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Voluntary Assisted Dying: The Impasse and a Way Forward

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Article abstract

The project to provide voluntary assisted dying (VAD) has grown significantly and at an accelerating rate over the past two decades in over 30 countries on four continents. Yet, concomitant with this rise is an increasing opposition to it based on legal, medical, and ethical grounds advanced by a wide range of detractors, giving pause to projects already underway, and bringing its enlargement to a halt. Simultaneously, persons seeking relief from suffering continue to be denied VAD access or are forced to wait for it by decreed compulsory living. Those assisting beyond the legislated parameters of a VAD regime are facing criminal prosecution. The contraposition to VAD has raised the risk of desperate persons seeking relief by committing violent suicide, endangering family, friends, and first responders. In light of this concerning development, I identify how the prevailing legislated approach at the source of these issues is both paradigmatic and problematic. Amendments to existing prohibitions for assisted dying or homicide become the foundation of an assisted dying regime that codifies its essential features, including client typology, life quality for service access or its denial, who is authorized to provide VAD, and when and how it can be administered. While this approach continues to be replicated extensively and has provided some relief to unbearable living, I show how an alternative, time-tested, evidence-based approach for VAD offers an optional pathway that could avoid many of the most challenging aspects of the prevalent model.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Voluntary Assisted Dying: The Impasse and a Way Forward

Juergen Dankwort[a]

Résumé

Le projet d'aide volontaire à mourir (AVM) s'est considérablement développé et à un rythme accéléré au cours des deux dernières décennies dans plus de 30 pays sur quatre continents. Pourtant, parallèlement à cet essor, une opposition croissante s'est manifestée sur la base de motifs juridiques, médicaux et éthiques avancés par un large éventail de détracteurs, ce qui a donné une pause aux projets déjà en cours et a mis un terme à leur expansion. Dans le même temps, les personnes qui cherchent à soulager leurs souffrances continuent de se voir refuser l'accès à l'AVM ou d'être contraintes d'attendre qu'il soit mis en place en raison d'une obligation de vie décrétée. Ceux qui aident au-delà des paramètres légaux d'un régime d'AVM s'exposent à des poursuites pénales. L'opposition à l'AVM a augmenté le risque que des personnes désespérées cherchant à être soulagées se suicident violemment, mettant en danger leur famille, leurs amis et les premiers intervenants. À la lumière de cette évolution préoccupante, nous identifions comment l'approche législative dominante à la source de ces questions est à la fois paradigmatique et problématique. Les amendements aux interdictions existantes de l'aide à mourir ou de l'homicide deviennent le fondement d'un régime d'aide à mourir qui codifie ses caractéristiques essentielles, y compris la typologie des clients, la qualité de vie pour l'accès au service ou son refus, les personnes autorisées à fournir AVM, ainsi que le moment et la manière dont il peut être administré. Bien que cette approche continue d'être largement reproduite et qu'elle ait apporté un certain soulagement à une vie insupportable, nous montrons comment une approche alternative, éprouvée et fondée sur des preuves pour l'aide à la mort volontaire offre une voie optionnelle qui pourrait éviter bon nombre des aspects les plus difficiles du modèle prédominant.

Mots-clés

aide médicale à mourir, euthanasie, suicide, politique de santé, éthique

Abstract

The project to provide voluntary assisted dying (VAD) has grown significantly and at an accelerating rate over the past two decades in over 30 countries on four continents. Yet, concomitant with this rise is an increasing opposition to it based on legal, medical, and ethical grounds advanced by a wide range of detractors, giving pause to projects already underway, and bringing its enlargement to a halt. Simultaneously, persons seeking relief from suffering continue to be denied VAD access or are forced to wait for it by decreed compulsory living. Those assisting beyond the legislated parameters of a VAD regime are facing criminal prosecution. The contraposition to VAD has raised the risk of desperate persons seeking relief by committing violent suicide, endangering family, friends, and first responders. In light of this concerning development, I identify how the prevailing legislated approach at the source of these issues is both paradigmatic and problematic. Amendments to existing prohibitions for assisted dying or homicide become the foundation of an assisted dying regime that codifies its essential features, including client typology, life quality for service access or its denial, who is authorized to provide VAD, and when and how it can be administered. While this approach continues to be replicated extensively and has provided some relief to unbearable living, I show how an alternative, time-tested, evidence-based approach for VAD offers an optional pathway that could avoid many of the most challenging aspects of the prevalent model.

Keywords

medical assisted dying, euthanasia, suicide, health policy, ethics

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PREVALENT APPROACH TOWARD VOLUNTARY ASSISTED DYING (VAD)

The prevalent model for sanctioned voluntary assisted dying (VAD) that is evolving around the world is, with few exceptions, created almost exclusively by lawmakers, placing licensed medical professionals centerstage in its implementation. It requires verification that the patient has given unequivocal consent and demands an incurable condition and cause of intolerable suffering for granting access to what constitutes active euthanasia. The design of all these regimes, commonly referred to by the acronym MAID (medical aid in dying), PAS (physician assisted suicide) or PAD (physician assisted dying), determines who may access them, where and when assisted dying can be done, and performed by whom. The similarity in their development lies in how governments first passed or amended existing prohibitions on assisting euthanasia through acts of parliament, chamber of deputies, or constitutional courts.

The approach has become a paradigmatic foundation for the establishment of regimes first set up in a US jurisdiction (Oregon) in 1997, and then in Belgium and the Netherlands in 2002, Luxembourg in 2009, Columbia in 2014, Canada in 2016, Austria, Spain, New Zealand, and Jersey (British Isles) in 2021, Portugal and all Australian states in 2023, and Ecuador in 2024. The ten US jurisdictions that have since allowed assisted dying likewise exist through specific legislation that also distinguishes medical aid in dying from the act of helping someone die by suicide, which is prohibited by statute and common law in most countries worldwide (1). Where assisted dying is allowed, only the US state of Montana has to date not legislated the creation of such a regime, while the practice by a physician is nevertheless protected through a Montana Supreme Court decision,

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citing its 2009 Rights of the Terminally Ill Act (2). Where there exists no absolute prohibition on assisted dying, only Switzerland, Germany, and the state of Montana presently have no legislated regime establishing the *modus operandi* of a VAD provision.

The complexity and challenge of establishing the minutiae workings of a VAD provision can be appreciated when examining in-depth the geneses of a typical legislated regime, such as the Canadian model with its subsequent amendments spanning over the past seven years. In anticipation of what was to come, a medicalized gateway to a VAD provision was at first understood and signaled as problematic to Canada's Supreme Court prior to its decision in 2015, in a factum presented by the Farewell Foundation for the Right to Die and the Association Québécoise pour le Droit de Mourir dans la Dignité (3). However, the Court nevertheless accepted a medically established system and instructed Parliament to legislate what became medical aid in dying (MAID) a year later, essentially modelled after earlier ones that had been set up previously in other jurisdictions. This particular sequential VAD history in Canada is relevant in comprehending the trend on how a legislated medicalized regime first evolved through a court decision overturning a prohibition for VAD, to become what is now the dominant legislated VAD apparatus worldwide.

A review of the Canadian model reveals its uneven, lengthy, and conflicted evolution, one that was marked by litigious contest advanced by those excluded from it and opposed by those alarmed at perceived harms from its further expansion. Initial legislation first defining VAD was twice appealed and amended through additional and lengthy court proceedings. Another promised revision to the latest legislation that would allow greater access has been twice delayed for several more years[1] (4). VAD has thus also become politicized, unreliable and unpredictable; its provisions today and in the future are subject to pressures from Parliament as well as outcomes of future elections, since governments can advance or reverse their course on any assisted dying measures.

One prominent issue with a legislated model regards a growing controversy where governments have defined access to VAD by establishing criteria through social policy proclamations regarding the quality of a person's life. If quality is deemed to be sufficiently bad, one gains acceptance for VAD; if a person is regarded as living with a painful but tolerable condition then they are obliged to continue compulsory living. When government becomes the arbiter on deciding this rather than an individual's personal experience of life quality, this highly subjective matter is elevated to an institutional level. Clearly, heated debates can be anticipated regarding the ensuing wide-reaching implications from the systematization of limiting personal autonomy to shield vulnerable populations, or the contrary, raising alarms that more autonomy will harm all of society. The criteria rests on the state's interpretation of what is acceptable or unacceptable for all. In Canada, for example, opponents for assisted dying, have argued that amendments to existing assisted dying law are unacceptable to allow others access, and that widening the gateway for MAID is now "infected by an expansionist ideology" that amounts to "a societal acceptance of euthanasia for almost anyone" (5). Any claims regarding respect for individual autonomy and complaints of discrimination by applicants wanting access are therefore to be denied. Foretelling similar opposition elsewhere, detractors in Canada are now pressing lawmakers to exclude persons whose intolerable suffering is "solely" grounded psychologically rather than physiologically and/or where death is not imminently foreseeable. The chorus of voices, even in the liberal media, is growing, and resounding: "Canada has gone too far!" (6).

Ethical, medical and legal issues are profound with any assisted dying provision, but they become intensified when elevated to a political plane and institutionalized. Even where Canadian court deliberations addressed such normative issues, imbroglios persist on how body and mind can be separated to exclude psychological suffering; that death can be predicted with certainty to exclude anyone else where it cannot be calendared; and that claims of autonomous decision making are "false" for anyone seeking the right to register an advance directive if later, as a disease progresses, that person lacks competence (e.g., dementia). Heightened, polarized positions then obscure more nuanced considerations. Persons suffering who are unwilling to gamble that a cure someday will appear on the horizon are not accounted for or are told to wait for a promised change in the law (7). Persons making claims on how singling out only certain illnesses or conditions for eligibility constitutes discrimination are dismissed as a case of "false discrimination" (8). In contrast, criticism is rarely, if ever, mentioned on how VAD eligibility based on illness, sickness, mental competency or age is demonstrably ableist, sanist, and ageist where enshrined in law. While such "-isms" may generally be regarded as unacceptable and unconstitutional in liberal societies, they nonetheless remain rooted within existing VAD access criteria and have yet to become salient in public forums (9).

Once raised to an institutional level in a legislated regime, as it has in Canada, criticism about MAID gained traction even when only based on inconclusive evidence citing grey literature, often with identical sensationalized narrative accounts in the media. Arguments against a MAID provision have included the notion that it may not be offered as long as inadequate health and social services, poverty, and other such social determinants exist, conditions allegedly driving people towards assisted euthanasia. Judgments typically conflate asking for MAID with receiving it; further, a person's right to VAD without criminal sanction where a state provides it remains unexamined (10).

The heightened criticism becomes alarmist and exaggerated (11); it is not mediated by mention of the courage and compassion of MAID providers. Instead, one is reminded how historically some health professionals have held a bias against minorities

[1] Subsequent legislation introduced a regime of two MAID pathways: Several restrictions from the initial regime (Bill C-14) were removed from what is now called "Track 1," a pathway for which an applicant previously had to have a "reasonably foreseeable natural death" (RFND). Bill C-7 added "Track 2," a new pathway for those with a serious disease, illness, or disability, and an "irreversible decline of capabilities, but who are not approaching their natural death." Promised legislation to allow access for persons suffering uniquely from a psychological affliction was to begin in March of 2023 but was postponed for another year, through legislation (Bill C-39). The Federal government then tabled Bill C-62 (an amendment to the Criminal Code) to delay MAID for this population for three additional years.

that would therefore place vulnerable persons at risk for unwanted euthanasia. Left out are considered and constructive ideas for alternative VAD regimes for what is claimed to be lacking in safeguards or oversight with the existing ones (12). While claims that Canada has become the Wild West for assisted dying with catastrophic consequences are arguably exaggerated, given the country's stringent access requirements and experienced providers, it is nevertheless exemplar of a heightened political drama resulting from the historical path that set MAID on its stormy course.

Evidence from presenters, including physicians, at the 2022 World Federation of Right to Die Societies Conference provided testimonials on how such struggles were not unique to Canada but are common elsewhere where VAD had been set up through the legislated approach (13). The consequences are notable. Whereas doctors previously facilitated end-of-life treatments congruent with medical evidence in an individual case, a reluctance to participate in VAD regimes has consequently emerged in light of widely publicized accounts in the media about its dangers (14). Reports from right-to-die organizations continue to chronicle such challenges and setbacks, detailing arduous legal efforts for an initially sanctioned gateway to VAD, or ongoing struggles to stop reversals for acquired VAD services (15,16).

An additional issue where a VAD regime was created legislatively regards the practice of criminalizing anyone who might be regarded as assisting or abetting in the suicide of another. Once carved out through laws that define its very operation, a presumption is established that any deviation involves breaking a law and so merits criminal prosecution. As noted below, persons have been prosecuted in jurisdictions that have legislated VAD regimes. Such roadblocks create uncertainty, and anxiety for anyone seeking relief, comfort, and control around death and dying, while creating a chill for both optional controlled dying innovation and research on VAD generally. This situation has even contributed to tensions among right-to-die societies within the right-to-die movement, thereby impeding inter agency collaboration for fear of being associated with an unsanctioned practice (17). It sends persons "underground" to find what is needed and produces an underworld market for VAD (18). Though convincing evidence is still lacking on how expanding a VAD regime's access allegedly leads to a slippery slope of harming the most vulnerable (19), it is plausible that increasing opposition and barriers will invite more impulsive, desperate suicides that traumatize and endanger friends, family, and first responders (20).

A full appreciation and understanding of the identified challenges that come with a legislated VAD regime raises the question of whether another approach to setting up a less institutionalized and successful VAD service might be possible. With such major existential questions at play, what approach might offer a way out of these predicaments? Which personal conditions are qualitatively acceptable for continued living or assisted dying, and should governments legislate life quality worthy of living? Should any deviation from standardized criteria institutionally codified by the state become criminal behaviour for anyone compassionately helping in an act that is not criminal? As suicide is no longer illegal in most jurisdictions that have now embarked on a VAD project, why is assisting suicide still illegal? Is there a way that these highly normative and substantive issues on death and dying can be negotiated less provocatively, more efficiently, and reliably?

AN ALTERNATIVE APPROACH

A recent European study contrasting two ways VAD services have been designed and how they function, identifies their relationship to their respective legal systems, the process of deciding who may access VAD, who may deliver it, and when the service may be provided (21). The legislated regime of Belgium – a prototype that informed Canada's and which resembles most existing regimes – was compared with the VAD process in Switzerland and serves as a useful example of how one might best develop a VAD option that could significantly avoid the pitfalls identified above.

The researchers premised their findings sociologically by first identifying the highly normative and complex elements involved, focusing on three different moments in the request for aid in dying: from initial contact with those authorized to help carry it out, to discussion of, and preparation for, the final gesture itself with its completion. They explain that any process requesting aid in dying involves the disciplines of law, medicine, psychology, and social work, and associations providing the service will inevitably be mindful of them. That is how a "socio-moral order surrounding death" is negotiated and achieved, and considers personal autonomy, self-determination, questions of vulnerability, dignity, integrity, and the welfare of others (21). The study revealed how Belgium sets out conditions and procedures, thereby formalizing the relationship between protagonists. For a Belgian applicant for VAD, such requests are always "humanly, relationally, and medically complex," and the applicant has to be monitored over a lengthy period to satisfy all the required medico-legal stages (21). Yet, the conditions and procedures were also liable to cause the applicant distress and discomfort. The researchers distinguish this process from what occurs in Switzerland where no pre-existing and legislatively designed framework exists, and where the request for, and access to, VAD are not regulated by the state.

Contrary to what some assume, assisting suicide in Switzerland is not legal if it is carried out for selfish, personal gain. It is also a misconception to assume that there are thus no medico-legal criteria in place. An added condition under which VAD is illegal establishes a very different socio-legal landscape for it than in countries or jurisdictions that have designed, inscribed, and implemented a legislated, medicalized process that implicitly or explicitly allows assisting dying. The authors note that norms underlying VAD in practice are not formally instituted or codified in the Swiss state. Instead, they were developed and are continually adapted in line with the experience of the helping services, but without ignoring criteria such as satisfying that the applicant is competent to freely request aid, and has reasonable grounds for the service, all verified by a validation step at the end of the process. Unlike in other jurisdictions, the physician is not directly involved in the final stage. The doctor-patient relationship is not omnipresent, as in Belgium, or set against a constant legal backdrop that enshrines physician authority and

creates a roster of specialists; instead, volunteers and applicants manage the procedure from beginning to end. This contrasts with a patient in Belgium and similar prevalent jurisdictions where one is never sure to obtain satisfaction, having first to negotiate within strict, legislated boundaries for permission to qualify. In Switzerland, the support process is managed differently and is more clearly separate from institutionalized power structures. This allows for a less overly political, less hierarchical, and less heterogeneous setting for the entire process. Whereas the centrality of a more vertical relationship between physician and patient "typifies the apparatus of euthanasia in Belgium," it is "… replaced with a more horizontal relationship … in Switzerland," one that is infused with subjectivities and a dialectic around different norms for aid in dying (21).

Lastly, according to the researchers, there was also evidence that this alternative approach to VAD conducted on a more individual and less formalized level is less likely to result in heated and polarized contention. This approach avoids precedent-setting, court-mandated proclamations encoding social policy for an entire country or jurisdiction. With ongoing and increasingly acrimonious responses to MAID in Canada, this different approach may present a welcome alternative setting for anyone involved. Physicians and others steeped in the procedure may be less concerned about crossing a legally set line (still obscure with its possible legal interpretations) juxtaposed against a backdrop of sensational media stories. Understandably, doctors who previously offered end-of-life treatment to mitigate suffering in Canada prior to MAID have expressed concern about doing so now in a highly publicized and inflammatory setting (22).

To be clear, no legislated system was erected in Switzerland that specifies through amendments or exceptions how, when, by, and for whom assisting suicide may be done. It has remained unlawful since 1937 in the Swiss Criminal Code with the decisive caveat if it is done for selfish motives (23). It does not insist on the specifics of a medical condition for its access and is grounded in a framework of informal custom instead of positive law. Both an altruistic motive of the helper and the decision-making capacity of the applicant who voluntarily requests this help comprise the legality of assisted dying. As others examining the legal landscape for VAD in that country have similarly noted, once the act of committing suicide was stricken from the legal code, claim rights emerged for persons seeking suicide assistance as well as for those providing it (24). A claim-right to control one's time and manner of death in Switzerland creates what amounts to a privilege of assisting suicide for anyone. No attempt is made through legislation to establish acceptable conditions for life or death, which is, therefore, symmetric with a recent German constitutional ruling on this matter and a possible forerunner for other jurisdictions across Europe and elsewhere to copy, whether liberal-pluralist or traditional-orthodox norms prevail.

In sum, significant differences were observed by the researchers that both reveal the challenges presently facing existing VAD regimes and suggest alternatives for consideration (21). The Swiss model was:

- less structurally hierarchical in decision-making,
- less institutionalized through legislation,
- less subject to resulting cultural and political opposition,
- unencumbered by delays to service based on lengthy court decisions regarding eligibility, best practice, who was authorized to perform the service, and
- more pliant as the normative decisions for service provision and administration could be determined by those immediately implicated on a case-by-case basis in line with changing health determinants.

GERMANY UPENDS THE PREVALENT APPROACH

In a remarkable judgment by the German Federal Constitutional Court in February 2020, regarding assisted suicide (25), a ground-breaking option for any country or jurisdiction contemplating the creation of an assisted dying regime was identified that may well avoid much of the controversy and many of the obstacles faced by existing ones. The German ruling signaled why legislatively establishing eligibility based on a person's state of health or, more generally, their quality of life, is unacceptable. That, in turn, suggests that a pathway to set up any VAD service needs to be based on an entirely different approach from the existing legislated model that began decades earlier in America and Europe.

The German Court's decision stated for the first time that matters of quality of life and degrees of suffering are wholly subjective and that governments should therefore neither prescribe nor proscribe assisted dying access based on population categories defined by individually experienced life determinants, because such restrictions would violate entrenched principles regarding personal autonomy and the liberal foundation separating state and personhood in pluralist societies. A VAD regime that adhered to this premise could then also avoid all expressed objections to assisted suicide which are no longer based on such normative criteria set up by governments (26). It is perhaps no coincidence that a German court deliberated the question in this way, given the heightened sensitivity for establishing any legislated standards regarding life quality or worthiness. It is in line with Germany's reconciliation over its dark history in the 1930s when the controversial state-implemented *Aktion 4* resulted in euthanizing individuals deemed to have an unworthy life (*lebensunwertes)*.

CONCLUSION

The legislated medical approach for VAD has been replicated in several dozen countries and jurisdictions on four continents. This approach, while not identical everywhere, generally follows the same formula of establishing exceptions to existing prohibitions on euthanasia, homicide or assisting suicide, through an explicit set of articles and amendments that in turn comprise the *modus operandi* of the provision itself. Attention to the many challenges and concerns that have accompanied

this development suggest it is instructive for others planning a VAD service to consider an alternative approach. Rather than adding amendments to a current prohibition on assisting suicide that specifies exemptions from criminal prosecution for designated providers who only accept the legally admissible, and setting up a state-run service, a simpler reformulation of the prohibition itself can offer a functional alternative. If left intact, and crafted with expert legal advice, the principal ban could more simply be conditioned by adding that assisting is criminal "*if done for selfish motives to exploit another against that person's will*." It would avoid establishing social policy comprising criteria that are arguably ageist, sanist, and ableist. It would bypass the need to create a complex legislated framework attempting to prescribe and proscribe a highly normative process, remove it from lawmakers, and instead place it aptly in the field of experienced health personnel. It would largely distinguish and separate a health provision from the criminal justice system, removing threats by prosecution of persons failing to act within rigid, yet often obtuse, legislated parameters such as the prosecution of Belgium doctors (27) and the recent arrest of a self-help group of Dutch septuagenarians (28).

If physicians are not considered as proprietary and inseparable from assisted dying in a legislated regime, it can avoid contrary outcomes regarding a person's right to life, liberty and security of the person and the right to self-determination. In the Canadian Supreme Court case, the 2015 ruling found that criminal laws prohibiting assistance in dying limited those rights under section 7 of the Canadian Charter of Rights and Freedoms. In the Netherlands, a jurisdiction with a legislated medicalized model, its Supreme Court ruled in the Albert Heringa case that a plea by a patient for more self-determination for assisted dying after a physician declined its approval could only be considered within the legislated framework of physician-assisted dying as enshrined in the Dutch Euthanasia Act. It was therefore denied by the Court. Even the European Court of Human Rights (ECHR) could not agree to counter that decision. It had previously explained that the *protection of life* in article 2 of the European Convention of Human Rights does not also confer a right to die, nor for an individual to choose death rather than life (29). Notably, in the Canadian Supreme Court ruling there was no regime in place when the 2015 milestone decision was rendered. In the Netherlands, there already existed a legislated medical regime that was referenced by the ECHR for its refusal to support the plaintiffs. Assisted dying had been monopolized, medicalized, and fully controlled by government legislation, subsequently referenced as acceptable law and not contrary to European law. As a group of researchers in New Zealand noted in their 2021 study on the question of autonomy regarding end-of-life options, a medical legislated regime of assisted dying, while offering a new provision for those suffering and wishing to die, paradoxically "reinforces health professionals as in control of the circumstances in dying thus limiting freedom for the dying person" (30).

While additional research is necessary to further validate assumptions and conclusions from the European study discussed above (21), other researchers have provided confirming information with similar observations regarding VAD practice within the legal Swiss framework (31,32). There exists ample descriptive material now in the literature that could facilitate building a similar regime elsewhere, that takes into account existing practices, the legal landscape, medical roles, ethics, demographics, cultural, and socioeconomic determinants.

The World Federation of Right to Die Societies and the US-based Final Exit Network have identified at least eight countries and more states or jurisdictions that are in a planning mode for establishing a VAD service. Countries and jurisdictions exploring a VAD gateway might consider taking a different route such as the one illustrated by the current Swiss approach and validated by a constitutional decision providing an added legal foundation by its European neighbour. An established legal principle provides a foundation for this approach, i.e., that one cannot be punished for something that is not defined by law to be illegal, known as *non poena sine lege*. This is what allows the Swiss service to function as it does, and why applicants who have been denied VAD in their own countries travel to that country for their VAD. This includes persons from progressive regimes such as Canada, for whom MAID (VAD) has nevertheless either been denied for one reason or another, or who consider MAID's pathway regarding a personal, private end-of-life decision as unacceptable, intrusive, and overly cumbersome. The Swiss way is accomplished by leaving its administration to those experienced and working in service organizations established for its delivery, implemented on a case-by-case decision that is negotiated by those on the ground and who are directly implicated. It signals an alternative approach, unincumbered by legislative boundaries that define and direct the VAD provision. This approach also bypasses the problems with a government legislating controversial social policy regarding acceptable or unacceptable life quality. Further, VAD need not function in an apparatus that must continually chase after variable medical circumstances. The realm of medicine is, after all, continually changing and adapting with recent discoveries, new or revised remedies, all bearing on diagnoses and prognoses. In a legislated regime, the legal framework must continually play catch-up to this mercurial world of medical science, as legislated VAD providers must regularly perform best practice within an exacting legal framework.

When a jurisdiction is considering a project for a VAD provision, it should include an appreciation for a provision where the apparatus might not necessarily be a government instrument and avoid ipso-facto that assisted dying be treated as a crime. Setting standards for a public, state-operated VAD service may be reasonably argued as necessary to protect the most vulnerable in society, as that is understandably the mandate where the provider is society's representative (the state). However, even that does not automatically signal the need to punish anyone who chooses a different course to end their life. It is thoughtless to conflate the matter of a state providing the VAD service and criminalizing anyone assisting in a death. There is a clear difference in establishing the complicated project of reasonable criteria for any assisted dying provision and justifying a rationale for punishing persons who assist a person in dying when that person has freely and without inducement sought this relief. Case law, for example, has already demonstrated where this distinction has been recognized and appreciated. Suzanne Ost in her study revealed how relative-assisted suicide (RAS) went unpunished because motives for helping were regarded as compassion-driven although an absolute prohibition on assisted dying exists in the UK (33). This exoneration from

what otherwise would likely have landed relatives in prison as per the law is also congruent with public opinion on assisted dying, where it is implicit in questions posed that no other way exists outside of a legislated regime. It is noteworthy that where polls increasingly indicate a favourable view for VAD in principle, the most reluctance consistently shows for cases where medical knowledge is fraught with ambiguity regarding, for example, provision for persons solely suffering from somatic pain. But as Ost noted, a better death can arguably be made where one's relatives or other loved ones can accompany the person and be involved with the act itself in the place of, or in addition to, health professionals on this final journey for a peaceful, reliable, and painless end. Such consideration in assisting or abetting is then the opposite from where a prosecutor has produced evidence of direct, personal support to obtain a conviction of helpers as in the recent pursuit of the Dutch septuagenarians and Belgium doctors. The Swiss model points to how one can have medico-legal standards in place, but not as a function of a criminal code, for assisting a person to die. That represents an important opening and reflection when looking at prevalent models for replication by those who do not yet have a VAD pathway in place. A perceived absence of a framework for an assisted dying provision does not have to follow the prevalent legislated approach to address the *vacatio legis*. It points to an alternative approach that may offer a better way forward. It may even be possible to have both a publicly-funded, state-run service as well as allowing alternative VAD to take place without the threat of criminalization.

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