other details include, eg, if the patient was assisted by an interpreter. The form must be forwarded to the Board within two business days of completion.
[87] Ibid s 48.

to die or lose decision-making capacity before that time.[88] Practitioners are also required to complete their reports as to eligibility within two business days of assessment and also to notify the patient within this timeframe.[89]

There is also a difference in connection with the ability of the applicants to challenge decisions by practitioners that they do not meet the eligibility criteria. Under the *WAVADA* there is a ground of appeal relating to 'legal matters' but not medical determinations.[90] As such there is a right of review in relation to decisions concerning the residence criterion, whether the person has decision-making capacity and whether the person is acting voluntarily and without coercion.[91] One author has defended the role of medical practitioners in making 'legal' decisions noting that this is as an appropriate approach given that 'health practitioners are required to make a host of decisions which involve legal standards'.[92]

C *Administration of the Substance*

Section 25(11) of the TIAB requires the co-ordinating doctor to be present with the patient at the time of taking the approved substance. It states that the doctor need not be in the same room as the patient but does need to 'remain with the person'.[93] Under the TIAB only self-administration of the substance is permitted.[94] Indeed the TIAB provides that the coordinating doctor 'may assist that person to ingest or otherwise self-administer the substance'[95] but that this does not authorise the doctor to 'administer an approved substance to another person with the intention of causing that person's death'.[96] It states that the decision to self-administer the approved substance and the final act of doing so must be taken by the person to whom the substance has been provided.[97]

It is on the issue of administration of the lethal substance that there is a significant difference when looking at the *WAVADA*. Firstly, there is no requirement of the medical practitioner being present at the time of administration of the substance. Secondly, and most importantly, the WA legislation, like all current AD schemes in

[88] Ibid s 48(3).
[89] See ibid s 40(2).
[90] Ricciardo (n 6).
[91] *WAVADA* (n 60) s 84(1)(a)(ii)–(iii).
[92] Ricciardo (n 6) 175.
[93] TIAB (n 49) s 25(11), (12).
[94] Ibid s 25(7), (8).
[95] Ibid s 25(8)(b).
[96] Ibid s 25(10).
[97] Ibid s 25(9).

Australia bar Victoria, permits a choice of self-administration or practitioner administration.[98] The WA Voluntary Assisted Dying Board notes that 94.9% of those accessing VAD over the 2023–2024 period chose practitioner administration.[99] This is consistent with, for example, evidence from jurisdictions such as Canada. The most recent Annual Report on MAID notes that

> MAID was administered by a practitioner in nearly all cases. In 2023, MAID was self-administered in fewer than five instances. While self-administration of MAID is permitted in all jurisdictions in Canada (except for Quebec), very few people have chosen this option since 2016.[100]

As will be suggested below, the limitation to self-administration in the TIAB has both conceptual and practical implications.

IV THE TIAB AND *WAVADA*: DISTINCT UNDERLYING PREMISE EQUATES TO DIFFERENTIAL ACCESS?

This analysis of the various provisions relating to accessing AD under the TIAB and *WAVADA* reveals a key difference in conceptual approaches to AD more generally. It is suggested that the TIAB in its current form continues to identify AD with the law relating to suicide and is thus focused on the provision of significant safeguards in relation to accessing the scheme.[101] As such it is not recognised as a genuine end-of-life choice, but rather as a limited exemption to an existing criminal offence. This, it is argued, contrasts with the *WAVADA* which is underpinned by core moral principles associated with autonomy, dignity and the reduction of suffering.[102]

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[98] Under s 46(c)(i) of the *Voluntary Assisted Dying Act 2017* (Vic), practitioner administration is limited to patients who are unable to self-administer or digest the substance.

[99] WA State Government, Department of Health (n 5) 6.

[100] Health Canada, *Fifth Annual Report on Medical Assistance in Dying in Canada* (Report, 2023) 16–17.

[101] MP Kim Leadbeater, the sponsor of the TIAB, has consistently touted that the safeguards in the scheme are the 'strongest in the world': Jessica Elgot, 'Kim Leadbeater: assisted dying bill will still have world's strongest safeguards', *The Guardian* (online, 11 February 2025) <https://www.theguardian.com/society/2025/feb/11/kim-leadbeater-assisted-dying-bill-worlds-strongest-safeguards>. However this has been criticised as overly narrowing the scope of the scheme: see the discussion in Eduardo Reyes, '"Safety" v autonomy', *The Law Society Gazette* (online, 11 April 2025) <https://www.lawgazette.co.uk/features/safety-v-autonomy/5122984.article>.

[102] See a statement of the Principles in *WAVADA* (n 60) div 2 s 4. The reference to these concepts is also reflected in other jurisdictions. For example, access to MAID requires the person to be experiencing 'unbearable or mental suffering from the illness, disease, disability or state of decline …': see discussion in Health Canada (n 100) 6.

A *Differing Characterisations of AD*

The political discourse leading up to the Western Australian Parliament's debate of the AD Bill was characterised, above all, by reference to the spirit of compassion underpinning the legislation.[103] On the passing of the Bill on 10 December 2019, the then WA Health Minister, Roger Cook, stated that West Australians had 'chosen compassion and the right to choose'.[104] At the earliest possible place in the *WAVADA* the principles governing the Act are set out, and these notably reference the 'equal value' of every human life, 'autonomy in respect of end of life choices', and the need to 'minimise the person's suffering'.[105] It is submitted that the inclusion of these principles is an important interpretative mechanism. It is notable that the TIAB contains no underlying statement of principles and in this sense is very 'legal' in its approach to AD. This is, it is argued, a reductionist approach in that it is acknowledged in the scholarship,[106] and indeed by the fact that both pieces of legislation were considered as a 'conscience' vote, that the law in this area is inextricably linked to core values underpinning humanity.[107] The focus on legal safeguards in the TIAB diminishes this fundamental dimension.

The absence of any reference to the subjective experience of the person seeking to access AD under the TIAB reinforces this legalistic approach. This is in contrast to the *WAVADA* which, as noted, refers to the disease, illness or medical condition 'causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'.[108] The inclusion of the personal experience as a central qualifying criterion is reflected in all Australian AD legislation,[109] and indeed other global models.[110]

The significance of the applicant's subjective experience more generally to the operation of the *WAVADA* scheme has been recognised in three decisions of the

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[103] See, eg, in WA, *Parliamentary Debates*, Legislative Counsel, 26 September 2019, where Stephen Dawson MLC repeatedly refers to compassion, citing examples given to the Joint Select Committee on End-of-Life Choices, Parliament of Western Australia, *Report: My Life, My Choice* (Report, August 2018) 23.
[104] 'Western Australia legalises voluntary assisted dying after 'momentous process', *The Guardian* (online, 11 December 2019) <https://www.theguardian.com/society/2019/dec/11/western-australia-legalises-voluntary-assisted-dying-after-momentous-process>.
[105] See *WAVADA* (n 60) div 2 s 4(1)(d).
[106] See the various papers featured in John Keown (ed), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge University Press, 1985).
[107] First expressed formally in *United Nations Declaration of Human Rights*, GA Res 217A (III), UN GAOR, UN Doc A/810 (10 December 1948) following the atrocities of World War II.
[108] *WAVADA* (n 60) s 16(c)(iii).
[109] *Voluntary Assisted Dying Act 2017* (Vic) s 9; *Voluntary Assisted Dying Act 2021* (Qld) s 10.
[110] Above n 62.

SAT dealing with appeals on residency criteria.[111] These decisions, in determining whether a person is 'ordinarily resident' in WA for the purposes of accessing the scheme, emphasised the importance of the applicant's personal and subjective attachment to WA. As the author of a recent study of these decisions notes:

> Allowing people who are ordinarily resident in WA to make those choices [to spend significant periods of time away from their usual home], and then also choose to be at home for medical reasons and end of life care, is consistent with the principles under pinning the VAD Act (including respect for autonomy and the provision of high quality care).[112]

The legalistic approach to AD in the TIAB is further reflected in the fact that the legality of AD is addressed through amendments to the *Suicide Act*.[113] As such it can be legislatively characterised as an exemption to an existing offence — it states that '[a] person is not guilty of an offence …' — rather than establishing a separate legislative scheme focused on end-of-life choices. This can be contrasted with the *WAVADA*, which explicitly states that a person utilising the provisions of the legislation is not committing suicide, thereby establishing it as a stand-alone statutory scheme providing specific end-of-life choices.[114]

B *Implications for Access*

The earlier section of this commentary identified specific provisions in the TIAB associated with access to the scheme. It is argued here that these provisions are consistent with a conception of AD as an exception to existing offences rather than a separate framework providing an additional end-of-life choice. For example, the TIAB only permits self-administration of the substance in bringing about death of the person through AD. In this respect it reinforces its association with suicide. Under the *WAVADA*, as noted above, applicants for AD have a choice between practitioner administration and self-administration. It should be noted that in Victoria, practitioner administration is only permissible where the applicant is unable to self-administer or digest the substance,[115] a restriction which has been

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[111] Above n 54.
[112] Ricciardo (n 6) 163.
[113] TIAB (n 49) s 32.
[114] *WAVADA* (n 60) s 12.
[115] Section 46(c)(i) of the *Voluntary Assisted Dying Act 2017* (Vic) states that a 'practitioner administration permit' only applies if 'the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance'.

associated with the proportionally lower numbers of people participating in that jurisdiction's statutory scheme and identified as an access challenge.[116]

A second example is the limitation in the TIAB of the professionals involved in the assessment of the person requesting access to the scheme. This is confined to medical doctors which is inherently limiting the operation of the scheme. Under the *WAVADA* medical professionals include both medical doctors and nurse practitioners,[117] meaning that both can assess patients, and supply and administer the lethal substance.

A third example is the sheer complexity of the approval scheme under the TIAB. It has been noted above that this incorporates significant periods of 'reflection' which implicitly extend the process of approval, particularly significant given that the legislation is only concerned with those who have a life expectancy of six months or less. The involvement of a second tier of decision-makers in the approval scheme — the Panel[118] — and the limited and legalistic grounds associated with challenging eligibility decisions are further evidence of this complexity.

It is argued that these provisions which are posited as safeguards will ultimately provide obstacles to those wanting to access the scheme in their dying weeks. The *WAVADA*, in its textual provisions, provides a more accessible scheme. And yet, the most recent Annual Report of the Voluntary Assisted Dying Board identifies difficulties of access to the WA scheme as its main challenge. The Annual Report cites the low numbers of applications for training by practitioners, as well as persistent issues of a lack of education around the scheme, as reasons for access problems.[119] The delays in processing applications have meant that those seeking to access the scheme have died before having the opportunity to utilise it.[120] It is logical to suppose that if this is a problem with a scheme which is comparatively more accessible, the TIAB scheme will experience more significant challenges.

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[116] Victoria State Government, Department of Health (n 46) 34.
[117] By virtue of the fact that *WAVADA* (n 60) references the status of medical practitioners under the Health Practitioner Regulation National Law.
[118] To include a social worker, lawyer and psychiatrist in its membership.
[119] WA State Government, Department of Health (n 5).
[120] Ibid.

V CONCLUSION

This commentary commends the progress which has been made with the passing of the TIAB. The failure to conceive of AD as a genuine end-of-life choice, however, has resulted in a perversion of language, whereby the narrative of 'safeguards' manifests as barriers to access. The TIAB as it stands presents a range of hurdles which applicants need to clear before being able to access the promise of a chosen death, at a time when they are probably experiencing considerable if not profound physical and existential suffering. Until AD is reimagined in terms of its broader social and moral context, accessing the scheme proposed by the TIAB is likely to be challenging.