STATES OF JERSEY

DRAFT ASSISTED DYING LAW 202- (P.65/2025): THIRD AMDENDMENT (P.65/2025 AMD.(3)) – COMMENTS

Presented to the States on 13th February 2026
by the Minister for Health and Social Services

STATES GREFFE

COMMENTS

1. The draft law provides that an individual, whose request for an assisted death is approved, may choose to self-administer the approved drugs (with or without support from a loved one or family member) or choose for the Administering Practitioner to administer the drugs. This amendment seeks to amend the law, requiring a person to self-administer unless they are physically unable to do so.

2. Self-administration and practitioner administration are referred to as the modes of administration. Allowing an individual to choose their preferred mode of administration accords with the principle of autonomy and control over the manner and timing of death and, as such it directly accords with the two previous States Assembly decisions.

3. Furthermore, retention of both modes best aligns with public engagement findings, expert ethical analysis, and international legislative practice. Restricting the option to choose practitioner administration reduces patient autonomy and both significantly, and unnecessarily, limits compassionate, support and choice for dying individuals in their last moments of life.

4. The Minister for Health and Social Services rejects this amendment and, in doing so, notes it was not a recommendation of the Panel's expert advisors.

<u>Development of Jersey proposals permitting both modes of administration</u>

5. There has been consistent support for the inclusion of both modes of administration during the assisted dying policy development process:

   a. the 2021 Citizen's Jury supported proposals to permit both modes of administration (65% voted in favour)

   b. P95/2021 – the Assembly supported, in-principle, both modes of administration

   c. the 2023 Ethical review stated that: "*If the States Assembly considers the arguments about the two modes to be balanced, then it may judge it appropriate to provide for both modes in law, with patients offered the choice of mode. If the (or a) central goal of the proposed law governing AD is to respect patient autonomy, then allowing patients the choice of mode of AD would also be consistent with this goal.*"

   d. P18/2024 – the Assembly explicitly agreed to a draft law should be brought forward which permitted both modes

   e. whilst no direct survey questions were asked about the inclusion of both modes in the Phase 1 & 2 public and stakeholder consultation, they were a clear feature of the consultation proposals and were discussed at length in public meeting. Neither those meetings nor the associated written submissions indicated majority opposition to providing individuals a choice of mode.

Respecting Autonomy and Choice

6. A key principle of the draft law is providing a terminally ill person with the choice to have some control over the **manner and timing** of their death.

7. It is a false argument to state that autonomy requires the person to perform the final act themselves (i.e., to self-administer); autonomy of choice is expressed when an individual determines the mode of administration which they prefer. Autonomy is having the option to choose.

8. Many people who are physically able to self-administer may nevertheless experience fear, concern or psychological barriers. If the law limits practitioner administration, it restricts choice for those who are physically able but unwilling to self-administer, reducing fairness and equity, and potentially resulting in unnecessary suffering, particularly for individuals fearing complications or feel overwhelmed by prospect of self-administration

9. As the Panel's own expert advisors observe, many people prefer practitioner administration for legitimate reasons, such as:
   - the drugs are more likely to work [and work more quickly if administered via IV, and with less risk of medical complications]
   - the person or family prefers a medicalised death
   - the person may not be well enough to self-administer, even with support

Evolution of the Australian model

10. Having regard to the importance of choice, is well illustrated when considering how different Australian states approach modes of administration in their assisted dying legislation.

11. The model presented in the Panel's amendment most closely resembles Victoria's 2017 legislation. This was the first assisted dying law enacted in Australia. The approach taken by subsequent States builds on the Victoria experience. For example:

    a. in Western Australia and Queensland, whose laws came into effect in 2021 and 2023, the legislation prioritises self-administration but allows for practitioner administration for reasons other than physical incapacity (e.g. if the person has fears or concerns about self-administering the substance.)

    b. in New South Wales and the Australin Capital Territory - the two jurisdictions where assisted dying legislation has most recently come into force - the model has further evolved and allows for a choice of self-administration or practitioner administration in consultation with the practitioner [i.e. as per the Jersey draft law as lodged]

12. Australian States have increasingly moved *towards* permitting both modes, with most jurisdictions now allowing practitioner administration beyond cases of physical incapacity, as each State learns from the experiences of others -

including assisted dying practitioners, the people having assisted deaths and their loved ones.

13. Furthermore, Australian assisted dying practitioners have directly told Government of Jersey Officers of the difficulties that can exist for them when left to determine if an individual can or cannot self-administer (whether based on physical or psychological capabilities); they spoke of difficulties they can experience when balancing a lack of legal certainty against compassionate for a fearful person.

14. Australia has moved towards compassionate, personcentred practice, which provides legal certainty for all – in comparison this proposed amendment is a retrograde step.

Safeguards in draft law do not depend on selfadministration

15. The Scrutiny Panel argue against permitting both modes of administration stating that permitting practitioner- administration would enable *'further safeguarding risks in terms of coercion'* on the basis that *'by requiring that the individual performs the final step, self-administration provides the clearest possible evidence that the decision is voluntary… In contrast, practitioner administration introduces a degree of dependency on a third party and requires the individual to transfer responsibility for the final act to a clinician'*.

16. The Minister rejects the argument that requiring selfadministration as default mode is necessary as it is a safeguard against coercion. The draft law embeds a whole framework of safeguards that protect against coercion at every step in the process (assessment, transition between steps, careplanning, and immediately before administration) regardless of mode.

17. The Administering Practitioner must halt the process if the individual's capacity or the voluntary nature of their decision is in doubt for either mode. Thus, **coercion is addressed through process safeguards**, not through limiting mode choice.

18. Reliance on self-administration as a backstop safeguard against coercion is an ineffective measure that runs the risk of creating a false impression of safety. *Especially*, if practitioner administration is still permitted in cases where the person is physically incapable.

Practitioner Administration is not a source of covert pressure

19. The Scrutiny Panel report notes that the 2023 Ethical Review expressed the following concerns in relation to practitioner-administration:

- *"increased use of this administration model over time in other jurisdictions..."*
- *"potential implications for healthcare professionals…",* and
- *"evidence* [from 2023 and before] *that fewer people withdraw from proceeding when practitioners are responsible for administering the drugs."*

20. Increased administration: It is correct that there have been increases in numbers of assisted deaths over time, but this is across all jurisdictions that permit assisted dying, including those that only permit self-administration. The reasons for this are complex and multifactorial and should be anticipated in jurisdictions for a period of time post- introduction.

21. With regard to the implications for healthcare professionals:

    a. the Minister's clarifying amendment (Amendment 2) to the draft law will allow Administering Practitioners to opt out of administering approved drugs at any time i.e., an Administering Practitioner is not required by law to administer the approved drugs, they may opt to only support self-administration;

    b. the 2025 survey of local health and care professionals (as per Appendix 2 of P65/2025) indicated 51 professionals would be willing to undertake the role of Administering Practitioner [though it should be noted the survey did not specifically ask if those professionals were willing to support both modes of administration. Anecdotally, however, on-island professionals have indicated they would be willing to administer the approved drugs]. Furthermore, international experience clearly demonstrates that many practitioners are willing to administer the approved drugs because they view it as a compassionate act.

    c. the draft law explicitly requires the provision of wellbeing support for assisted dying practitioners, which will include support to practitioners who have chosen to administer the approved drugs.

22. Non-administration of approved drugs / 'completion' of an assisted death: The 2023 Ethical report, as referenced in the expert advisors' report, refers to 'non-completion' data in Canada and Oregon. It notes that more people in Oregon (who, by law, must self-administer) end up not taking the approved drugs when compared to Canada (where people can choose practitioner administration) i.e., there is a higher 'completion rate' of assisted deaths in Canada than Oregon:

    - in Oregon - 65% of people issued an approved drugs prescription proceed to have an assisted death (ie. 35% do not have an assisted death)
    - in Canada - 81% of people whose assisted death is approved, have an assisted death (i.e., 9% do not have an assisted death).

23. However, these two jurisdictions have very different legislative frameworks, and it would be more meaningful to compare completion rates for self-administration and practitioner administration in a jurisdiction that permits both modes. For example, New South Wales (NSW) permits individuals a choice of either mode and, whilst the non-completion rates are higher for self-administration, the difference is not as pronounced as that suggested in 2023 Ethical Review. In NSW there is a 13 percentage point difference between in the rate of 'non-completion' based on modes of administration, which is exactly half the 26 percentage points difference suggested if equivalence is drawn between Oregan and Canada.

24. It should also be noted that:

    a. higher completion rates in practitioneradministered systems may reflect reduced fear and anxiety and improved medical support at the end of life. It is supposition to conclude that the involvement of a health care professional makes it harder for people to choose not to take the final step (i.e., that there is covert pressure to proceed if a practitioner is administering the substance) as referenced Panel's advisors

    b. Jersey's model requires a practitioner to be present both modes of administration. This differs from Oregon and most Australian states, where selfadministration typically occurs without clinician presence.

25. The Panel's amendment report states that the Panel is of the view that *"the self-administration model enables individuals to choose the moment, the context, and the circumstances in which they act, reinforcing their agency"* - but the Minister contests that this clearly applies to the draft law as lodged; indeed the draft law provides greater agency, because it allows for agency of choice.

26. Furthermore, the Panel state that*: "Practitioner administration, by contrast, typically requires more structured, clinical involvement, which may limit flexibility or impose conditions that constrain personal choice"* – whilst is it accepted that this may be the case in the Oregon model, this is <u>not</u> the case in Jersey model as both modes of administration require the Administering practitioner to be present – i.e. the draft law provides for clinical involvement and oversight regardless of whether the person self-administers the approved drugs, or they are administered by the practitioner.

<u>Conclusion</u>

27. Retaining both selfadministration and practitioner administration ensures the Jersey assisted dying model remains compassionate, ethically grounded and upholds the principles of autonomy and choice. Furthermore, it ensures the draft law remains aligned with public expectations and previous Assembly decisions.

28. Restricting practitioner administration reduces choice and autonomy and create inequities without providing the benefit of significant additional safeguards.

29. Accordingly, Members are asked not to support the amendment.