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Article

Adjusting Assisted Dying Law, Policy, and Practice During the COVID-19 Pandemic: Some reflections on available evidence from Canada, the United States, England and Wales, and Switzerland

Adaptações na legislação, regulamentação e prática relativas à morte assistida durante a pandemia de COVID-19: algumas reflexões sobre dados disponíveis do Canadá, dos Estados Unidos, da Inglaterra e País de Gales e da Suíça

Adaptaciones en la legislación, las normas y la práctica de la muerte asistida durante la pandemia de COVID-19: algunas reflexiones sobre datos ya disponibles procedentes de Canadá, Estados Unidos, Inglaterra y Gales, y Suiza

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Abstract

Objective: To analyse how the COVID-19 pandemic affected access to and the provision of assisted dying services, and how legal, regulatory, and professional frameworks adapted to this context. **Methodology**: The article is based on recurring themes identified in the empirical literature, including studies, legislation, case law, professional guidance, government publications, and parliamentary debates on assisted dying in Canada, the United States, England and Wales, and Switzerland. **Results**: Pandemic restrictions in Canada and some US states intensified existing barriers related to eligibility assessments, witnessing, provider availability, family presence, geographic inequality, and travel. Telemedicine and flexible procedural arrangements helped maintain legally authorised assisted dying services, but also raised concerns about the development of relationships between healthcare professionals and patients, safeguards, and professional accountability. England and Wales are considered a contrasting case, as assisted dying remained criminally prohibited, while pandemic-related travel restrictions made access to assisted suicide in Switzerland more difficult. **Final considerations**: The analysis indicates that measures adopted in emergency situations should become permanent only when they contribute to improving practical access while preserving fundamental elements such as voluntariness, informed consent, eligibility safeguards, and public oversight.

Keywords: Suicide, Assisted; COVID-19; Legislation as Topic.

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Resumo

Objetivo: analisar como a pandemia de COVID-19 afetou o acesso e a prestação de serviços de morte assistida, e como os marcos jurídicos, normativos e profissionais se adaptaram a esse contexto. **Metodologia**: o artigo se fundamenta em temas recorrentes na literatura empírica, incluindo estudos, legislação, jurisprudência, orientações profissionais, publicações governamentais e debates parlamentares sobre a morte assistida no Canadá, Estados Unidos, Inglaterra e País de Gales e Suíça. **Resultados**: as restrições impostas pela pandemia no Canadá e em alguns estados dos Estados Unidos intensificaram as barreiras já existentes relacionadas às avaliações de elegibilidade, à presença de familiares, às desigualdades geográficas e à necessidade de deslocamento. A telemedicina e a flexibilização de procedimentos contribuiram para a manutenção dos serviços de morte assistida legalmente autorizados, mas também suscitaram preocupações quanto a construção de vínculos entre profissionais e pacientes, às salvaguardas e à responsabilização profissional. lnglaterra e País de Gales são considerados caso contrastante, vez que a morte assistida permaneceu criminalmente proibida, enquanto as restrições de deslocamentos impostas durante a pandemia dificultaram o acesso ao suicídio assistido na Suíça. **Considerações finais:** A análise indica que as medidas adotadas em situações de emergência somente devem se tornar permanentes quando contribuírem para ampliar o acesso efetivo, preservando, ao mesmo tempo, elementos fundamentais como a voluntariedade, o consentimento informado, as salvaguardas relacionadas à elegibilidade e a supervisão pública.
Keywords: Morte Assistida; COVID 19; Legislação como Assunto.

Resumen

Objetivo: Analizar cómo la pandemia de COVID-19 afectó el acceso y la prestación de servicios de muerte asistida, y cómo los marcos jurídicos, normativos y profesionales se adaptaron a este contexto. **Metodología**: El artículo se basa en temas recurrentes identificados en la literatura empírica, incluidos estudios, legislación, jurisprudencia, orientaciones profesionales, publicaciones gubernamentales y debates parlamentarios sobre la muerte asistida en Canadá, Estados Unidos, Inglaterra y Gales, y Suiza. **Resultados**: Las restricciones impuestas durante la pandemia en Canadá y en algunos estados de Estados Unidos intensificaron las barreras existentes relacionadas con las evaluaciones de elegibilidad, la presencia de familiares, la disponibilidad de profesionales, las desigualdades geográficas y la necesidad de desplazamiento. La telemedicina y la flexibilización de los procedimientos contribuyeron a mantener los servicios de muerte asistida legalmente autorizados, pero también suscitaron preocupaciones respecto de la construcción de vínculos entre profesionales y pacientes, las salvaguardas y la responsabilidad profesional. Inglaterra y Gales constituyen un caso contrastante, dado que la muerte asistida permaneció penalmente prohibida, mientras que las restricciones de desplazamiento impuestas durante la pandemia dificultaron el acceso al suicidio asistido en Suiza. **Consideraciones finales:** El análisis indica que las medidas adoptadas en situaciones de emergencia solo deberían convertirse en permanentes cuando contribuyan a ampliar el acceso efectivo, preservando al mismo tiempo elementos fundamentales como la voluntariedad, el consentimiento informado, las salvaguardas relacionadas con la elegibilidad y la supervisión pública.
Palabras clave: Suicidio Asistido; COVID-19; Legislación como Asunto.

Introduction

Assisted dying has become an increasingly significant subject of legal, medical, and public-policy debate as more jurisdictions globally move from criminal prohibition towards regulated forms of assistance at the end of life. Legalisation, however, does not conclude the process of regulation. Once a framework is introduced, its procedures, professional responsibilities, safeguards, and access mechanisms must continue to respond to changing social, medical, and institutional circumstances. Globally, assisted dying frameworks have emerged through different legal and political pathways,

including citizens' initiatives in the United States (US)[1], confirmed by means of a referendum in New Zealand[2], or as a result of judicial action followed by legislation in Canada[3]. Assisted dying frameworks indeed continue to change after their initial introduction, such as in relation to their substantive or procedural criteria. Just one example is Canada, which made a major change in the eligibility concerning the condition of the individual requesting access in 2021[4]. Such developments demonstrate that assisted dying frameworks require continuing legal, professional, and procedural review to bring assisted dying into closer alignment with evolving regulatory, professional, and societal needs.

In March 2020, the World Health Organisation declared COVID-19 a pandemic, and in May 2023 declared it no longer a public health emergency of international concern[5]. The COVID-19 pandemic provided an important test of that continuing process for jurisdictions with regulated access to assisted dying. By disrupting ordinary healthcare delivery, limiting personal contact, and restricting international travel, the pandemic revealed how assisted dying systems functioned when the conditions they depended on suddenly changed. This article examines some of these resulting changes in law, policy, and practice across selected jurisdictions, including both established regulatory systems and England and Wales, as a case study, where assisted dying remained criminally prohibited. The article also considers the factors that shaped the responses adopted and assesses which emergency adaptations may appropriately be retained, together with the legal and professional safeguards necessary to preserve patient protection, professional accountability, and public trust.

The terminology surrounding assisted dying is contested and varies between jurisdictions. In this article, 'assisted dying' is used as an umbrella term encompassing assisted suicide, in which an eligible person self-administers medication supplied for the purpose of ending their life, and euthanasia, in which the medication is administered by a healthcare professional at the person's voluntary request[6]. Assisted suicide is not a term that the authors endorse but used here because of the criminal prohibition that still exists in England and Wales. Throughout this article, 'assisted dying' is used for cross-jurisdictional discussion, while 'medical assistance in dying' ('MAiD') is reserved for Canada because this is the terminology used in Canadian legislation and related legal and professional materials. Since eligibility requirements, procedures, and legal status differ across jurisdictions, the examples discussed below are illustrative rather than exhaustive.

Canada permits both clinician-administered and self-administered MAiD under federal legislation, supplemented by provincial laws, healthcare administration, and professional standards[7]. In the US, jurisdictions such as Vermont and Washington permit eligible adults with a terminal illness to obtain medication that they may self-administer, subject to procedural safeguards established by state law[8,9]. England and Wales, by contrast, prohibit assisted dying through the general criminal law: assisting another person's suicide is an offence under the Suicide Act 1961, while directly causing another person's death may constitute murder or manslaughter[10,11,12]. As a result, some individuals from England and Wales travel abroad, particularly to Switzerland, to seek assistance in dying[6]. In Switzerland, assisting suicide is lawful provided that the person who performs the final act and the assistance is not motivated by selfish motives, with some Swiss organisations providing assistance to non-residents[13]. Although Brazil does not currently permit assisted dying, the experiences examined in this article show how different legal and healthcare systems addressed questions of patient autonomy, professional responsibility, access, safeguards, and

service continuity during an unexpected crisis which may be of use in the future. They are presented not as models for Brazil to adopt, but as examples that can inform the broader discussion of end-of-life law and policy.

The article identifies and interprets recurring patterns or themes across already available empirical literature, including studies, legislation, case law, professional guidance, government publications, and parliamentary debates. It first examines the barriers that the COVID-19 pandemic created or intensified for assisted dying access and service provision. It then considers the practical and regulatory adaptations during the pandemic, including telemedicine and flexible witnessing arrangements. The following section examines the effect of travel restrictions on access from England and Wales to assisted suicide in Switzerland, while the final section considers which pandemic-related adaptations were subsequently retained and what they suggest for future assisted dying regulation. The jurisdictions examined in this article were selected purposively rather than exhaustively, where the authors especially identified available literature on the impact of the COVID-19 pandemic to accessing assisted dying. Thus, the jurisdictions used in this article serve as illustrative reference points representing different legal and institutional approaches, rather than an exhaustive or systematic comparison. The primary focus is on jurisdictions with established assisted dying frameworks and on how those systems adapted law, policy, and practice during the COVID-19 pandemic. England and Wales are included as a contrasting case because assisted dying remained prohibited domestically during the COVID-19 pandemic (and is still the case to date), while pandemic restrictions affected access mainly through international travel to Switzerland. The article does not cover access issues more generally, that, for instance, arising from geographic challenges or procedural safeguards preventing access, but issues that arose specifically during the COVID-19 in the jurisdictions were data and literature is available.

Discussion

Part A: Challenges to Assisted Dying Service Provision and Access During the COVID-19 Pandemic

This section examines how the COVID-19 pandemic affected service provision and access within legally regulated assisted dying systems. It focuses on the challenges created or intensified by pandemic restrictions, rather than on the legal models themselves. Drawing on empirical studies that involved patients, loved ones, and service providers, it identifies challenges regarding assessments, witnessing requirements, provider availability, access to appropriate locations, communication, and family presence. The studies discussed in this part concern jurisdictions with established assisted dying frameworks and are not limited to England and Wales. England and Wales, where assisted dying remained criminally prohibited, are examined separately in later parts of this article as a contrasting case involving cross-border access.

A good starting point is an important Canadian empirical study which examined the experiences of seven patients who had requested MAiD and 23 family caregivers during the COVID-19 pandemic. Researchers recruited participants from two academic health centres in Toronto between April 2020 and May 2021. All seven patients had been approved for MAiD, and six received it. Six patients had cancer, and one had hypertrophic cardiomyopathy[14]. Unlike most available studies, which focus on service providers, this study examined the perspectives of patients

and family caregivers. Participants reported that changing pandemic restrictions caused 'additional stress' and 'needless suffering', increased feelings of isolation, and, in some cases, accelerated or intensified the timing of assisted dying decisions. They also reported appointment delays, difficulties accessing safe and appropriate home or specialised care, and restrictions on family members' physical presence. Limited contact and delayed communication between healthcare teams, patients, and families sometimes impaired families' understanding of patients' conditions and clinical progression. The study also identified challenges on the day of the assistance in dying, although some participants appreciated staff showing flexibility and limited departure from ordinary restrictions to accommodate individual needs.

Among providers, studies report very similar themes regarding challenges in provision during the pandemic. For instance, several studies report that providers observed increased suffering among patients[15,16,17]. Reported causes included patients' isolation from loved ones, reduced time with patients, cancelled or rescheduled appointments, and reduced service provision. A common theme was also that providers had difficulty establishing rapport and closeness, or guaranteeing the 'human element', due to distancing restrictions, the requirement to use personal protective equipment ('PPE'), and telemedicine assessments[15,16]. Some participants struggled with 'providing the best patient-centred care and respecting public health imperatives',[16] while some MAiD providers in Canada noted feelings of increased anxiety while organising MAiD practicalities[18].

In addition to providers noting an increase in suffering for assisted dying patients and difficulty with establishing rapport, studies note several logistical and practical challenges with access provision. For instance, some participants said that certain existing problems with provision were exacerbated, such as finding witnesses for the request forms and the general challenge of provider availability, especially in certain geographical areas[15]. Another international study covering, among others, Europe, the US, and Canada reported further challenges, including problems accessing sites, restrictions affecting requests and patient assessments, reduced provider capacity because professionals were redeployed to COVID-19 services, and increased enquiries about expedited procedures, assessors, waiting times, medication, venues, and eligibility[17].

These challenges faced by both providers, patients and loved ones reinforced the need for adaptive policy responses during and, at times, after the COVID-19 pandemic. These challenges show that access to assisted dying cannot be assessed only by asking whether the law formally permits the practice. A legal framework may exist, but patients may still be unable to use it if assessors, witnesses, providers, family presence, or suitable locations are unavailable. Thus, the pandemic exposed the difference between formal legality and practical accessibility. The problem was not simply that pandemic restrictions interrupted service delivery; some frameworks lacked sufficiently resilient procedures to maintain access while preserving legal and ethical safeguards.

Part B: Pandemic Adaptations in Assisted Dying Service Provision

In response to the challenges identified in Part A, assisted dying service provision had to adapt to meet demand while operating safely and efficiently. For service providers, these challenges required rapid adaptations in practice and increased emotional labour. For example, the 2020 MAiD report in Canada praised service providers' 'adaptability', 'resilience', 'sensitivity', and 'compassion'[19]. The published literature identifies a recurring tension between complying with

changing public-health restrictions and continuing to provide assisted dying services in accordance with legal and ethical obligations to patients[16].

Several studies identified increased flexibility in applying public-health and institutional restrictions. This was also reported in the Canadian study by Tong et al., in which some patients and family caregivers regarded the restrictions as 'arbitrary' and expressed gratitude for providers' accommodations and 'small gestures', particularly close to the day of MAiD. Examples included allowing some family members to stay overnight and permitting more people to be present in the room than institutional rules ordinarily allowed[14]. Similar flexibility was reported in Oliver et al.'s international survey and interview study of assisted dying providers, drawing evidence from multiple jurisdictions. This was described as 'service flexibility and nimbleness', including instances of 'calculated rule-breaking' undertaken by providers who sought to continue meeting their professional and ethical obligations to patients. The findings indicate that providers were attempting to reconcile patient-centred and ethical obligations with changing regulatory requirements[17].

Examples reported by Oliver et al. included continuing home visits where these reduced the burden of assessment, accepting virtual witnessing, and allowing more than one family member to attend an assistance in dying process. The study also reported that some providers adopted these measures only after weighing the relevant pandemic restrictions, professional obligations, and assisted dying requirements. Some participants made 'meticulously considered team decisions, weighing up the core bioethics principles and existing practitioner legal protections alongside compliance with the fluctuating pandemic regulations, to determine their individual responses as ethical and competent health professionals in the pandemic context'[17]. This evidence should not be read as an endorsement of informal rule-breaking. Rather, it shows that where legal and institutional rules are too rigid to respond to crisis conditions, professionals may be pushed into ethically difficult discretionary decisions, which is undesirable. Assisted dying systems should not depend on informal flexibility by individual providers; they should contain clear, lawful mechanisms for adapting procedures during emergencies while preserving core safeguards. This is crucial for healthcare professionals, patients, as well as the future-proofing of the system itself.

Because MAiD in Canada operates within a federal system, Canadian law permits MAiD nationally through the federal Criminal Code, which sets eligibility criteria, consent requirements, and core procedural safeguards. Provinces cannot create a separate MAiD regime or relax these federal requirements. However, provinces and provincial professional regulators have authority over healthcare delivery and the professional regulation of physicians. The provincial examples discussed below should therefore be read as implementation variations, not departures from Canadian MAiD law. These provincial standards and temporary measures did not automatically apply throughout Canada; their application was limited to the relevant province, institution, or professional jurisdiction. British Columbia and Nova Scotia are two useful examples: both permitted telemedicine-based MAiD assessments during COVID-19, but British Columbia later incorporated these temporary telemedicine revisions into its permanent MAiD standards, while Nova Scotia appears to have retained more limited, situational flexibility. British Columbia and Nova Scotia are both Canadian provinces. Both examples remained consistent with Canadian law as a whole, provided that federal MAiD safeguards continued to be met.

A Canadian study reported that some providers did not follow, or did not insist that others follow, applicable public-health measures and institutional policies, particularly restrictions on

visitor numbers and physical distancing. These were public-health and institutional rules concerning visitors, physical distancing, and the organisation of care, rather than evidence that providers were authorised to disregard the federal statutory requirements governing MAiD. Participants used rhetorical techniques to 'minimise, rationalise, justify or excuse' these departures, frequently invoking the exceptional and emotional nature of MAiD during the pandemic[16]. Reported examples included allowing more visitors than institutional policies permitted and not strictly enforcing physical distancing on the day of MAiD. Providers nevertheless used mitigating measures, including masks, symptom checks, and arranging provision at quieter times when fewer people were present[16]. The evidence therefore concerns departures from public-health and institutional restrictions, rather than a general authorisation to disregard the statutory safeguards governing MAiD. This is a crucial distinction and underlines the central and essential role of healthcare providers for MAiD delivery.

In more practical, logistical solutions, studies report adjustments of systems and processes to meet demand. For instance, in one study, this included adapting systems and procedures at short notice to comply, as much as possible, with restrictions, identifying practice constraints and developing solutions, modifying systems and protocols at the governance and management level, to support frontline practitioners, working as a team and trying sometimes new approaches[17]. This was at the back of a strong ethical, moral, and legal commitment on the part of some providers to continue with what they considered 'an essential service'[17].

One of the most significant practical adaptations was increased use of telemedicine, which helped maintain access, particularly for eligibility assessments and witnessing requests, in the studies identified by the authors of this article. One study reported that telemedicine continued despite uncertainty about whether it was authorised under the applicable rules[16,17]. The use of telemedicine indeed improved access to the service both for patients and providers by eliminating 'stressful travel costs, time and discomfort for both patients and assessors'. With more frequent interaction facilitated by telemedicine, there was less pressure to cover 'emotional and logistical aspects in a single conversation'[17]. Telemedicine was found to be an essential tool, especially in 'underserviced areas', i.e., areas with insufficient assessors and providers[20]. However, the use of telemedicine was not without its challenges. In one study, the authors report concerns about a 'decrease in rapport' between the provider and the patient due to telemedicine assessments[16]. There were also difficulties regarding 'empathy, eye contact, nonverbal communication and missing contextual factors'[20]. Virtual witnessing also did not come without challenges. Sometimes, the process was complicated and extended when participants were unfamiliar with the technology or when witnesses were not present simultaneously[17].

Within Canada's federal structure, the College of Physicians and Surgeons of British Columbia regulates physicians' professional practice in the province; it does not create a separate MAiD law. Its professional standards could therefore modify the practical procedures for MAiD assessments and witnessing during the pandemic, but they could not alter the federal eligibility criteria or remove federally required safeguards. During the COVID-19 pandemic, the College temporarily permitted MAiD eligibility assessments by telemedicine and allowed an alternative to the usual witness requirement where an independent witness was not reasonably available, provided another regulated health professional was present, unless that professional was also unavailable. The assessments

remained subject to the federal Criminal Code and the substantive standards applicable to in-person assessments, and video quality had to be sufficient to preserve procedural safeguards[21].

Although these changes were originally introduced as an emergency response to COVID-19, they later became part of the ordinary regulatory framework for MAiD practice in British Columbia. In early 2024, the College adopted the 'temporary revisions made during the COVID-19 pandemic as permanent changes'[22]. This illustrates how a provincial regulator may convert temporary pandemic guidance into continuing professional standards, provided those standards remain consistent with federal MAiD law. So far, qualitative evidence suggests that many providers found telemedicine practical after initial concerns and have come to appreciate its usefulness. Some challenges included showing empathy through a screen; however, skilled providers found ways to overcome them, and some patients felt more at ease in their own environment[15]. Evidence suggests that telemedicine-supported assessment processes have been feasible and effective, particularly for those in remote communities who might not easily find an eligible witness in person[23].

Nova Scotia provides a useful comparison because it also adopted temporary telemedicine measures during the COVID-19 pandemic, but the available evidence does not suggest the same permanent regulatory change as in British Columbia. During the COVID-19 pandemic, the College of Physicians and Surgeons of Nova Scotia adopted temporary amendments to its MAiD Standard permitting physicians to conduct eligibility assessments by telemedicine. The amendments further allowed an alternative to the ordinary witness requirement when an independent witness was not reasonably available due to COVID-19, provided that the applicable safeguards were maintained[24]. Similar to the British Columbia amendments, these changes concerned the manner in which MAiD was delivered during the pandemic; they did not create a separate provincial MAiD regime or displace federal legal safeguards. The Canadian Association of MAiD Assessors and Providers emphasised the need to keep providers, patients, and loved ones safe while maintaining consistent MAiD practices. They recommended adjustments such as allowing formal MAiD requests via video conferencing and virtual consultations, reducing physical contact by using support staff as final consent proxies and IV extension tubing to maintain physical distance during medication administration[25].

Nonetheless, in Nova Scotia, no permanent post-COVID-19 changes to provincial policy/regulatory standards have generally replaced the independent witness requirement. In practice, however, there is limited flexibility in how the witnessing process is arranged. For example, organisations like Dying With Dignity Canada have facilitated remote/virtual witnessing through volunteers when necessary, using video calls provided the applicable federal and provincial legal and regulatory requirements are satisfied[26]. Thus, British Columbia and Nova Scotia adopted different implementation measures in response to similar pandemic pressures: British Columbia later incorporated telemedicine into its continuing professional standards, whereas Nova Scotia retained a more limited and situational approach to telemedicine and witnessing. The contrast between British Columbia and Nova Scotia shows that Canadian provinces could respond to similar MAiD access problems through different regulatory pathways while still operating within the same federal MAiD framework. This may well be the case for other jurisdictions in the future.

In March 2020, the American Clinicians Academy on Medical Aid in Dying issued professional guidance encouraging increased use of telemedicine for assisted dying evaluations and care during the COVID-19 pandemic[27]. This guidance was not federal law and did not automatically

apply nationwide. The legality and regulation of assisted dying in the US are primarily state-based, meaning that the legality and scope of telemedicine in assisted dying practice depended on each state's own legislation, emergency rules, and professional standards. The US examples illustrate pandemic-related telemedicine adaptations rather than serving as primary case studies in the article's comparative analysis.

The Oregon and New Jersey material helps to illustrate the broader development and practical effects of telemedicine but does not form part of the article's primary jurisdictional comparison. During 2020–2022, prescriptions for assisted dying medications in Oregon rose by nearly 49%, from 290 in 2019 to 432 in 2022. These figures should be interpreted cautiously, as the available data do not establish that telemedicine caused this increase. Rather, they show that assisted dying access continued, and even expanded numerically, during the period in which telemedicine became more prominent. New Jersey is included as a clinical-practice example rather than a population-level statistical comparison. Dr Robin Plumer, a New Jersey MAiD physician, estimated that, without online prescribing and virtual visits, 35–40% of her patients would not have been able to access MAiD[28].

The rapid pivot to telemedicine and flexible enforcement of rules seemed to be a widespread trend during the COVID-19 pandemic. A global survey of assisted dying providers found that roughly one-quarter explicitly reported transitioning to virtual consultations in place of face-to-face meetings[29]. Providers initially found virtual assessments challenging; they expressed worry about reduced rapport, limited body-language cues, and difficulty showing empathy through a screen. Over time, however, many adapted and even recognised advantages. The World Federation of Right to Die Societies also reported that eliminating travel for patients and assessors reduced cost, time, and discomfort, while shorter and more frequent video calls reduced the pressure to address all emotional and logistical issues in a single conversation[29].

Crucially, telemedicine became an essential means of maintaining access to assisted dying services during periods of pandemic restrictions, particularly in jurisdictions where in-person assessments were difficult or impossible. However, telemedicine should not be treated as a complete substitute for in-person assisted dying services after the pandemic. Its main value is as a complementary option, especially for patients in remote or underserviced areas, patients whose illness makes travel burdensome, and situations where timely assessment would otherwise be difficult. The cost and access benefits are significant, but they do not automatically outweigh the limitations identified above, including reduced rapport, difficulty assessing non-verbal communication, technological barriers, and the risk that some patients may feel less supported. For this reason, post-COVID-19 use of telemedicine should remain available but carefully regulated, with in-person assessment or support used were clinically, ethically, or legally necessary. This position also distinguishes between access-enhancing flexibility and safeguard-reducing flexibility. Telemedicine may be justified where it improves access without weakening eligibility assessment, voluntariness, informed consent, or clinical judgement. It should not be justified merely because it is cheaper or administratively easier.

Part C: The Effects of the Pandemic on Cross-Border Access from England and Wales

England and Wales, suicide itself is not a criminal offence, but section 2 of the Suicide Act 1961 criminalises acts intended to encourage or assist another person's suicide. Decisions to

prosecute require the consent of the Director of Public Prosecutions and are informed by the Crown Prosecution Service's policy of factors in favour of and against prosecution[30]. Directly causing another person's death is governed by the general law of homicide and may constitute murder or manslaughter depending on the circumstances. The prohibition has remained the subject of sustained domestic debate. Legal challenges, particularly R (Purdy) v Director of Public Prosecutions, have addressed the clarity and application of the prosecution policy,[31] while several parliamentary initiatives have considered whether assisted dying should be available to terminally ill adults. To date, the criminal prohibitions remain in place. Even so, these attempts demonstrate that the domestic position remains contested. Before and during the pandemic, some residents of England and Wales travelled to Switzerland to access assisted suicide through organisations providing services to eligible non-residents[32].

Travel restrictions, which were introduced in May 2020 to combat the spread of the virus,[33] created uncertainty for those seeking to access this service abroad. In November 2020, both Houses of Parliament raised the issue of travelling abroad for assisted deaths during the COVID-19 pandemic[34,35]. In the House of Commons, the then Secretary of State stated that travelling abroad for the purpose of assisted dying could constitute a 'reasonable excuse' under the COVID-19 regulations. This statement certainly did not legalise assisted suicide in England and Wales or alter the domestic criminal prohibition, however it remains problematic and has not received the attention it deserved. A fundamental concern is that this 'exception' was created without prior scrutiny, an exception that permitted individuals to travel within the jurisdiction against pandemic restrictions in order to then travel abroad for conduct that would remain criminal if undertaken domestically. The Health Secretary was wary of reaffirming that this 'exception' does not change the domestic prohibitions, but even after establishing the 'exception', the government did not provide further or additional guidance, except for a brief discussion in the House of Lords[35]. For instance, the government did not clarify whether such travel qualified under 'medical reasons' or 'attending an appointment',[36] nor was any guidance issued on whether police, prosecutors, or airlines were aware of this exception or if it extended to individuals accompanying the patient.

Beyond legal uncertainty, COVID-19 pandemic restrictions created logistical barriers for British citizens seeking to access this service in Switzerland. Despite a recurring 'stay at home' order, flights continued from the UK,[37] but cancellations and delays made travelling to Switzerland difficult[38]. Data from the Swiss Federal Office of Public Health showed that between 14 and 21 December 2020, 92 UK flights were affected as over 40 countries halted travel[39]. Between the creation of 'the exception' in November and this disruption in December, individuals had a margin of about a month to complete the process in Switzerland. Some reports show that some patients expedited plans to avoid new restrictions,[38] while others postponed or abandoned their plans[40]. Accessing required documentation was another challenge, as healthcare professionals cannot actively assist beyond advising[41,42,43,44]. Most of these issues predated but were very likely exacerbated by the COVID-19 pandemic, highlighting the continuing importance of legal and policy reform in England and Wales.

The England and Wales case study demonstrates that cross-border access cannot serve as a resilient substitute for domestic regulation. Its availability depends on circumstances beyond domestic control, including the ability to travel and obtain assistance abroad. The case therefore illustrates the importance of considering access not only in terms of formal legality, but also in terms

of reliability, equality, and accountability. Future reform discussions in England and Wales should address this question by determining whether a transparent domestic framework can provide lawful access while maintaining appropriate eligibility criteria, safeguards, and professional oversight.

Part D: Post-COVID-19 pandemic lessons leading to change

With providers realising that access to assisted dying could continue safely and efficiently, many started considering which COVID-19 pandemic-driven adaptations could become permanent,[29] and suggested some long-term improvements. The same study showed, for example, that many providers realised that these adaptations 'improved not only patients' ease of access, but also practitioners' sense of efficacy in their AD&E roles'[17]. The same study reports that many providers started increasing or revising information available to patients, expanding or revising guidelines and processes around eligibility, the assessment, and administration of drugs, as well as giving more advice on how to prepare for assisted death practically and emotionally[17]. It appears also that many agencies and providers started reflecting more on 'client-centred' processes, re-thinking about unnecessary procedures, waiting times, and prohibitions,[17] with another study suggesting something similar, that there should be more reflection about prioritisation of 'family inclusion and presence', which would recognise the process for its relational dimensions[14].

Some jurisdictions with established frameworks have already revised regulations to incorporate COVID-19 pandemic adaptations. Consistent with the US's state-level structure, Vermont is one example of a jurisdiction that made a pandemic-era adaptation permanent. The Vermont measures discussed here apply within Vermont and should not be understood as US-wide reforms. The state had maintained strict in-person consultation requirements, prohibiting telemedicine for aid-in-dying consultations, but amended its law in April 2022 to allow online prescription requests, replacing the requirement for two in-person consultations with a physician[27,45]. This change remains in effect, with Patient Choices Vermont noting that allowing telemedicine has made the process smoother and more comfortable for patients, especially those with medical conditions that make travel difficult[46] Following these reforms, requests increased between 2021 and 2023[47].

Washington State provides a second state-level example; its statutory amendments apply within Washington State rather than throughout the US. Similarly, Washington State's Death with Dignity Act was amended in July 2023 to improve access. Changes included allowing physician assistants and Advanced Registered Nurse Practitioners (ARNP) to prescribe medications and reducing the 15-day waiting period between the two oral requests to seven days[48]. These statutory amendments remain in force. A recent Bill to further relax the waiting period was proposed in 2025; specifically, it was intended to exempt patients not expected to survive the full seven days. However, it did not advance out of the House Committee[49]. Data suggest that Washington's post-COVID-19 pandemic reforms have perhaps made assisted dying more accessible. For example, the Washington State Department of Health's 2024 Death with Dignity Act Report, issued in July 2025, notes that 655 people participated in Washington's Death with Dignity Program in 2024, the highest annual count up to that point[50]. This rise may indicate that the process is now more efficient, as eligible patients can more effectively exercise their rights under the legislation.

These examples support the article's broader argument: pandemic-era adaptations should not be preserved simply because they are convenient or because they increased access speed. They should be retained only where they demonstrably improve access while remaining consistent with eligibility

criteria, consent requirements, clinical judgement, professional accountability, and public oversight. The lesson of the pandemic is therefore not that assisted dying safeguards should be relaxed, but that they should be designed with enough resilience to operate in crisis conditions.

Conclusion

The COVID-19 pandemic exposed the fragility of assisted dying frameworks in both regulated and prohibitive jurisdictions. In jurisdictions where assisted dying was already lawful, the main challenge was not whether the practice was legally permitted, but whether patients could actually access (and healthcare providers provide it) it under crisis conditions. Restrictions affected assessments, witnessing, provider availability, family presence, and travel, revealing the gap between formal legality and practical accessibility. The pandemic responses, including telemedicine, flexible witnessing arrangements, and revised professional guidance, show that assisted dying systems can adapt without abandoning core safeguards.

However, this article has argued that not all flexibility should be treated equally. Pandemic-era adaptations should not be retained simply because they are convenient, cheaper, or faster. They should become permanent only where they improve access while preserving eligibility criteria, voluntariness, informed consent, clinical judgement, professional accountability, and public oversight. Telemedicine, for example, is best understood as a complementary tool rather than a complete substitute for in-person care. Its continued use may be justified for patients in remote or underserviced areas, or where illness makes travel burdensome, but it must remain embedded within clear legal and professional standards.

The experience of England and Wales raises a different but related problem. Because assisted dying remains criminally prohibited domestically, some individuals rely on travelling to Switzerland to access assistance in dying. The pandemic exposed the instability and inequality of this arrangement: only those with sufficient money, health, documentation, and time could realistically pursue cross-border access, and even that access became fragile when travel restrictions changed. The temporary recognition of assisted dying travel as a ‘reasonable excuse’ did not resolve the underlying legal inconsistency; it only made it more visible. Reform in England and Wales should therefore not be framed as preventing citizens from travelling abroad, but as requiring transparent domestic debate about whether assisted dying should be available at home, and if so, under what criteria and safeguards.

The broader lesson is that assisted dying law does not end with legalisation. Once introduced, these frameworks require ongoing maintenance, evidence-based review, and institutional preparedness for both expected and unexpected change. For jurisdictions considering reform, including Brazil, the pandemic experience shows the importance of designing assisted dying systems that are accessible in practice, workable for professionals, resilient in crisis, and safe for patients and the wider public.

References

1. Hillyard D, Dombrink J. Dying right: the death with dignity movement. New York: Routledge; 2001. 324 p.

2. Electoral Commission New Zealand. End of Life Choice Referendum [Internet]. Wellington: Electoral Commission; 2020 [cited 2026 Oct 12]. Available from: https://www.electionresults.govt.nz/electionresults_2020/referendums-results.html

3. Canada. Supreme Court of British Columbia. Carter v. Canada (Attorney General), 2012 BCSC 886. [s.l.], 2012 Jun 15 [cited 2026 Oct 12]. Available from:

https://bccla.org/wp-content/uploads/2012/06/Carter-v-Canada-AG-2012-BCSC-886.pdf

4. Canada. Superior Court of Quebec. Truchon c. Procureur général du Canada, 2019 QCCS 3792. Montréal, 2019 Sep 11 [cited 2026 Oct 12]. Available from: https://www.canlii.org/judgmentTabs/history/?judgmentId=37480049&lang=en

5. World Health Organization. WHO Director-General's opening remarks at the media briefing – 5 May 2023 [Internet]. Geneva: World Health Organization; 2023 May 5 [cited 2026 Oct 12]. Available from: https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing---5-may-2023

6. House of Commons Health and Social Care Committee. Assisted dying/assisted suicide: second report of Session 2023–24 [Internet]. London: House of Commons; 2024 Feb 29 [cited 2026 Oct 12]. Report No.: HC 321. Available from: https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html

7. Canada. Criminal Code, R.S.C. 1985, c. C-46. An Act respecting the Criminal Law [cited 2026 Oct 12]. Available from: https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html

8. Vermont. Vermont Statutes Annotated, title 18, chapter 113. Patient choice at end of life. Vermont General Assembly [cited 2026 Oct 12]. Available from: https://legislature.vermont.gov/statutes/fullchapter/18/113

9. Washington State. Revised Code of Washington, chapter 70.245. The Washington Death with Dignity Act. Washington State Legislature [cited 2026 Oct 12]. Available from: https://app.leg.wa.gov/rcw/default.aspx?cite=70.245

10. United Kingdom. Suicide Act 1961 (c. 60), (1961 Aug 3). An Act to amend the law of England and Wales relating to suicide, and for purposes connected therewith. London: The National Archives [cited 2026 Oct 12]. Available from: https://www.legislation.gov.uk/ukpga/Eliz2/9-10/60/section/2

11. United Kingdom. House of Lords. R v Cunningham [1982] AC 566. London, Jul 8, 1981[cited 2026 12 Oct]. Available from: https://vlex.co.uk/vid/r-v-cunningham-793681693

12. England and Wales. Court of Appeal (Criminal Division). R v Inglis [2010] EWCA Crim 2637. London, Nov 12, 2010 [cited Oct 12, 2026]. Available from: https://www.bailii.org/ew/cases/EWCA/Crim/2010/2637.html

13. Switzerland. Swiss Criminal Code, SR 311.0, of 21 December 1937 [cited 2026 12 Oct]. Available from: https://www.fedlex.admin.ch/eli/cc/54/757_781_799/en

14. Tong E, Nissim R, Selby D, Bean S, Isenberg-Grzeda E, Thangarasa T, et al. The impact of COVID-19 on the experiences of patients and their family caregivers with medical assistance in dying in hospital. BMC Palliative Care [Internet]. 2023 Jun 13 [cited 2026 12 Oct];22:70. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC10261826/ doi:10.1186/s12904-023-01191-8

15. Wiebe E, Kelly M, McMorrow T, Tremblay-Huet S, Sum B, Hennawy M. How the experience of medical assistance in dying changed during the COVID-19 pandemic in Canada: a qualitative study of providers. CMAJ Open [Internet]. 2021 Apr 16 [cited 2026 12 Oct];9(2):E400-E405. Available from: https://www.cmajopen.ca/content/9/2/E400 doi:10.9778/cmajo.20200163

16. Tremblay-Huet S, McMorrow T, Wiebe E, Kelly M, Hennawy M, Sum B. The impact of the COVID-19 pandemic on medical assistance in dying in Canada and the relationship of public health laws to private understandings of the legal order. Journal of Law and the Biosciences [Internet]. 2020 [cited 2026 12 Oct];7(1):lsaa087. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC7799035/ doi:10.1093/jlb/lsaa087

17. Oliver P, Wilson M, McLaren C, Jonquiere R. Providing legal assisted dying and euthanasia services in a global pandemic: lessons for ensuring service continuity. OMEGA - Journal of Death and Dying [Internet]. 2024 Aug [cited 2026 12 Oct];89(3):1253-1272. Available from: https://journals.sagepub.com/doi/10.1177/00302228221089120 doi:10.1177/00302228221089120

18. Stewart DE, Viens P, Muralidharan O, Kastanias P, Dembo J, Riazantseva E. E-survey of stressors and protective factors in practicing medical assistance in dying. Journal of Palliative Medicine [Internet]. 2021 Oct [cited 2026 12 Oct];24(10):1489-1496. Available from: https://journals.sagepub.com/doi/10.1089/jpm.2020.0664 doi:10.1089/jpm.2020.0664

19. Health Canada. Second annual report on medical assistance in dying in Canada 2020 [Internet]. Ottawa: Health Canada; 2021 Jun [cited 2026 12 Oct]. Available from: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2020.html

20. Dion S, Wiebe E, Kelly M. Quality of care with telemedicine for medical assistance in dying eligibility assessments: a mixed-methods study. CMAJ Open [Internet]. 2019 Dec 13 [cited 2026 12 Oct];7(4):E721-E729. Available from: https://www.cmajopen.ca/content/7/4/E721 doi:10.9778/cmajo.20190111

21. College of Physicians and Surgeons of British Columbia. Practice standard: medical assistance in dying (version 7.2) [Internet]. Vancouver (BC): College of Physicians and Surgeons of British Columbia; 2022 May 10 [cited 2026 12 Oct]. Available from: https://www.cpsbc.ca/news/publications/college-connector/2024-V12-02/06

22. College of Physicians and Surgeons of British Columbia. Revised medical assistance in dying practice standard and FAQs published [Internet]. Vancouver (BC): College of Physicians and Surgeons of British Columbia; Feb 26, 2024 [cited Oct 12, 2026]. Available from: https://www.cpsbc.ca/news/revised-medical-assistance-dying-practice-standard-and-faqs-published

23. Dying With Dignity Canada, Canadian Association of MAiD Assessors and Providers. Guidance for virtual witnessing for a request for medical assistance in dying (MAiD) [Internet]. Toronto: Dying With Dignity Canada; 2020 Jun [cited 2026 12 Oct]. 7 p. Available from: https://camapcanada.ca/wp-content/uploads/2022/02/FINAL-Tele-witnessing-guide-June-26-2020-copy.pdf

24. College of Physicians and Surgeons of Nova Scotia. Temporary amendments to MAiD standard [Internet]. Halifax (NS): College of Physicians and Surgeons of Nova Scotia; 2020 Mar 31 [updated 2025 Dec 9; cited 2026 12 Oct]. Available from: https://cpsns.ns.ca/news/college-news/temporary-amendments-to-maid-standard/

25. Canadian Association of MAiD Assessors and Providers. Guidance for assessors and providers of medical assistance in dying (MAiD) during the COVID-19 pandemic [Internet]. [s.l.]: Canadian Association of MAiD Assessors and Providers; 2020 Apr [cited 2026 12 Oct]. Available from: https://camapcanada.ca/wp-content/uploads/2022/02/Formatted-Final-MAiD-in-Covid-2.pdf

26. Dying With Dignity Canada. Find an independent witness for MAID [Internet]. Toronto: Dying With Dignity Canada; [s.d.] [updated 2024 May 27; cited 2026 12 Oct]. Available from: https://www.dyingwithdignity.ca/end-of-life-support/find-an-independent-witness-for-maid/

27. Committee to Evaluate Telemedicine for Aid-in-Dying Requests in the Context of the Coronavirus Epidemic. Telemedicine policy statement [Internet]. [s.l.]: American Clinicians Academy on Medical Aid in Dying; 2020 Mar 25 [cited 2026 12 Oct]. Available from: https://www.acamaid.org/telemedicine/

28. Aleccia J. Dying patients protest looming telehealth crackdown. STAT [Internet]. 2023 Apr 23 [cited 2026 12 Oct]. Available from: https://www.statnews.com/2023/04/23/dying-patients-protest-looming-telehealth-crackdown/

29. World Federation of Right to Die Societies. Providing legal assisted dying and euthanasia services in a global pandemic: provider experiences and lessons for the future [Internet]. [s.l.]: World Federation of Right to Die Societies; 2021 Jan 31 [cited 2026 12 Oct]. Available from: https://wfrtds.org/wp-content/uploads/2021/02/Report-PAM-Survey-FINAL-.pdf

30. Crown Prosecution Service. Suicide: policy for prosecutors in respect of cases of encouraging or assisting suicide [Internet]. [s.l.]: Crown Prosecution Service; 2010 Feb updated 2014 Oct 16 [cited 2026 12 Oct]. Available from: https://www.cps.gov.uk/prosecution-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide

31. United Kingdom. House of Lords. R (on the application of Purdy) v Director of Public Prosecutions [2009] UKHL 45. London, Jul 30, 2009 [cited Oct 12, 2026]. Available from: https://www.bailii.org/uk/cases/UKHL/2009/45.html

32. Dignitas. Accompanied suicide of members of DIGNITAS, by year and by country of residency 1998–2025 [Internet]. Zurich: Dignitas; 2025 [cited 2026 12 Oct]. Available from: https://dignitas.ch/wp-content/uploads/FTB-nach-Jahr-und-Domizil-1998-2025.pdf

33. Cabinet Office. Our plan to rebuild: the UK Government's COVID-19 recovery strategy [Internet]. London: HM Government; 2020 May 11 [cited 2026 12 Oct]. Available from: https://www.gov.uk/government/publications/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy

34. United Kingdom. House of Commons. Coronavirus regulations: assisted deaths abroad. Hansard [Internet]. 2020 Nov 5 [cited 2026 12 Oct];683. Available from: https://hansard.parliament.uk/Commons/2020-11-05/debates/A10D8E3C-C301-4163-890F-775B6E48F192/CoronavirusRegulationsAssistedDeathsAbroad

35. United Kingdom. House of Lords. Covid-19 regulations: assisted deaths abroad. Hansard [Internet]. 2020 Nov 10 [cited 2026 12 Oct];807. Available from: https://hansard.parliament.uk/Lords/2020-11-10/debates/9907DD7E-0857-41DA-A35E-D8B7DFEB3C12/Covid-19RegulationsAssistedDeathsAbroad

36. United Kingdom. The Health Protection (Coronavirus, International Travel) (England) Regulations 2020, SI 2020/568, 2020 Jun 2. Public health, England. London: The National Archives [cited 2026 12 Oct]. Available from: https://www.legislation.gov.uk/uksi/2020/568/contents/made

37. Clark P, Harding R, Chazan G, Dombey D, Shepherd C, Hughes L, et al. Britain's open borders make it a global outlier in coronavirus fight. Financial

Times [Internet]. 2020 Apr 16 [cited 2026 12 Oct]. Available from: https://www.ft.com/content/91dea18f-ad0e-4dcb-98c3-de836b1ba79b?syn-25a6b1a6=1

38. Gregory A. My Dignitas flight to beat lockdown. The Times [Internet]. 2020 Oct 31 [cited 2026 12 Oct]. Available from: https://www.thetimes.com/uk/healthcare/article/my-dignitas-flight-to-beat-lockdown-m3gqtcsv7

39. SWI swissinfo.ch. Swiss impose entry ban for travellers from UK and South Africa [Internet]. 2020 Dec 21 [cited 2026 12 Oct]. Available from: https://www.swissinfo.ch/eng/politics/swiss-impose-entry-ban-for-travellers-from-uk-and-south-africa/46237718

40. My Death My Decision. Covid-19 has exposed the need for a review of our assisted dying laws, says MDMD to parliamentary human rights committee [Internet]. London: My Death My Decision; 2021 Jan 12 [cited 2026 12 Oct]. Available from: https://www.mydeath-mydecision.org.uk/2021/01/12/covid-19-has-exposed-the-need-for-a-review-of-our-assisted-dying-laws-says-mdmd-to-parliamentary-human-rights-committee/

41. General Medical Council. When a patient seeks advice or information about assistance to die [Internet]. London: General Medical Council; 2013 Jan 31 [updated 2024 Dec 13; cited 2026 12 Oct]. Available from: https://www.gmc-uk.org/professional-standards/the-professional-standards/when-a-patient-seeks-advice-or-information-about-assistance-to-die

42. General Medical Council. Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide [Internet]. London: General Medical Council; 2013 Jan [cited 2026 12 Oct]. Available from: https://rcem.ac.uk/wp-content/uploads/2021/11/Guidance_for_Investigation-Committee_When_Considering_Allegations_About_a_-Doctor.pdf

43. British Medical Association. Responding to patient requests for assisted dying: guidance for doctors [Internet]. London: British Medical Association; 2019 Jun [cited 2026 12 Oct]. Available from: https://www.bma.org.uk/media/ob5pfuz0/bma-responding-to-patient-requests-for-assisted-dying-20250074.pdf

44. Royal College of Nursing. When someone asks for your assistance to die: RCN guidance on responding to a request to hasten death [Internet]. London: Royal College of Nursing; 2016 [cited 2026 12 Oct]. Available from: https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/Obselete/2021/April/005822.pdf

45. Vermont. An act relating to modifications to Vermont's patient choice at end of life laws, S.74 (Act 97), 2022 Apr 27. Vermont General Assembly [cited 2026 12 Oct]. Available from: https://legislature.vermont.gov/bill/status/2022/S.74

46. Patient Choices Vermont. More Vermonters qualifying for medical-aid-in-dying [Internet]. [s.l.]: Patient Choices Vermont; 2024 Jan 1 [cited 2026 12 Oct]. Available from: https://www.patientchoices.org/news-events/more-vermonters-qualify-medical-aid-in-dying

47. Vermont Department of Health. Report concerning patient choice at the end of life [Internet]. Burlington: Vermont Department of Health; 2024 Jan 15 [cited 2026 12 Oct]. Available from: https://legislature.vermont.gov/assets/Legislative-Reports/Patient-Choice-Legislative-Report-Final.pdf

48. Washington State. Washington Administrative Code, chapter 246-978. Death with Dignity Act requirements. Olympia: Washington State Legislature [cited 2026 12 Oct]. Available from: https://app.leg.wa.gov/wac/default.aspx?cite=246-978

49. Washington State. HB 1876, 2025-26 regular session. Concerning the requirements for accessing the Washington death with dignity act. Olympia: Washington State Legislature, 2025 Feb 7 [cited 2026 12 Oct]. Available from: https://app.leg.wa.gov/billsummary?BillNumber=1876&Year=2025

50. Center for Health Statistics, Disease Control and Health Statistics.. Report to the Legislature - 2024 Death with Dignity [Internet]. Olympia: Washington State Department of Health; 2025 Jul [cited 2026 12 Oct]. Available from: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=2024%20Death%20With%20Dignity%20Report_c04f2cd1-b32a-45a2-a0b3-a1d0e09ec986.pdf

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N. Papadopoulou: conception/design of the article, data analysis and interpretation, drafting of the article, critical review of its content, and approval of the final version of the article.
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