

## 1. Questions on sharing your responses:

We are asking these questions so we can process your data correctly and understand more about who is responding to this consultation.

Do you give permission for your comments to be quoted? \*

- No
- Yes, anonymously
- Yes, attributed

Name or organisation to attribute comments to, if applicable:

General Medical Council

2. Do you, or the organisation on whose behalf you are responding, hold a strong view on whether or not assisted dying should be permitted? \*

- Yes
- No
- Prefer not to say

The GMC does not take a position on whether the law on assisted dying should change; we consider this to be a matter for relevant governments or legislatures.

In terms of our responses to this consultation, some of the questions fall outside our regulatory remit or areas of expertise – or for which we would not take a view because of our position on assisted dying. We have therefore restricted our comments to a specific number of areas. Where we do not hold a position on a particular question, we have marked it as a 'Prefer not to say' or 'Don't know'.

## 3. Key questions on Section 3 - eligibility criteria

Life expectancy for neurodegenerative diseases (see consultation report paragraphs 16-19)

The States Assembly agreed in principle that assisted dying should be available to a person who has been diagnosed with a terminal illness, which is expected to result in unbearable suffering that cannot be alleviated and is reasonably expected to die within six months.

It is proposed that for those with a neurodegenerative disease this should be extended to people with a life expectancy of 12 months or less.

**Do you agree that the eligibility criteria should be changed to allow for those with a neurodegenerative disease to become eligible for assisted dying when they have a life expectancy of 12 months or less? \***

- Yes
- No
- Don't know

Please tell us the reason for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change (see question 2). As such, we would not take a position on the eligibility criteria for an assisted death.

4. Resident definition (see consultation report paragraphs 25 & 26 and note 'Jersey resident' on p.17)

The States Assembly agreed, in principle, that assisted dying should only be available to Jersey residents in order to avoid 'death tourism'. It is proposed that a person will only be considered 'resident' if they have ordinarily resident in Jersey for at least 12 months immediately before requesting an assisted death.

This means that a person who was born in Jersey, but has been living elsewhere, would not be eligible for assisted death unless they had returned to live in Jersey for the 12 months prior requesting an assisted death.

**Do you agree that the definition for Jersey resident should only include those ordinarily resident in Jersey for 12 months? \***

- Yes

- No
- Don't know

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change (see question 2). As such, we would not take a position on the eligibility criteria for an assisted death.

5. Eligibility – age (see consultation report paragraphs 25 & 26 and note 'Age limit' on p.17)

**Do you agree that assisted dying should only be permitted for people aged 18 or over? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change (see question 2). As such, we would not take a position on the eligibility criteria for an assisted death.

## 6. Key questions on Section 4 - Assisted Dying Service

**Do you agree that the Jersey Assisted Dying Service should be free to people who want an assisted death and meet the criteria? \***

- Yes, it should be free
- No, it should be paid for
- Don't know

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change. As such, we would not take a position on questions of funding.

## 7. Conscientious objection – Supporting assessments (see consultation report paragraph 50)

The Law will explicitly provide that no person can be compelled to directly participate in the assessment, approval or delivery of an assisted death.

In drafting the law, consideration will be given as to which tasks or activities constitute direct participation in assisted dying (such as undertaking a specified role in the process such as ‘Coordinating Doctor’ or being present at the time of administration of the assisted dying substance), as opposed to tasks which are ancillary to the provision of an assisted death service (such as related administrative tasks such as booking an assessment or the delivery of equipment or medical supplies.)

It is proposed that the provision of supporting opinions or assessments requested by an Assessing Doctor to help support their determine of whether a person is eligible for an assisted death would be considered as direct involvement, for example:

- professional opinion provided by a specialist on the person’s prognosis or life expectancy
- pulmonary function tests, carried out by a physiotherapist
- assessment to determine decision-making capacity by a psychiatrist or psychologist

**Do you agree that health professionals should have the right to refuse to undertake a supporting assessment (or provide their professional opinion), if that information may be used by an Assessing Doctor to make a determination on the person’s eligibility for an assisted death? \***

- Yes - they should have the right to refuse
- No - they should not have the right to refuse
- Don't know

Please tell us the reasons for your response

It doesn’t fall within our remit to advise on whether or not providing supporting assessments constitutes ‘direct participation’ in line with the legal principles set out in the Supreme court ruling on Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland).

Although we are supportive of the principle of introducing a statutory right, these questions of scope are legal ones that we do not have specific expertise on.

However, it might be helpful to provide some background on our conscientious objection guidance and the interface with a statutory right to conscientious objection.

The GMC supports the right for doctors to practice in line with their beliefs and supports the proposal to introduce a statutory right to conscientiously object to participate in an assisted death.

Our guidance on 'Personal beliefs and medical practice' sets out that doctors can opt out of providing a procedure which they have a conscientious objection to, as long as this does not result in direct or indirect discrimination against individual patients or groups of patients nor that it obstructs patients from accessing services.

[Paragraphs 8-16](#) also sets out the steps a doctor should take when exercising a conscientious objection.

Our guidance is not limited to activities for which there is a statutory right to conscientious objection. In the UK, this is limited to participating in abortion and activities falling under the Human Fertilisation and Embryology Act 1990. A statutory right to conscientious objection would ensure that healthcare providers are not under any duty from, for example, an employing or contracting body to participate in a procedure that they conscientiously object to (except, in emergencies). In the case of other activities (where there is no statutory right to conscientious objection), doctors' freedom to work in accordance with their conscience could be restricted by contractual requirements from employing or contracting bodies.

Our guidance is in line with the UK law; however, it is important to stress that it does not amount to legal advice, nor are we able to provide legal advice. Further, although we set out detailed guidance on this issue, the types or range of activity that a doctor can conscientiously object to is not specified in our guidance.

8. [Conscientious objection -Premises owner right of refusal \(see consultation report paragraph 50\)](#)

**Do you think that conscientious objection clause should provide a premise owner / operator the right to refuse an assisted death on their premises (for example, a care home provider may choose not to permit a resident to have an assisted death in their room, even though it is the person's place of residence or care) \***

- Yes - they should have the right to refuse
- No - they should not have the right to refuse if the person who wants an assisted death is resident or being cared for in the premises
- Don't know

Please tell us the reasons for your response

The GMC does not take a position on this question as it falls outside our remit.

#### 9. Public or private register (consultation report paragraphs 56-59)

It is proposed that assisted dying practitioners, who can demonstrate the necessary competencies, and who have undertaken the necessary training, will be required to register with the Jersey Assisted Dying Service. Registration will be the mechanism via which they 'opt-in' to be an assisted dying practitioner.

The registers for healthcare and medical practitioners, as held by the Jersey Care Commission, are currently public registers i.e. anyone can search the register to find out about the qualifications of a named practitioner. This is to ensure transparency.

**Do you agree that the assisted dying register should be public? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

We have a neutral stance and neither agree nor disagree that the assisted dying register should be public. Our view is that any decision in terms of whether the assisted dying register should be public or private rests with the relevant authorities in Jersey.

The GMC's approach to publication and disclosure may be of interest to those considering this issue. Information about UK registered doctors is published on the [List of Registered Medical Practitioners](#) (LRMP). We publish this information to fulfil our legal obligations and help meet our objectives to:

- protect, promote, and maintain the health, safety, and well-being of the public
- promote and maintain public confidence in the medical profession
- promote and maintain proper professional standards and conduct for members of the profession.

Our [Registration & Revalidation publication and disclosure policy](#) sets out our general approach to the publication and disclosure of registration and revalidation information relating to registrants. Paragraphs 25-30 explain the limited circumstances, such as where publication of information presents a significant risk of serious harm to the physical or mental wellbeing of a registrant, where we'll consider requests to withhold registration and revalidation information from the LRMP'.

## **10. Key questions on Section 5 - assisted dying process: request and approval**

### Request and approval process

Page 33 of the consultation report includes a diagram of the nine proposed steps in the assisted dying process:

- Step 1 - First request
- Step 2 - First assessment
- Step 3 - Independent assessment
- Step 4 - Second request
- Step 5 - Request approval
- Step 6 - Planning and preparation
- Step 7 - Prescribing the substance
- Step 8 - End of life
- Step 9 - After the death

**Do you agree that the nine proposed steps are all necessary? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

We recognise the need for a robust set of steps to ensure that treatment is only offered and provided in cases where it is unequivocal that patients meet the eligibility criteria and have made a clear and settled decision to end their lives. This is vital with decisions of this nature and magnitude. The nine proposed steps include the requirement that two doctors independently assess and determine a patient's eligibility and asks patients to re-affirm their request for an assisted death, all of which should help to create necessary safeguards. We also note that the process is designed to ensure that patients have control throughout (in terms of whether to continue with the request and, if so, at what pace), which we fully endorse.

The service model would necessarily require the involvement of multiple professionals at various stages, including the assessment stages, which we understand could present a challenge to delivering a service in Jersey from a staffing point of view. As such, we note that the consultation states (at page 21) that *'should the HCS not be able to recruit or contract the staff needed to deliver the Jersey Assisted Dying service, it would be permitted in law but no service available. Hence, people would not have assisted deaths in Jersey.'*

**11. Do you think there are any further steps / actions that should be included?**

(Please note, further Sections of this document include more detailed questions about specific steps) \*

- Yes
- No
- Don't know

If yes, please detail the further steps or actions you think should be included.

We have some comments about the sequencing of decision making and consent as it is set out in the consultation document, since it is not consistent with our guidance. We suggest addressing this by introducing an additional step to the proposed assisted dying process.

This additional step would be introduced after step 5 (i.e. after the necessary assessments and after an assisted death has been approved), and would involve the patient formally recording their consent to an assisted death, and the scope of that consent. This would be different to the written declaration recording their decision to proceed with an assisted death – i.e. the second request (at step 4) as it would be a formal record of the option(s) agreed by *both* the relevant clinician(s) and the patient and would not be conditional on a future approval of a request for an assisted death.

Alternatively, we suggest that this stage of providing a written record of consent (and its scope) could be explicitly incorporated at the ‘planning’ step (step 6).

### **Rationale**

Steps 1-4 concern establishing the patient’s eligibility for an assisted death and, as such, whether an assisted death is an option for them. However, the consultation suggests that during the assessment stages (steps 2 and 3), the patient will be asked whether they wish to provide ‘confirmation of consent to proceed’ and/ or ‘a ‘waiver of final consent’ (see [paragraph 101c](#) and [paragraph 172b](#)). The consultation also states that a ‘confirmation of consent to proceed’ and/ or ‘a ‘waiver of final consent’ can be given at step 4, when the patient is making their second formal request (see [paragraph 143](#) and [paragraph 150](#)). (It is not entirely clear if the intention is that consent could be provided at any or all of these steps (i.e. steps 2,3 or 4) or just at step 4, when the patient makes their second formal request. Either way, the consultation envisages that consent would be sought *before* a final determination that a patient is eligible for an assisted death.)

We suggest that seeking consent at this stage (i.e. steps 2,3 or 4) may be premature, given the possibility that the patient might not be eligible for an assisted death. Although it is entirely appropriate to discuss these issues with patients, it is our view that an actual consent should *only* be sought after eligibility is established and the option of an assisted death is confirmed.

At [paragraph 14](#) of our guidance on ‘Treatment and care towards the end of life’, we set out a decision making model which makes clear that it is only *after* an assessment has been carried out and relevant options are

identified and offered that the patient decides amongst those different options.

Indeed, seeking consent after (rather than during) the assessment and approval stages seems to best meet the description of the purpose of the assessment, at paragraph 100 of the consultation document. This states:

*‘The purpose of the first assessment is:*

- a) For the person to fully explore, in dialogue with the doctor:*
  - their request for an assisted death and the fears, anxieties and suffering that gives rise to that request*
  - other care / treatment options and other ways to alleviate their fears and anxieties (for example, they may have financial concerns or concerns about being a burden on family carers)*
  
- b) for the doctor to determine if the person meets the eligibility criteria in law and, if so, on the grounds of*
  - Route 1 (terminal illness); i.e., they have a physical medical condition, which is expected to result in unbearable suffering that cannot be alleviated and are reasonably expected to die within six months or 12 months or*
  - Route 2 (unbearable suffering); i.e., they have an incurable physical medical condition, that is giving rise to unbearable suffering that cannot be alleviated in a manner that the person deems tolerable*
  
- c) to consider the decision-making capacity of the person.*

Finally, we suggest that the scope of the patient’s consent could also be clearly established and documented at this new step, including whether they wish to provide ‘confirmation of consent to proceed’ and/ or ‘a ‘waiver of final consent’. These decisions should be reviewed regularly.

At [paragraph 31](#) of our guidance on ‘Decision making and consent’, we set out the importance of being clear about the scope of decisions, so that patients understand exactly what they are consenting to. It goes on to explain that:

*‘Agreeing the scope of a patient’s consent with them in advance is particularly important if:*

- a. *treatment or care will be provided in stages with opportunities to review and adjust in between*
- b. *different healthcare professionals will provide different parts of the treatment or care*
- c. *there may be opportunity, once an intervention is underway and the patient's decision-making ability is compromised, to carry out another intervention*

Finally, [Paragraphs 56-59](#) of 'Decision making and consent' set out the importance of regularly reviewing decisions.

## 12. Period of reflection (see consultation report paragraphs 72-79)

The States Assembly agreed, in principle, that the assisted dying assessment process should allow a period of reflection, hence the proposed the minimum amount of time between the first request (step 1) and the end of life (step 8):

- 14 days minimum for those eligible under 'Route 1 (terminal illness)
- 90 days minimum those eligible under 'Route 2 (unbearable suffering)

**Do you agree with the proposed minimum timeframe for those with a terminal illness of 14 days? \***

- Yes - I agree
- No - I do not agree
- Don't know

Please tell us the reasons for your response

It is vital that patients have sufficient time and opportunity to reflect on their decision to end their own life, to ensure it is 'clear and settled'. This principle is reflected at [paragraph 27g](#) of our guidance on 'Decision making and consent' and is particularly important given the grave nature of the decision.

However, it is not clear that this requires a mandatory minimum timeframe (see [paragraphs 74-76](#) of the consultation), set out in legislation. The risk is that introducing such a timeframe would not allow for the exercise of flexibility and judgement in cases where a patient is suffering acutely, and this is unduly prolonged (for example, because the patient had been reflecting on their decision for a significant period of time before approaching the service). An alternative may be to introduce minimum timeframes in guidance, whilst allowing for any exemptions in exceptional circumstances (with the onus on decision makers to justify any deviations from guidance). The other benefit of covering this type of issue in guidance instead of legislation is that guidance is more amenable to being reviewed and amended (if necessary), as evidence bases develop and good practice evolves.

**13. Do you agree with the proposed minimum timeframe for those with unbearable suffering of 90 days? \***

- Yes - I agree
- No - I do not agree
- Don't know

Please tell us the reasons for your response

Please see our response to question 12 above.

**14. Key questions on Section 5 - assisted dying process: request and approval**

Duty on professionals to tell patients / not tell patients about assisted dying (see consultation report paragraphs 84-87)

It is proposed that the law neither prohibits health and care professionals from raising the subject of assisted dying with their patients or clients, nor requires them to do so. This means, for example, a GP could raise the subject with a terminally ill patient without waiting for them to raise the subject first or, conversely a GP could choose not to tell their patients about assisted dying.

**Do you agree that the law should not prohibit professionals for raising the subject of assisted dying? \***

- Yes - I agree
- No - I do not agree
- Don't know

Please tell us the reasons for your response

We agree that the legislation should be silent on this issue, but that this is an area that could be covered in guidance instead.

A blanket prohibition would mean that doctors would be prevented from exercising judgement and there may be situations where a patient has not actually raised the subject of assisted dying - but where the discussion is such that the clinician judges they would benefit from them openly bringing it up.

Addressing this area in guidance (rather than legislation), would allow for greater flexibility and personalised decision making. As outlined at question 12, it is also quicker and easier to review and amend guidance (if necessary) than it is to change legislation, as evidence bases develop and good practice evolves.

**15. Do you agree that the law should not place an explicit requirement on relevant professionals (e.g. those working in GP surgeries or hospital departments) to tell people about the assisted dying service? \***

- Yes - I agree
- No - I do not agree
- Don't know

Please tell us the reasons for your response

For similar reasons as those outlined at question 14, we don't believe that there should be an explicit requirement to inform people about the assisted dying service. Indeed, it may be inappropriate to do so with some patients. Discussions with patients should be tailored to their individual circumstances. For example, where the clinician is aware that they have deeply-held convictions about the sanctity of life.

In addition, it might be challenging to identify which groups/ categories of patients any such requirement would apply to, given that the assisted dying service is intended to be available for non-terminal patients who are experiencing ‘unbearable suffering’ (a predominantly subjective determination – see paragraph 198 and 199 of the consultation). For example, we would query the appropriateness of an explicit requirement to raise the issue with all accident victims with severe, life-limiting injuries – as it should clearly not be assumed that they are all experiencing what they would consider to be ‘unbearable suffering’.

We believe that these types of decisions should be matters of judgement, which will vary from case to case. In addition, as outlined above at question 12, covering this type of issue in guidance would allow for greater flexibility and personalised decision making. It is also quicker and easier to review and amend guidance (if necessary) than legislation, as evidence bases develop and good practice evolves.

#### 16. Second opinion (see consultation report paragraphs 116-122)

It is proposed that the law sets out that a person, who has been found to be ineligible for an assisted death is entitled to ask for one second opinion. This can be after the assessment by the Coordinating Doctor, if they are found ineligible at this stage OR after assessment by the Independent Doctor, if they are found ineligible at this stage, but not at both stages of the process as this would indicate that the person did not clearly meet the criteria.

**Do you agree that a person should only be entitled to one second opinion? \***

- Yes - I agree
- No - I do not agree
- Don't know

Please tell us the reasons for your response

It is not clear to us why legislation should limit a patient’s right to a single second opinion only. This may be unnecessarily inflexible and it might not be in line with our guidance, which states, at [paragraph 16e](#) of ‘Good

medical practice', that doctors should '*respect a patient's right to seek a second opinion*'.

In addition, it is not obviously true that just because a further second opinion is sought, this is evidence that the patient's case (for an assisted death) is not sufficiently clear and unequivocal. This is particularly the case if the co-ordinating doctor, who originally judged the patient not to meet the relevant criteria, is convinced by the second opinion doctor's overriding judgement. In this situation, both doctors would be in agreement that the patient meets the eligibility criteria.

17. Confirmation of consent to proceed (see consultation report paragraphs 143-146)

It is proposed that the law provides for the person to complete a 'confirmation of consent to proceed form', allowing the Administering Practitioner to take an appropriate intervention such as administering the substance intravenously, if, for example, a person who has self-administered the substance was to lose consciousness part way through ingesting the substance and hence does not die.

**Should the law allow for confirmation of consent to proceed? \***

- Yes - I agree
- No - I do not agree
- Don't know

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change. As such, we would not take a position on the circumstances when it should be possible to carry out an assisted death.

However, as long as there is no evidence that the patient may have changed their mind, this proposal would not be inconsistent with our guidance (in particular, see [paragraph 31](#) of 'Decision making and consent', discussed above at question 11).

18. Waiver of final consent (see consultation report paragraphs 147-156)

It is proposed that the law should include the option for the person to

complete a 'waiver of final consent'.

This is a document that is completed after the assessment process that confirms that the person wishes to proceed with an assisted death should they lose their decision-making capacity AFTER their request for an assisted death has been approved (Step 5) but BEFORE they are due to give their final consent (Step 8).

**Should the law allow for the option of a waiver of final consent? \***

- Yes - the law should allow for a waiver of final consent
- No - the law should not allow for a waiver of final consent
- Don't know

Please tell us the reasons for your response

As with question 17 above, this is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change. As such, we would not take a position on the circumstances when it should be possible to carry out an assisted death.

However, as long as there is no evidence that the patient may have changed their mind, this proposal would not be inconsistent with our guidance (in particular, see [paragraph 31](#) of Decision making and consent, discussed above at question 11).

In addition, at paragraph 35 of Decision making and consent, we state that:

*If a patient has a condition that is likely to impair their capacity as it progresses, [doctors] should sensitively encourage them to think about what they might want to happen if they become unable to make healthcare decisions.*

That said, if the law were to allow this, practitioners would need to be alert to any signs or behaviour that could suggest the patient's wishes had changed. We suggest that if this provision is included in legislation, this area will need to be covered in guidance.

Finally, from a conceptual point of view, the 'waiver of final consent' may be better described as a 'waiver of final *confirmation* of consent'. To make clear that consent to an assisted death has already been provided and is reasonably believed to have endured up until the time that the patient lost capacity.

## 19. Key questions on Section 5 – approval process

### Routes for approval (see consultation report paragraphs 189-203)

It is proposed that there are two different approval routes:

- a. Route 1 (terminal illness) which will entail approval by the Coordinating Doctor based on their assessment and that of the Independent Assessment Doctor (ie. two doctor assessments)
- b. Route 2 (unbearable suffering), which will entail approval by the Coordinating Doctor based on their assessment and that of the Independent Assessment Doctor (ie. two doctor assessments), and then confirmation of that approval by a specialist tribunal

### **Do you agree with the two different approval routes as proposed? \***

- Yes
- No - all approvals should be by the Coordinating Doctor based on their assessment and that of the Independent Assessing Doctor (i.e. 2 doctor assessments only for all requests)
- No - all approvals by the Coordinating Doctor should be confirmed by a Tribunal (i.e. a Tribunal involved in all cases)
- Don't know
- Other (please specify):

Please tell us the reasons for your response

The GMC does not have a position on this question.

### 20. Tribunal (see consultation report paragraphs 211-235)

It is proposed that the Tribunal:

- always reviews a decision of a Coordinating Doctor to approve a Route 2 assisted dying request (on the basis that it provides an additional safeguard)
- does not review a decision of a Coordinating Doctor not to approve as assisted dying requests (on the basis there can be an appeal to Court).

**Do you agree that the Tribunal should only review decisions of the Coordinating Doctor to approve Route 2 assisted dying requests? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

The GMC does not have a position on this question.

21. Appeals (see consultation report paragraphs 236-255)

**Do you agree that the Law should provide for appeals to the Royal Court? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

The GMC does not have a position on this question.

22. It is proposed that the law will provide for appeals to the Royal Court on the following grounds:

- whether the person has, or has not, been ordinarily resident in Jersey for at least 12 months
- a determination by either of the Assessing Doctors that the person has or does not have the decision-making capacity to request an assisted death OR the person's wish is, or is not, voluntary, clear, settled and informed
- a failure, or perceived failure, to make determinations or act in accordance process set out in law

**Do you agree with proposed grounds for appeal? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

The GMC does not have a position on this question.

### 23. Timeframe for appeals

It is proposed that there is at least 48 hours between a request being approved (Step 5) and the final review before the assisted death (Step 8) in order to allow an interested person to make an application for an appeal, if they think an assisted dying request should not have been approved, whilst avoiding protracted delay or distress for the person who has requested the assisted death.

**Do you agree with there should be at 48-hour time period between approval and the assisted death to allow for appeals?**

- Yes
- No – I do not agree, there should be no minimum time period for appeals
- No– I do not agree, there should be a time period longer than 48-hours
- Don't know

Please tell us the reasons for your response

The GMC does not have a position on this question.

### 24. Who can appeal

It is proposed that an appeal can be made by the person (or their agent) or an interested person (ie. a person who the Court is satisfied has a special interest in the care of the person such as a family member or close friend). It would not include a third party, such as a representative of a lobby group.

**Do you agree that the right to appeal should be restricted to the person (or their agent) or a person with special interest? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

The GMC does not have a position on this question.

25. Expiry of approval (see consultation report paragraphs 256-258)

It is proposed that there is no expiry date for an approval for an assisted death as a person should not feel pressured into ending their life on the basis that their assisted dying approval may expire.

**Do you agree that there should be no expiry date for the approval of an assisted death? \***

- Yes - I agree, there should be no expiry date
- No - I disagree, there should be an expiry date
- Don't know
- Other (please specify):

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change. As such, we would not take a position on whether or not an approval should expire after a certain period of time has elapsed.

However, if the legislation were to exclude an expiry date, we suggest that a system of regular review would need to be in place, to ensure that there have been no relevant developments that could have a bearing on the original approval. This could include, for example, ensuring that the patient's wishes and circumstances haven't changed. It might also include establishing whether there have been any significant therapeutic developments since the approval was granted, that could materially affect whether the patient remained eligible under the statutory criteria.

[Paragraph 58](#) of our guidance on 'Decision making and consent' states that:

*Reviewing a decision is particularly important:*

- a. *if you haven't personally had a discussion with the patient because they were initially seen by a colleague*
- b. *if significant time has passed since the decision was made*
- c. *if the patient's condition has changed*

- d. *if you have reason to believe the patient might have changed their mind*
- e. *if any aspect of the chosen treatment or care has changed*
- f. *if new information has become available about the potential benefits or risks of harm of any of the options that might make the patient choose differently.*

## **26. Key questions on Section 6 – assisted dying process – planning and delivery of an assisted death**

### Administering the substance (see consultation report paragraphs 295-302)

It is proposed that an Administering Practitioner needs to stay with the person, or nearby the person, at the time of administration as an additional safeguard in the unlikely event that something goes wrong.

#### **Do you agree that there should be an Administering Practitioner with the person or nearby?**

\*

- Yes
- No
- Don't know

Please tell us the reasons for your response

We agree that this should be a necessary safeguard, in the event something goes wrong. Indeed, the patient may have provided a 'confirmation of consent' in case the self-administration does not go to plan and an administering doctor would need to be present for precisely this type of eventuality. In addition, if the proposal to allow a loved-one to support the person to self-administer (see question 27 below) is taken forward, the doctor may need to be available or present in order to provide supervision.

27. It is proposed that a loved one (ie. friend or family member) may support the person to self-administer the substance as an extension of the care they may have been providing over previous days or weeks. This is to ensure the person is supported by their loved ones up until their last

moment, albeit it is recognised that not all jurisdictions permit loved ones to be involved.

**Do you agree that a loved one should be able to support the person to self-administer the substance?**

**substance? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change. As such, we would not take a view which different options for administering the medication should be legal, (other than that they should be safe and meet the patients' needs).

That said, it may be helpful to set out some GMC guidance relevant to this question.

We recognise that loved ones can play a vital role in supporting and helping to deliver care and treatment to their loved ones (see [paragraphs 17-19](#) of our guidance 'Treatment and care towards the end of life').

However, it is important to be clear that the treating doctor retains overall responsibility for their patient's care when, under their direction, particular treatments are being administered by others (including the patient themselves, with or without the help of loved ones). It is part of the doctor's responsibility to make sure that arrangements are appropriate and safe and that the person providing care has been suitably trained and has support.

Therefore, if the legislation were to permit a loved one to support a person to self-administer, doctors should ensure that arrangements are appropriate and safe for both the patient and the loved one. This may mean that supervision is needed, both to ensure that administration is carried out correctly, as well as to ensure that there are no signs to suggest that the patient may, in the moment, have changed their mind about proceeding with an assisted death. (See our response to question 18).

28. Recording the cause of death (see consultation report paragraphs 314-318)

It is proposed that the medical certificate of the facts and causes of death would reference the administration of the assisted dying substance as the cause of death. This would, in turn, be recorded in the register of deaths which is a public document.

**Do you agree that the medical certificate of the fact and cause of death, and hence the register of deaths, should accurately record the cause of death as assisted dying? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

We do not provide specific advice to doctors on how to fill in death certificates. However, our guidance (see [paragraph 71](#) of 'Good medical practice') makes clear that when completing certificates and other documents, doctors are expected to be honest and that any forms they sign should not be misleading.

## **29. Key questions on Section 7 – Regulation and oversight**

It is proposed that three distinct structures / systems are put in place to ensure the safety and quality of the assisted dying service. These structures include:

- an HCS Service Delivery and Assurance Board
- an assisted dying review committee to undertake a post-death administrative review of each individual assisted death
- independent regulatory oversight by the Jersey Care Commission.

**Do you agree that an HCS Service Delivery and Assurance Board is needed to provide oversight of the safety and quality of the assisted dying service? \***

- Yes
- No

- Don't know

Please tell us the reasons for your response

We agree that the service should be subject to oversight to ensure the safety and quality of the service, however it does not fall within our remit to comment on what form this should take.

**30. Do you agree that post-death administrative review of each assisted death is required? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

We agree that the service should be subject to oversight to ensure the safety and quality of the service, however it does not fall within our remit to comment on what form this should take.

**31. Do you agree that the Jersey Care Commission should independently regulate and inspect the assisted dying service? \***

- Yes
- No
- Don't know

Please tell us the reasons for your response

We agree that the service should be subject to oversight and regulation, however it does not fall within our remit to comment on what form this should take.

**32. Do you agree the Jersey Assisted Dying Service should not be considered as an essential service? (i.e. that the JCC should have the powers to close the service down) \***

- Yes - I agree, it should not be considered an essential service
- No - I disagree, it should be considered an essential service
- Don't know

Please tell us the reasons for your response

This is not a question that the GMC would take a view on, given that we do not take a position on whether the law on assisted dying should change.