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# Assisted Dying/Assisted Suicide in the UK: An Idea Whose Time Has Come?

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## ABSTRACT

Assisted dying/assisted suicide (AD/AS) has emerged as an important policy issue across the world, with an increasing number of jurisdictions legalizing the practice in recent years. In this context, the article by Bache published earlier this year (2025) in *Politics & Policy* applied agenda-setting theory to consider why AD/AS has not been legalized in the United Kingdom (UK) despite consistently high levels of public support. In addition, it considered the prospects for policy change and identified the factors that made policy change likely in the near future. Shortly after this article was published, a Parliamentary vote indicated that AD/AS would likely become available in the UK within a few years. While the original article outlined a range of factors that explained this probable policy change, it offered very limited space to consider developments in other jurisdictions and to reflect on what might be learned about the nature, pace, and timing of developments in the UK from these cases. Therefore, this additional piece is intended to extend and update the previous article in these areas. The discussion looks at the three cases that have featured most prominently in UK debates, and which have legalized through different routes—Oregon (referendum), Canada (courts), and the Netherlands (legislature)—thus drawing attention to systemic differences that provide insights for the UK case. I situate the discussion within the literature on morality policy, taking the comparativist "Two Worlds" approach as its starting point.

**Related Articles:**

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## RESUMEN

La muerte asistida/suicidio asistido (DA/SA) se ha convertido en un importante tema de política pública en todo el mundo, con un número creciente de jurisdicciones que la han legalizado en los últimos años. En este contexto, el artículo de Bache, publicado en este año (2025) en *Politics & Policy*, aplicó la teoría de la "agenda-setting" para analizar por qué la DA/SA no se ha legalizado en el Reino Unido a pesar del alto apoyo público constante. Además, consideró las perspectivas de cambio de política e identificó los factores que la hacían probable en un futuro próximo. Poco después de la publicación de este artículo, una votación

parlamentaria indicó que la DA/SA estaría disponible en el Reino Unido en pocos años. Si bien el artículo original describía una serie de factores que explicaban este probable cambio de política, ofrecía un espacio muy limitado para considerar los avances en otras jurisdicciones y reflexionar sobre lo que se podría aprender sobre la naturaleza, el ritmo y el ritmo de los avances en el Reino Unido a partir de estos casos. Por lo tanto, este artículo adicional pretende ampliar y actualizar el artículo anterior en estas áreas. El debate examina los tres casos que han ocupado un lugar más destacado en los debates del Reino Unido y que se han legalizado a través de diferentes vías (Oregón (referéndum), Canadá (tribunales) y los Países Bajos (legislatura)), llamando así la atención sobre las diferencias sistémicas que ofrecen información para el caso del Reino Unido. Sitúo el debate en la literatura sobre políticas morales, partiendo del enfoque comparativista de los «dos mundos».

Assisted dying/assisted suicide (AD/AS) has emerged as an important policy issue across the world, with an increasing number of jurisdictions legalizing the practice in recent years (see Bache 2025a, 1). This trend is often seen as emerging from the rise of individualism, as the right to die is increasingly viewed as an extension of "the choice and control people now expect to have in all aspects of their life" (Richards 2016, 66). In this context, my article earlier this year in *Politics and Policy* (Bache 2025a) applied agenda-setting theory and the multiple streams framework (Kingdon 2011) in particular to consider why AD/AS has not been legalized in the United Kingdom (UK) despite consistently high levels of public support. In addition, it considered the prospects for policy change and identified the factors that made policy change likely in the near future.

In the postscript to the original article it was noted that in September 2024, Kim Leadbeater MP came first in the Private Members Bill (PMB) ballot and put forward a bill on AD/AS—the Terminally Ill Adults (End of Life) Bill. This would be the first House of Commons vote on the matter since 2015, when the vote against legalization was carried by a resounding 330-118 and settled the issue for some time to come (even though the scale of MPs voting against AD/AS contrasted sharply with the scale of public opinion in favor). Thus, it was after almost a decade of AD/AS debates and developments operating in the shadows of mainstream politics that the Leadbeater Bill brought the issue back into the center of media attention and public debate. And, by this point, much had changed in relation to the issue since 2015 that made policy change more likely. In particular: there had been shifts to neutrality on the issue by key medical associations who had traditionally been opposed; religious influence had declined; evidence from other jurisdictions where legalization had taken place was increasingly used in debates; and generational and political changes in the composition of the House of Commons since 2015 were seen to favor the pro-legalization side (Bache 2025a; see also Bache 2025b).

Thus, it was no great surprise to those close to the issue that on November 29, 2024, the House of Commons voted 330-275 in favor of the principle of AD/AS as set out in the Leadbeater Bill (i.e., for mentally competent adults with less than 6 months to live). The Bill then went into committee stage before a third reading and final vote in the Commons on June 20, 2025. The Bill passed this time by 314 votes to 291 before going to the House of Lords for further scrutiny. This is how things stood at the time of writing this update. However, it was generally thought "likely, although not guaranteed" that the House of Lords would approve the bill later in 2025, which would allow ministers up to 4 years to implement the provisions (BBC 2025).

While AD/AS had appeared on the parliamentary agenda through PMBs several times since the 1990s, it was not until this point that the politics stream had connected sufficiently to the policy and problem streams in order to facilitate policy change (see Bache 2025a). While the various factors highlighted above were crucial in moving developments toward policy change, the tipping point was arguably the outcome of the 2024 UK general election. Here, the number of Conservative MPs returned fell to 121, compared with 330 at the time of the 2015 AD/AS vote, while both the Labour Party and the Liberal Democrats significantly increased their Parliamentary presence. The impact of these changes was evident in the third reading vote in the Commons, when Labour MPs voted 224-160 in favor of the Leadbeater Bill, Liberal Democrat MPs 56-15 in favor, and Conservative MPs 92-20 against.

So, at the time of writing, developments pointed to AD/AS becoming available to terminally ill adults in the UK within a few years. In the original article, it was noted that the acceleration of legalizing AD/AS in other jurisdictions played an increasing role in UK debates. In particular, these developments gave confidence to pro-AD/AS campaigners to argue that a safe, robust, and resilient law could be introduced in the UK. However, there was very limited space in the original article to consider developments in other jurisdictions and to reflect on what might be learned about the nature, pace, and timing of developments in the UK from these cases. This is the purpose of the present discussion, which looks at the three cases that have featured most prominently in UK debates, and which have legalized through different routes—Oregon (referendum), Canada (courts), and the Netherlands (legislature)—thus drawing attention to systemic differences that provide insights for the UK case. The present study situates the discussion within the literature on morality policy, taking the comparativist 'Two Worlds' approach as its starting point.

## 1 | The "Two Worlds" Approach

Engeli et al. (2013) build on earlier work (Green-Pedersen 2007; Engeli et al. 2012), in identifying "Two Worlds" of morality politics: a religious world in which party systems embody a significant conflict between secular and confessional (religious) parties, and a secular world where there is no conflict of this type. Here, the "religious world" refers specifically to the nature of party conflict and not to the religiosity of the jurisdiction as a whole. In the religious world, secular-religious party conflict on morality issues is usually present because of the prominence of Christian Democratic parties. The Two Worlds approach argues

that, because of this conflict, jurisdictions in the religious world tend to be more permissive on morality policies because there is an electoral advantage to be gained by Christian Democrats' opponents in giving prominence to morality issues that have high public support. By contrast, jurisdictions in the secular world generally lack the conflict line that leads to politicization, and parties tend to avoid morality issues. Thus, while religious arguments still feature in debates in the secular world, they play only a very limited role in party politics. Here, parties allow a free vote in parliament and "policy processes depend on the interests that can be mobilised around a particular issue and the initiatives of individual MPs and interest groups" (Green-Pedersen and Little 2021, 1394). Moreover, in the absence of party competition on morality issues, public opinion is less important than in other policy areas (Engeli et al. 2012, 196).

This distinction between religious and secular worlds provides a theoretical framework for understanding "how different factors interact to determine policy choices and how the dynamics of political conflict make policies change or remain stable over time" (Engeli et al. 2012, 194). However, while the Two Worlds approach can help explain why morality policies are taken up by parties in religious but not secular systems, it does not account for differences *within* the secular or religious world. Thus, in the case of AD/AS, legalization is present in parts of the secular world, but not in others; and in parts of the religious world, but not in others.

Studies adopting the Two Worlds approach have provided contrasting empirical findings on some key issues. For example, some studies have found that the relative strength of parties with different values matters significantly for morality policy change (e.g., Schmitt et al. 2013; Heichel et al. 2013). On this, Willmott and White (2021, 264) argued that "generally speaking, changes are more likely to occur with progressive governments." However, other scholars have found that "the colour of the government generally matters less, with both left and right-wing governments introducing morality policies" (Engeli et al. 2012, 196). As such, while the Two Worlds approach provides a useful starting point for highlighting key systemic features, it is important to go beyond this to understand the importance of context-specific dynamics in each case.

While taking a comparative approach allows for analysis of the role of the systemic features, placing the UK case into a broader international perspective has other advantages. In particular, it highlights the importance of international norms and international trends: an aspect that has been neglected in studies of morality policy until relatively recently (Heichel et al. 2013, 330). In particular, it brings into view the potential for policy diffusion across jurisdictions. Thus, the understanding of international processes and their potential influence on domestic politics matters for morality policy.

## 2 | Comparative cases

We now turn to our comparative cases, two of which (Oregon and Canada) are in the secular world with the UK and the Netherlands in the religious world.

### 2.1 | Oregon

A major turning point in the history of AD/AS legalization came in 1994, when the Oregon Death with Dignity Act was passed. The Act allowed "terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose." The Act came through a ballot initiative led by the activist group *Oregon Right to Die*, which was passed with a majority of 51% to 49% in November 1994. However, implementation of the law was delayed until 1997 because of legal challenges by the National Right to Life Committee, who claimed that the law was unconstitutional because it denied terminally ill patients the protection of laws intended to prevent suicide and forbid manslaughter (Yount 2007, 30). By the time the legal challenges had ended, supporters of legalization had put the issue on the ballot for a second time in November 1997. This time the vote was more decisive, with 60% in favor.

Various explanations are offered for why Oregon became the first US state to legalize AD/AS. The first is that it learned from previous failures of ballot initiatives in California in 1988 and Washington in 1991 (Stefan 2016, 153), which themselves had followed on from unsuccessful bills in their state legislatures. In particular, the Oregon initiative addressed fears expressed in those cases of powerful physicians administering lethal medications (euthanasia) by stipulating that AD/AS would be through self-administered medications only. Also, the Oregon Act provided additional safeguarding clauses and would make AD/AS available only to state residents, which addressed concerns that the first state to legalize would become the focus of "suicide tourism." Oregon's law additionally clarified that "Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide."

The second explanation for the success of the initiative relates to Oregon's political culture. Along with California and Washington, Oregon was seen as "liberal on personal freedom and individual rights" (Glick and Hutchinson 1999, 756), with Oregon viewed as a particularly independent territory. It was the first state to implement the citizen's initiative process and had a long history of using this as a tool of legal and social change in defiance of both organized religion and outside political pressure (Purvis 2012, 274). It also had a history of resisting authoritarian decision-making in the field of health care and, in this context, public support for AD/AS was consistently favorable.

Third, along with California and Washington, Oregon is one of the least religious states in the US. At the time of the ballot initiative, only 12% of the Oregon population identified as Catholic and 62% were "unchurched" (Ball 2012, 133). This helped neutralize the influence of the Catholic Church, which was the lead opponent. Moreover, at the time of the initiative, anti-Catholic sentiment was heightened due to the Church endorsing a controversial measure that undermined state protection for gay people. Advocates of the Death with Dignity legislation exploited this hostility by attacking the Church's active role in politics. Although the Church changed its strategy after its defeat in 1994 to focus more on the potential for misdiagnoses and clinical failures rather than religious arguments, neither strategy succeeded (Purvis 2012).

The fourth reason identified for Oregon's success was that, unlike previous initiatives, it had the active political support of the state governor, Barbara Roberts (Stefan 2016, 152). Her husband, State Senator Frank Roberts, had been a passionate advocate for AD/AS before his death from cancer in 1993, having tried unsuccessfully to introduce bills in 1987, 1989, and 1991. In 1991, his bill was given a courtesy hearing, which Barbara Roberts described as a "watershed moment," noting that: "It was the first time some of [the legislators] who supported it knew that other people they knew supported it ... At that point, the world changed" (Roberts 2019).

Finally, Oregon was the first case where the state medical association did not take an active role in opposing legislation, instead remaining officially neutral. This reflected the evenly divided views of its membership but was also influenced by the initiative eliminating the requirement that physicians administer the lethal injections (Grossman 2021, 298). For some, the neutrality of the Oregon Medical Association (OMA) was the most important factor in the 1994 vote (Stefan 2016, 142). Although the OMA changed its position after 1994, following lobbying by Catholic organizations and right-to-life campaigners (Purvis 2012, 277), it was unable to stop the momentum in favor of legalization.

In the first half of 1997, the US Supreme Court was required to consider the question of actively hastened death for the first time (Yount 2007, 30). In June 1997, the Supreme Court upheld state laws banning AD/AS and ruled that there was no constitutional right to die. However, nothing in the ruling suggested that laws permitting AD/AS were any less constitutional than those forbidding it and, as such, the ruling allowed individual states to decide independently on the issue, thus allowing Oregon to proceed.

There was to be no immediate spread of the law beyond Oregon. Michigan rejected AD/AS in 1998 and Maine followed in 2000. Proponents of the legislation believed that the experience of religious opponents in Oregon inspired them to organize more effectively and campaign more aggressively in these cases (Dowbiggin 2005, 174). However, by 2024, 10 other US jurisdictions had legalized AD/AS. Of these, nine were mandated by state law and two (Montana and California) by court ruling. Many of these states followed the requirements of the Oregon model (Carstens 2021, 185).

## 2.2 | Netherlands

As in many other Western countries, attitudes toward AD/AS began to change in the 1960s as issues of individual rights and personal autonomy came to the fore and religion and religious institutions began to lose influence. In 1969, the psychiatrist D.J.H. van den Berg published a book challenging established medical ethics by arguing that there were cases in which prolonging human life made no sense. At a time when the medical establishment was firmly against AD/AS, the attention it generated "started the euthanasia debate in earnest" (Cohen-Almagor 2002, 99). However, the major turning point came early in the following decade.

In 1973, the physician Geertruida Postma was found guilty of murder for responding to her terminally ill mother's request for death by giving her a fatal injection. However, while Postma was convicted, her punishment was only symbolic. Moreover, the court signaled that there may be circumstances in which a physician could shorten a patient's life: circumstances that would be clarified and formalized in subsequent case law. This first euthanasia test case in the Netherlands broke social taboos linked to Christian traditions and also "reflected a wave of awareness among many young medical professionals about the limits of medical care and patients' self determination" (Rietjens et al. 2009, 272). It was in this context that the Dutch Euthanasia Society was formed in 1973 and public support for AD/AS began to rise. Sensing the changing public mood, politicians also began to respond.

From the mid-1970s, political parties began to include policies on euthanasia in their manifestos, and in the 1980s the government set up a State Commission on Euthanasia in response to public concerns. In 1984 the first bill aiming to legalize euthanasia was introduced in Parliament. These developments put pressure on the Liberal/Christian Democrat coalition government to act on the issue. However, through a variety of strategies, the government delayed significant action, while secular parties tried to keep the issue alive and "mobilize politics around the religious/secular conflict to challenge the dominant position of the CDA [Christian Democrats]" (Green-Pedersen 2007, 281–282), knowing that public support for AD/AS was high. Alongside these political developments, court cases kept the issue in the public domain, while medical opinion was also becoming more permissive.

A key moment in the history of AD/AS legislation in the Netherlands came in 1994 when the parliamentary elections returned a government without the CDA for the first time in 75 years. Instead, the new government consisted of social democratic and liberal parties that had previously supported AD/AS. This government brought forward a change in the criminal code to decriminalize AD/AS, which was approved in 2001 and resulted in the Euthanasia Act of 2002. Within the Netherlands, the Act was widely seen as symbolic: the courts had already provided *de facto* legalization, and AD/AS had been widely practiced before 2002. The main purpose of the Act was to legally exempt from punishment those physicians who complied with the requirements of due care in relation to AD/AS. The guidelines developed were similar to those that accompanied the law in Oregon. However, one major difference was that while in Oregon the patient had to be suffering from a terminal illness, in the Netherlands the patient's condition did not need to be terminal or even physical. Further, while the Oregon law only permitted self-administered medications, the Netherlands law also covered euthanasia; a reflection of higher levels of doctor-patient trust than in the US (Patel 2004, 52).

Beyond the trends evident in many other Western countries at the time (e.g., toward individual rights), several domestic factors have been identified to explain why the Netherlands was an early adopter of AD/AS. Of particular importance were: the permissive nature of Dutch culture and society; permissive court judgments; the strong doctor–patient relationship; and the

liberal and ultimately active contribution of the Royal Dutch Medical Association (Pijnenborg 1995; Cohen-Almagor 2002; McCann 2015). However, the nature of the party system played a critical role in the timing of legislation. The religious-secular cleavage gave the Christian Democrats' opponents a strong incentive to politicize AD/AS, as many of the CDAs supporters opposed the party's position on the issue (Green-Pedersen 2007, 277).

### 2.3 | Canada

In February 2015, the Supreme Court of Canada (SCC) ruled in the case of *Carter v Canada* that mentally competent adults who were suffering intolerably and permanently had the right to physician-assisted dying. Historically, all forms of euthanasia had been a criminal offense, but the Court found that this prohibition violated Section 7 of the Canadian Charter of Rights and Freedoms, which states that "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (Government of Canada 2022).

The first case on AD/AS referred to the SCC had been *Rodriquez v British Columbia* in 1993. Rodriguez, a woman with a degenerative neurological condition, had argued that the prohibition of euthanasia violated her rights under Section 7. However, by a margin of 5-4, the Court ruled that a universal prohibition on Medical Assistance in Dying (MAiD) was demonstrably justifiable as it served to protect the vulnerable, noting the "consensus among 'western countries' prohibiting assisted suicide" (Downie 2022, 323). However, by 2015 when the law was next challenged, there was evidence from Oregon, Washington, the Netherlands, and Belgium claiming that it was possible to protect the vulnerable without prohibiting everyone from accessing MAiD (Downie 2022, 329). By a margin of 9-0 the Court ruled that the blanket prohibitions on MAiD found in the criminal code violated the Charter, thus allowing access to MAiD for those suffering a "grievous and irremediable medical condition" causing intolerable suffering.

The Court's ruling was suspended for 12 months to allow the government to draft legislation and policies to comply with the ruling, although the government was under no obligation to do so: had it not responded, MAiD would have been regulated through the provincial/territorial administration of health care, and the regulation of health care providers through their provincial/territorial colleges (Downie and Chandler 2018, 5). After a change in government (from Conservative to Liberal) within the 12-month window, the Court extended the period for a response by 4 months. In June 2016, the incoming Liberal Government passed an Act allowing for both euthanasia and self-administered medication.

As in the Netherlands, the practice of AD/AS was happening in Canada before legalization. As Downie (2022, 323–324) put it: "the police knew, but people were either not being charged or were being charged only to then receive suspended or very light sentences as part of plea bargains." Moreover, while the issue was ultimately forced onto the governmental agenda by the Carter ruling, there had been 16 previous attempts to change the law: 15 Private Members' Bills (PMBs) and one motion introduced into the House of Commons. It was an issue that commanded significant public support, with 78% of the public agreeing with the Supreme Court's 2015 ruling (Research Forum 2016, 1).

Initially, the Canadian Medical Association refused to take a position on the Carter v Canada case. In its submission to the Court, it stated that whether MAiD should be legal was "for lawmakers, not medical doctors, to determine" (Tatalovich 2020, 63). It also emphasized that physicians should not be compelled to participate in MAiD and that those who did not participate should be given legal protection. However, after the Court ruled, the Association became involved in the development of the law and policy and in training its members to implement the ruling (Roehr 2018, 2).

Snow and Puddister (2018) noted that the Conservative government initially moved slowly following the Court's judgment, with the Prime Minister reluctant to introduce legislation on contentious moral issues that were problematic for the more socially conservative members of his party. However, the Liberal government was far more amenable to change. The Liberals had "long positioned themselves as the Charter party" and had "also promised to 'restore dignity and respect to the relationship between government and the Supreme Court'" (Snow and Puddister 2018, 50). Despite controversial aspects of the bill, it received royal assent on June 17, 2016.

## 3 | Comparative Analysis

Taking a comparative approach and drawing specifically on the insights of the Two Worlds approach provides a number of insights on the nature, pace, and timing of developments in the UK case. First, the comparative perspective highlights the importance of the potential venues for change. Thus, while in the Netherlands legalization took place through parliament because of religious-secular conflict, early attempts at change via legislatures in the secular world of the US and Canada proved fruitless. In the United States, campaigners had to turn to the ballot initiative for their initial successes, and, in Canada, decisive change came via the Supreme Court. Neither of these routes is open to UK campaigners as viable alternative venues to the legislature for changing the legal status of AD/AS, thus contributing to the maintenance of the status quo position for a sustained period. In addition, the Two Worlds approach places the UK firmly in the secular world and thus highlights the absence of religious-secular party conflict as central to understanding the extended period of legislative stasis on the issue.

The comparative perspective also highlights the potential of learning from other jurisdictions and for policy diffusion, with evidence from elsewhere of increasing significance to UK developments over time; most importantly, the adoption of the Oregon model by pro-AD/AS campaigners. This model was adopted partly because Oregon was seen to demonstrate that a 'slippery slope' from a narrow law covering just the terminally ill to broader legislation is not inevitable, thus heading off a potentially damaging line of criticism from opponents. The potential for policy diffusion is also possible within the UK, for example from England and Wales to Scotland (or vice versa).

It is clear that in all three cases reviewed here, public opinion, the role of courts, religion, the position of medical associations, and political support were key factors leading to policy change. How then does this relate to the UK? First, sustained public support for AD/AS is an important prerequisite for legalization and has long been present in the UK, but, as with other cases, is not decisive. Second, the courts have played a central role in the comparator jurisdictions but have arguably been less significant in the UK: they have been important in raising the profile of AD/AS and in requiring Parliament to consider the matter, but have ultimately deferred to Parliament on the substantive issue of legalization. Third, religious opposition to legalization is also a common feature across cases but has become less significant in the UK over time, as with the comparator jurisdictions. Fourth, the position of key medical associations has been important in the comparator jurisdictions, and this has been the case in the UK also, with the shift to neutrality of some key UK associations removing a major obstacle to legalization.

Finally, and decisively, the political support for AD/AS that has been evident in the comparator jurisdictions has been largely absent in the UK until relatively recently. According to interviewees, opposition to AD/AS had begun to soften in Parliament before the July 2024 general election due to the impact of the developments described above. However, the change in the composition of Parliament after the election, and the commitment of the new Prime Minister to provide sufficient Parliamentary time for AD/AS, arguably proved the tipping point for the issue in the UK (see Bache 2025a).

## 4 | Conclusion

This discussion reflected on the nature, pace, and timing of AD/AS developments in the UK by placing the UK case in comparative context and drawing on the insights of the Two Worlds approach. Two of the comparative cases selected were in the secular world (Oregon and Canada), like the UK, and the other in the religious world (the Netherlands). While taking this approach highlighted the importance of systemic differences across jurisdictions, the comparative perspective also highlighted the role of international trends and the potential for diffusion in the UK case. In addition, it identified common factors in the debates and variation in their importance across cases. Indeed, one contribution of this discussion is the clear identification of the factors that matter most in relation to AD/AS, which are likely to have relevance for other morality policy issues. These factors are: public opinion, the courts, religion and religious lobbying, the role of medical associations, developments in other jurisdictions, and political support. However, understanding the nature and importance of these factors requires the in-depth study of particular cases.

In short, a combination of systemic and case-specific factors matters in the UK case. At the systemic level, the absence of religious-secular party conflict contributed to a prolonged period of stasis. Related to this, risk-averse politicians tended toward a position of opposition that was long-supported by the major medical associations. However, as developments in the UK increasingly resembled the confluence of factors that had facilitated legalization in other jurisdictions, AD/AS was increasingly viewed by decision-makers as an idea whose time had come, and legalization for the first time became a real possibility.


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### Conflicts of Interest

The author declares no conflicts of interest.

### Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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