SUBMISSION to the JERSEY CITIZENS JURY ON ASSISTED DYING
(prompted by two great principles: compassion and self-determination)

End of Life Choices Jersey wishes to see legislation that would establish a doctor's right to assist, without infringing the law, in the death of qualified adult[1] patients who are Jersey residents[2], by supervising the administration of lethal medication, typically by setting up an intravenous appliance which the patient can control to end their own life.

Even in cases of severe physical disabiity, modern technology usually allows such control to be exercised by the patient. Therefore it should not be necessary for the doctor to take more than a supporting role.[3]

Safeguards

To receive such assistance, patients would be required to have in place the following four documents, appropriately signed, dated and witnessed:

1. *Medical Document A*: (*Grievous Irremediable Condition*). Two[4] qualified medical professionals must certify that the patient suffers from a grievous and irremediable[5] condition, the nature of which has been explained to them, and which impacts on their quality of life in a way which they find unbearable. No predicted length of remaining life need be specified.[6] Note: only the health problem and its effects on the patient's life should be evidenced by doctors—the unbearability of those effects should remain solely a matter for the patient's own judgment.[7]

2. *Medical Document B*: (*Capacity for Discernment*). An appropriately qualified doctor must certify that the patient has the capacity to make such a decision, and that their decision does not arise from a treatable[8] mental condition such as depression.

3. *Patient Document A*: (*Own Considered Wish*).[9] This must state that having been fully informed of all possible alternatives, including further counselling and palliative care[10], it is the patient's carefully considered wish to be assisted to die, and that they have not been persuaded to this by any other influence, whether from family, friend or medical professional. This document must be signed, dated and witnessed on the day of the assisted death.

In those cases where the patient, though otherwise competent, is physically unable to sign, it should be sufficient for a verbal or other clear assent equivalent to the above to be recorded by assisting physicians.

4. *Patient Document B*: (*Consistency Over Time*).[11] If used, this would show that to be assisted to die as and when the relevant circumstances might arise has been the patient's consistent wish for an extended period (e.g. six months). The States could helpfully produce, alongside or within the Advanced Decision to Refuse Treatment, a document designed for this purpose, to record in advance a patient’s wish for a future assisted death.

However, for those with a short-term terminal diagnosis, an alternative version of the document should be accepted, which would demonstrate the patient’s consistent wish during the course of the illness.

Notes: - These are particular matters, arising within the above text, which we believe the Jury will need or wish to consider:

1. Age. In Jersey the age of majority is 18, and that is what we propose here. In rare, sad cases, the law might enable parents to decide with and for their children in this matter.

2. Residence. One might wish to help patients travelling from elsewhere, but we do not recommend that. Our hope is that UK law will soon make its own similar provision. Local cases are likely to be sufficiently few in number for our health service to handle effectively wthout extra infrastructure.

3. Euthanasia? Should the doctor be able to act on behalf of the patient, as opposed to only enabling them to act for themself? We think this will rarely arise, because a patient who is able to signal consent will be able by the same means to set off the procedure. However, a suitable 'living will' might also deal with this problem.

4. Doctors. More than one doctor to be involved, as a safeguard. We imagine (say) six doctors trained/qualified to handle this, of whom two would be available at any one time. It would not need to be a full-time specialty. No doctor would be obliged to take part.

5. Irremediable? Medical science advances—so what the doctors would be saying is that current medical knowledge/practice does not offer any hope of cure within a reasonable time.

6. Here we are asking you to reject the so-called 'Oregon model' which requires a prognosis of 6-months to live. Doctors generally do not like to be tied down to this or any other precise period, because progression/remission are inherently tricky to predict. Also morally, since we are talking about patients who find their life absolutely unbearable—otherwise they would not be candidates for assisted dying in the first place—how can it be just to say we will help the patient who is looking at under 6 months of this unbearable condition, but not the patient who is sentenced to a longer term, or to indefinite suffering? The latter patient is the more to be pitied and should not be less eligible for our mercy.

7. We should not ask doctors to decide whether a patient's life is bearable: only the patient can know that. Self-determination is central to this legislation. The doctors should be asked only to say that the patient's condition is 'grievous and irremediable.'

8. Depression is usually treatable, and so would not normally justify assisted dying—but cases vary: a severe long-term depression that has resisted treatment could itself meet the requirement of a "grievous and irremediable condition."

9. Own Wish. Central to what we propose is that the patient's own wishes be paramount. They must not be pressured either to die or to live on.

10. This is obviously an important safeguard.

11. Time. The jury might consider whether this last safeguard document is truly needed. In our view, assisted dying should never be a last-minute decision, but in any case, in practice, the documentation and the medical set up will always take some time to prepare. However, it is a difficult to say that there should be a mandatory minimum period of lead-in, and if so what that should be, because this might impact cruelly upon patients whose condition develops rapidly. So we recommend flexibility here.

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for End of Life Choices Jersey