‘First do no harm’

Concerns from senior doctors regarding the Terminally Ill Adults (End of Life) Bill

August 2025

Table of contents

Introduction and Executive Summary

This paper has been written by senior doctors who have many years of experience caring for patients with life-limiting and life-threatening conditions in hospitals, primary care and hospices.

The publication of the Terminally Ill Adults (End of Life) Bill has provoked serious concerns from within the medical profession.[1,2,3] Many of these concerns are supported by evidence from jurisdictions such as Oregon and Canada, where assisted suicide has been legal for a number of years, and from Australia and New Zealand which have health care systems and demography similar to the UK.

Having scrutinised the Bill in detail, our conclusion is that it is unsafe and will harm more patients than it will help. We are concerned that if it becomes law, it will change the practice and culture of medicine in ways that no amendment of the Bill can prevent.

This briefing paper is designed to be read alongside the Bill as a commentary; it seeks to highlight practical, legal and ethical concerns.

Summary

Treatment or existential choice

- The Bill assumes that death is a treatment by relying on doctors to assess, prescribe and administer 'substances', and in the use of the Mental Capacity Act. This assumption undermines the foundational principles and purposes of the NHS and the role of Secretary of State.

  At the same time, it sets assisted suicide in a different category from medical treatments, for example with respect to regulation and monitoring. The practical and legal implications of these ambiguities and contradictions make the Bill unworkable and unsafe.

Eligibility criteria

- The eligibility criteria are imprecise and the 6-month prognosis cut-off is arbitrary. They will not prevent expansion over time.

Capacity

- The Bill relies heavily on the Mental Capacity Act 2005, but this is not a suitable tool for assessing decision-making ability to choose to die. Inadequate consideration of capacity will fail the vulnerable

Preliminary discussions

- Inexperienced doctors with no training can take part in preliminary discussions. Allowing doctors to initiate such conversations has been shown to be coercive, with some people interpreting this as medical advice.

The role of doctors

- The process that culminates in the supply of lethal drugs lacks the multidisciplinary approach that usually characterises the making of complex, critical decisions. Usual clinical practice does not allow the time required. The assessing doctor does not need to know the patient well and is not required to ask the reasons for the request for assisted suicide. The training schedule proposed in the Impact Assessment is inadequate for acquiring the high level of skills needed to conduct the assessments thoroughly.

Approved substances

- The usual processes for testing and licensing drugs for assisted suicide will be bypassed. The adverse effects can be powerful and may not fulfil expectations of an easy, comfortable death.

Obligation to provide assistance

- The opt-out clause for individual practitioners is unworkable in practice. The lack of institutional opt-out will result in many staff being unable to avoid caring for people accessing assisted suicide. This increases the risks of moral injury and burnout and will exacerbate workforce challenges.

The Suicide Act 1961

- The Bill requires amendment of the Suicide Act 1961 and will create contradictory roles for doctors. They will be called on to validate the wishes for assisted suicide of some people whilst seeking to prevent suicide in others.

Investigation of deaths

- The Bill challenges the accepted definitions of natural and unnatural death. It removes coronial scrutiny from deaths by assisted suicide, and with it an important safeguard. The failure to state the accurate cause of death on medical death certificates will impact national statistics, public health and research.

Monitoring

- The Bill requires no monitoring of individual doctors participating in the provision of assisted suicide or of clinical outcomes, thereby reducing the opportunities for learning, research and the detection and challenge of poor practice.

Risk to the vulnerable

- The Bill provides inadequate safeguards for those many groups in society who are particularly vulnerable to coercion or feelings of being a burden. Some may feel they have no options open to them other than assisted suicide, increasing the potential for social injustice.

Impact on palliative care

- Many people who need specialist palliative care at the end of life cannot access it. The Bill does not have a requirement for review by specialist palliative care services. Specialist palliative care does not improve when assisted suicide is legalised and often suffers through funding freezes or cuts.

Conclusion

Having examined the Bill in detail, our conclusions are summarised below:

- Autonomy cannot be the only ethical principle deserving of consideration in this debate. The principle 'First do no Harm' must be upheld for individuals and for wider society.
- Assisted suicide is not a medical treatment but an existential personal choice.
- This Bill has inadequate safeguards that put some people at risk of premature death through misinformation or lack of information. The processes outlined in the Bill do not fit within the parameters of safe practice.
- Regulation is inadequate, review is only retrospective and it is unclear the extent to which wrongful decisions to provide lethal drugs are seen as acceptable.
- Many who are supportive in theory or neutral about some form of 'assisted dying' have extensive concerns about this Bill. These concerns have been expressed by several of the Royal Medical Colleges and Professional Societies.
- True choice at the end of life cannot exist for patients without significant investment in and expansion of specialist palliative care services and overall upskilling of generalists.

Terminology: We use the term 'assisted suicide', referring to self-administration, rather than 'assisted dying' for several reasons. First, choosing to ingest lethal drugs to end one's life fulfils widely accepted international definitions of suicide. Second, because of limitations in the accuracy of prognostication, some of those who would be eligible to end their lives under the terms of the Bill may not be imminently dying. Third, the term 'assisted dying' is used in jurisdictions where lethal drugs are injected intravenously by the physician to refer to euthanasia, whereas this Bill states that the final act must be by the patient. In jurisdictions that allow both assisted suicide and euthanasia, the vast majority of deaths are euthanasia and the numbers of such deaths are much higher.

Is death a treatment or an existential choice?[1]

A treatment is commonly understood to be an intervention that improves a person's health or quality of life.
By this definition alone, the provision of 'assisted dying' in any form cannot be considered a treatment as it supports neither health nor life.

The Bill is ambiguous and contradictory

- It assumes that death is a treatment by relying on doctors in assessing, prescribing and administering 'substances', and in assuming use of the Mental Capacity Act.[2]
- It sets assisted suicide in a different category from medical treatments in relation to the regulation of 'substances', use of a Commissioner (Clause 4), exemption from coronial oversight (Clause 38) and the potential for its use for existential reasons.
- These ambiguities and contradictions have legal and practical implications that make the Bill unworkable and unsafe in today's healthcare system.

The foundational principles and purposes of the NHS are undermined, and the role of Secretary of State conflicted

- According to the 2006 National Health Service Act Clause 1(1):[3]

  > *'The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—*
  >
  > *(a) in the physical and mental health of the people of England, and*
  >
  > *(b) in the prevention, diagnosis and treatment of physical and mental illness.*

- The Bill runs contrary to these purposes. It will require the Secretary of State to change the NHS Act to remove any conflict in approving substances used to bring about death (Clause 37).

Key regulatory requirements for treatments are bypassed

- The requirements of the Medicines and Healthcare products Regulatory Agency (MHRA) in approving and licensing drugs and devices used for medical treatments (Clause 37) do not apply to 'substances' used for assisted deaths by whatever route.[4]
- The involvement of the coroner in deaths brought about by drugs (Clause 38) is bypassed.

Assisted suicide could be approved for solely existential reasons

- Research from other jurisdictions indicates that 'assisted dying' is commonly sought to alleviate existential matters brought about by a person's social or economic circumstances, such as loss of autonomy and feelings of being a burden.[5, 6]
- The broad eligibility criteria of the Bill (Clause 2) would allow a person to be eligible for assisted suicide if they made that choice on purely existential grounds. The Bill makes no requirement that the person is suffering in any way.

Doctors will be obliged to offer death alongside conventional treatments

- If assisted suicide is regarded as a treatment option, then the Supreme Court ruling in *McCulloch* will apply.[7] Doctors will be obliged to present assisted suicide as a 'reasonable alternative treatment' when discussing end of life and palliative care needs, in spite of the provisions of Clause 31 of the Bill. Patients and families could reasonably argue negligence if it is not offered.

CLAUSE 2:

Terminal illness – what are the eligibility criteria?

Definitions are imprecise and will lead to expansion of eligibility over time

"(1) For the purposes of this Act, a person is terminally ill if (a) the person has an inevitably progressive illness or disease which cannot be reversed by treatment…"

- 'Inevitably progressive' and 'cannot be reversed by treatment' are broad, imprecise terms that are open to interpretation.
- Many chronic illnesses are 'inevitably progressive' and lead to death if the person chooses to refuse the treatment that keeps their illness stable. These include insulin dependent diabetes, chronic renal failure, cystic fibrosis and anorexia. It is not clear whether people with such conditions would be eligible for assisted suicide under the terms of this Bill. In many chronic conditions, accurate estimation of prognosis is particularly difficult (see below).
- Treatment, even in advanced disease in some patients, can reverse disease progression dramatically but this change is not predictable and only becomes evident over time.
- Without greater precision, interpretation of eligibility will expand over time, as has been well documented in other jurisdictions. For example, in 2017 Oregon officials conceded having reinterpreted the law without any change to that law, to include those likely to die within 6 months of stopping treatment. Consequently, people with anorexia and arthritis made successful applications for assisted suicide.

Estimating prognosis is notoriously unreliable and 6 months is an arbitrary cut-off

"…(b) the person's death in consequence of that illness or disease can reasonably be expected within six months."

- Six months is an arbitrary cut-off point. It has no basis in clinical practice as it is very variable, is a best guess and can only be shown with certainty in retrospect for an individual.[1]
- Estimating prognosis with any degree of accuracy is notoriously difficult, even for specialists.
- A large study in patients with cancer, dementia, heart and respiratory disease showed a prognostic accuracy of only 32% for those with an estimated survival of 'weeks' or 'months'.[2]
- Estimates of prognosis will be open to clinical and legal challenges; prognosis is not a safeguard as it is inherently flawed.[3]
- It is likely that people with estimated prognoses greater than 6 months will press their 'right' to have access to assisted suicide on the grounds that the reasons for their choice is just as valid as for those of people with a prognosis of 6 months or less.

> We've all seen patients given a six-month prognosis who are still alive and living well five years later. Rather than shortening dying these 'safeguards' could deprive people of valuable time to live well and make valuable memories with their loved ones.

Diagnostic error

In evidence to the 2004 Select Committee on the Assisted Dying for the Terminally Ill Bill, the Royal College of Pathologists stated:

> 'Post-mortem research and clinical audit studies performed in the UK, Europe, USA and many other countries consistently show a c. 30 per cent error rate in the medically certified cause of death. Significant errors (i.e. misdiagnosis of the terminal illness resulting in inappropriate treatment) occurs in c. five per cent of cases. Therefore, the procedure of making "a determination that the patient has a terminal illness" is not as reliable as the Bill implies. Almost all histopathologists (doctors who perform postmortem examinations) have experience of cases deemed to have died from an untreatable terminal illness, but postmortem examination discloses another condition—that would have been treatable—that was responsible for the patient's death.'[4]

Informed choice

- For any choice to be real and valid, it must be based on accurate information (about their diagnosis, the wide margins of error around prognosis and what alternatives are available) and be free from coercion or pressure. The person must be competent to make the choice and understand its implications.
- Without experiencing specialist palliative care input and support that meets their needs, as well as meticulous diagnostic review, there are real risks that the fundamentals of sound decision-making will not be met as the Bill does nothing to minimise the risk of error.

CLAUSE 3:

The Mental Capacity Act – an unsuitable tool for assessing decision-making ability to choose to die

The purpose of the Mental Capacity Act (MCA) and its associated Code of Practice is to protect and enable people who may lack capacity to make or partake in decisions. It tests for capacity to refuse or withdraw medical treatments, not to choose medical treatments. It recognises that capacity applies to specific decisions made at specific times and cannot be generalised. One of the bedrock principles of the MCA is the presumption of capacity. Using the MCA as the reference point for capacity in assisted suicide raises a number of issues:

The MCA is not designed for assistance with dying. The MCA provides the framework for the refusal or withdrawal of life sustaining treatment. Such withdrawal is not based on intending death but is based on the ruling in *Bland*[1] that identified that medical interventions are an intrusion on bodily integrity and autonomy. This means that a patient with capacity can decline such intrusions on their bodily integrity even if doing so leads to their death. The MCA provides a framework for determining whether such bodily intrusions can be justified where the person lacks capacity. The MCA was not designed to deal with requests for help with ending one's life.

The MCA does not provide clarity. For over a decade, concerns have been expressed that there is a lack of clarity as to what mental capacity means in the context of 'assisted dying'. The lead author of a study analysing evidence given to Lord Falconer's 2012 Commission on Assisted Dying stated: '*There is no consensus amongst experts on what mental capacity is, what level of capacity is acceptable or how it should be assessed[…]there were varying interpretations of the use of the Mental Capacity Act with respect to assisted suicide, implying that the proposed framework does not provide a strong enough safeguard for patients'.*[2] Sadly, there is no evidence that these concerns have been resolved.

The MCA's presumption of capacity has prompted concerns. The review of the MCA by the House of Lords Select Committee in 2013-14 highlighted serious issues with this presumption, stating it was 'misunderstood' and at times 'deliberately misappropriated to avoid taking responsibility for a vulnerable adult'.[3]

Inadequate consideration of capacity will fail the vulnerable.

- The Bill requires consideration of capacity at several points, but it is not clear to what extent consideration needs to be more than superficial.
- Any assessment of capacity needs to be commensurate with the decision being made, and surely no decision can be as momentous as the decision to end one's life?
- The vulnerabilities of some people, be these physical, emotional or financial, will almost certainly impact their choices and decision-making abilities, and these need to be taken into account.
- Suspending presumption during the process of assessing capacity is the course of action advocated by Astrachan *et al* 'when a momentous decision is faced by a vulnerable patient' and where harm could otherwise result.[4] It is hard to see how proper consideration can be given otherwise. In such circumstances, it must always be for the person to satisfy the assessor that they have capacity, not for their capacity to be presumed.

Information required for decision-making. Doctors will need to take into account the Supreme Court ruling in *Montgomery*[5] and be confident that the person has all the information they need to give informed consent to have their life ended by lethal drugs. It is hard to imagine what information a doctor could give to help a person decide that they would be better off being dead in the absence of empirical evidence to support that conclusion.

CLAUSES 5-7:

Preliminary discussions

Terminally ill persons who raise the subject of assisted suicide may be unwell, symptomatic, depressed, and fearful. Professionals will need significant skills in communication, along with time and an appropriate environment to conduct these discussions well.

Who is a registered medical practitioner (RMP)?

A Registered Medical Practitioner is a doctor who is registered on the General Medical Council List of Registered Medical Practitioners.[1] Doctors who have worked at Foundation level for only one year after graduating fall into this category, as do retirees who wish to remain registered but no longer hold a license to practice. Physician Assistants are also registered with the GMC, but the Bill fails to clarify their involvement, if any.

Qualifications and experience

- Preliminary discussions can be conducted by an RMP who has never met the person before.
- There is no requirement for an RMP to have undergone training. The impact assessment allows for two online training sessions (90 and 60 minutes) in conducting preliminary discussions[2], but these are not mandatory.
- There is no stipulation that an RMP must refer the person to another professional if they themselves would be acting beyond their own competence and training.

Exercising professional judgment to initiate the discussion 5.2

This clause has the potential to violate the principle 'First do no harm', and worse, may instigate a hastened death.

- **Limits of professional judgement in assisted suicide.** Medical practitioners make assessments all the time about which particular treatments are in their patient's best interests to improve their health and wellbeing. Professional judgement is informed by experience, qualifications, familiarity with best practice, clinical research and knowledge of the person being treated. Patients risk harm when complex judgements are made by the inexperienced and unqualified.
- **Unconscious bias** can affect the way a doctor influences decisions made by their patients.[3]

Hazards of a doctor-initiated conversation about assisted suicide 5.2

- Clause 5.2 has the potential to cause harm. Allowing RMPs to initiate discussions about assisted suicide could be experienced as suggesting that this might be the best option and hence be coercive. As medical error is not infrequent, this allows error and even mismanagement to go undetected, particularly as coroner oversight is excluded (38.1).
- There have been many published examples of individuals who have felt distressed and coerced, perceiving the suggestion as a recommendation from a trusted professional.[4]
- In Belgium and New Zealand doctors are forbidden from raising assisted suicide with patients in case is it interpreted as medical advice.[5]
- Western Australia's higher rate of assisted deaths compared with Victoria may be due to Victoria's prohibition on health care professionals initiating discussions about assisted death.[6]

Scope of the discussion 5.3 and 5.5.a-c

- **Diagnosis, prognosis, and treatment.** These discussions should be carried out by specialists in the person's condition and who are familiar with their medical history, not doctors with minimal experience and training.
- **The reason behind the request.** Good practice requires a clinician to explore the factors behind distress, but this was dismissed at Committee stage in the House of Commons.
- **Palliative care.** Non-specialist RMPs are often unaware of the range of palliative care services available and hence unable to discuss these in an informed way. Referral to a specialist in palliative care needs to be statutory at this point to ensure a full holistic needs assessment.

Evidence from abroad is that 'assisted dying' is an individual's existential choice, rather than a medical treatment required for their health and wellbeing[7]. As such it falls outside the scope of doctors' professional judgement and duties. A doctor's primary duty is to provide care and treatment to patients, encompassing prevention, diagnosis, and evidence-based management of illness and injury while promoting overall health.

Conscientious objection 5.6

Although the Bill does not require an unwilling RMP to refer to another doctor to conduct the preliminary discussion, the duty to 'ensure' that the person is directed to 'where they can obtain information and have the preliminary discussion' goes beyond signposting. Doctors with an objection to assisting suicide of a particular patient, whatever the circumstances, will find they are forced to comply or leave the profession.

In short

The Bill lacks precision about who may undertake preliminary discussions. RMPs could take part in discussions without adequate training and experience.

The scope of the discussion should cover areas that only experts in the person's medical condition and palliative care services could fully address. A referral for palliative care assessment should be a requirement.

CLAUSES 8-22:

Assessments, procedures, and the role of doctors

These clauses describe the process that culminates in the supply of lethal drugs with which a person may end their own life. Serious concerns have been raised by the medical profession that this process is not fit for purpose.

Complex, critical decisions require a multidisciplinary approach

A joint June 2025 statement by the Royal Colleges of Physicians and Psychiatrists expressed concern about

'… the way doctors and healthcare professionals would be expected to work. Taking critical decisions alone would not happen in any other aspect of clinical practice. Doctors' core duties and expertise are in the diagnosis and treatment of patients as part of the multidisciplinary team. Complex clinical decisions are and must be made in this way, and through face-to-face assessments.'[1]

The process does not require: the co-ordinating doctor to know the patient well. Exploration of the reasons for requesting assisted suicide is not required and neither is a holistic assessment of physical, psychological, social needs that might identify remediable problems. It would be negligent in other areas of clinical practice to omit such an assessment in someone expressing suicidal ideas.

Referral to specialists is entirely at the discretion of the co-ordinating doctor.

The multidisciplinary panel (Clauses 16 and 17) must hear from the co-ordinating or the independent doctor, but need not question either. The panel must hear from the person seeking death (17.4 (b)) but this can be done remotely. The psychiatrist and social worker on the panel do not need to conduct independent formal assessments. This potentially makes the panel's role a tick-box exercise.

Which doctors will be involved?

Doctors are essential to the delivery of the Bill: the word 'doctor' is mentioned 189 times. General Practitioners (GPs) are typically the first point of contact for terminally ill patients; an assisted suicide service within the NHS would be likely to rely heavily on GPs to deliver, as evidenced by their extensive involvement in other jurisdictions.[2]

In 2019 only 7% of GPs considered that delivery of assisted deaths should be part of a GP's role.[3] The Royal College of GPs has made clear that any assisted suicide service must be outside core general practice and separately funded, and that doctors should be able to refuse to participate in the process on any grounds.[4]

A survey of 28,986 doctors in the UK in 2020 found that 47% of respondents would not be prepared to actively participate in any way if 'assisted dying' was legalised.[5]

Evidence from Canada and Oregon suggests that some doctors may become 'specialists' in 'assisted dying'. In Canada, 17% of MAiD (Medical Aid in Dying) practitioners provide the service to 35% of terminally ill applicants, and 4% provide it more than 30 times per year.[6]

The initial assessment and discussions require significant time and expertise

The initial assessment (Clause 10.2) requires extensive discussions, as described in Clause 12.2. These cover areas of complexity and sensitivity. They will require time (possibly more than one interview), an appropriate environment and a doctor with training and expertise. It is debatable whether such requirements could be met in GP surgeries or in hospitals without compromising the provision of other services. In addition, the person being assessed is terminally ill, and may be vulnerable, with limited physical and emotional energy. There is a serious risk of pressure to expedite the process, which will become a 'tick-box' exercise. Factors like coercion that take time and skill to detect may be overlooked.

Experience and training of doctors

The training schedule is set out in the Impact Assessment (IA).[7] It would be possible for a doctor with only one year of experience to undertake three days of training to become a co-ordinating doctor. The budget in the IA assumes cheaper, middle grade doctors would be trained rather than those who are more senior and experienced. The IA assumes that each co-ordinating doctor will oversee one applicant per year. It is hard to envisage how these doctors can develop and maintain any level of expertise if they put their training into practice so infrequently.

Workload

The IA seriously underestimates the likely workload. Data from New Zealand suggests that a figure of around 4,600 deaths is likely to be reached by year 2 (0.9%) of all deaths, not by year 10 as suggested in the IA. New Zealand's healthcare system, culture and demography are similar to the UK.

The IA estimates that 40% of requests would not progress, but New Zealand data suggests a higher number of applications should be anticipated in planning for workload and costs.

Jurisdictions that recently introduced an 'assisted suicide service' have reported increased numbers of such deaths by about one third each year.

Implications for doctors undertaking assisted suicide

Pressure on doctors to participate

In the Netherlands, GPs are responsible for around 85% of reported euthanasia cases. They report pressure to participate, including 'emotional blackmail' from patients and relatives.[8]

> A family member threatened to murder a patient if the GP did not help 'Well, will I have to do it myself then, will I have to put a pillow over her head? And then you will be the guilty one'[8].

Moral distress for health care professionals

Studies have shown that participation in assisted deaths leads to long term emotional consequences for 15-20% of doctors.[9]

CLAUSES 25-30:

Provision of assistance to end life – Drugs and Devices

No internationally agreed protocols

- There are no internationally agreed protocols governing the drugs and methods used to bring about the death of a person[1] and no pharmacological research has been undertaken.
- Various combinations of unlicensed drugs at untested lethal doses are used in different jurisdictions. This stands in sharp contrast with the research-based protocols used for many complex medical conditions and raises issues of patient safety and informed consent.[2]

Adverse effects

- Drug regimens comprise large numbers of tablets (up to 100) or large volume intravenous (IV) injections which take time to administer.
- In Oregon, data on whether complications occurred was missing in 68% of cases.[3]

- Vomiting, seizures, muscle spasms, reawakening (nine cases) and prolonged dying are reported[3].
- The time between taking lethal drugs orally and death is unpredictable, with a median time to death of 37 minutes from ingestion (range: one minute to 137 hours).[3]
- Families and health care workers have been distressed when 'death happened too quickly'.[4]

Mode of death by lethal drugs

- The process of ending life with lethal doses of drugs has three stages: i) unconsciousness; ii) cessation of breathing and loss of control of blood pressure; iii) cardiac arrest.
- As long as the heart beats, drugs may be 'washed out' of the brain by the circulation and breathing and, in some cases, consciousness may even return. Some regimens include drugs with a specific action on the heart, for example digoxin, at 200-1500 times the daily dose for an elderly person.
- Drugs which paralyse the muscles can be used to hasten death by stopping breathing, but consciousness can return while paralysed. Sedative and anaesthetic agents used can also mask awareness and distress that the person may experience during dying.[5]
- In Canada, a 'backup' kit of intravenous drugs is administered if the initial drug infusions fail to cause death.[6] This has to be administered by a health care professional as the unconscious person cannot do it themselves.

Regulation - deviation from best practice

(1): MHRA bypassed

- The approval and licensing of drugs and medicinal products by the Medicines and Healthcare products Regulatory Agency (MHRA)7 will be bypassed, leaving the Secretary of State for Health with responsibility for stating what lethal substances are to be used. (Clause 37).

(2): Coroner bypassed

- 'Assisted deaths' will be specifically exempt from referral to the coroner (Clause 38), contrary to standard procedures following any death brought about by drugs or medication. This removes independent oversight of medically-related deaths and potentially allows errors or unlawful assisted deaths to go unrecognised.

(3): No provision for review and clinical oversight

- No audit or observation review of any aspect of individual cases is required, leaving poor practice to be concealed or unchallenged.

In short

There are no licensed or adequately tested 'substances' for bringing about death. Use of unlicensed 'substances' at untested lethal doses can use distress and harm for patients, their loved ones and for health care professionals.

The mode of death and adverse effects may not align with expectations of a peaceful, uncomplicated death and intervention by healthcare professionals may be required to complete the process.

The regulation of 'substances' and devices specified in the Bill falls far short of the standards expected in routine clinical practice.[2] This may lead to concealment of complicated or unlawful deaths.

CLAUSE 31:

No obligation to provide assistance

Clause 31.1 states that: '*No person is under any duty to participate in the provision of assistance in accordance with this Act*'.

> *'There may be a range of reasons (including but not limited to conscientious reasons) why people may feel strongly that they wish not to be involved in assisted dying. Reasons like traumatic personal experience, deep cultural resistance to the idea of being involved in the ending of human life, or personal beliefs about the nature and role of healthcare and the proper duties of the health professional, are not necessarily 'conscientious' reasons for wanting to opt out, but they are no less legitimate.'*
>
> Mary Neal, Reader in Law, TIAB341[1]

At first glance, clause 31 appears straight forward but the 'no obligation' protection it offers to individuals is superficial and fails to recognise the complex way the NHS works in practice.

The Bill Committee's rejection of an institutional opt-out has far-reaching consequences that give further concern to staff with conscientious objections. (clause 5.6 and 31.7(c)).

Limitations of the 'opt out' clause for individuals

- In her 2014 Supreme Court judgement in relation to termination of pregnancy, Lady Hale concluded that *'participation means taking part in a 'hands-on' capacity'*[2]
- In relation to this Bill, 'hands-on' participation is likely to be referring to specific processes specified, such as assessments or prescribing and assisting ingestion of lethal medication.
- The Bill appears to give an 'opt out' from participating in only these specific activities rather than a clear opt-in.

In the absence of institutional opt-out:

1. **Many staff will be unable to avoid caring for people undergoing assisted suicide**

   The lack of provision for institutions to opt out means that health professionals have limited options to avoid general involvement with assisted suicide.

   Staff are likely to be required to care for people accessing assisted suicide in many capacities, for example, contributing to multidisciplinary team discussions, being available during an 'on call' shift to help deal with medical complications or providing general nursing care, especially if death is prolonged.

   The Bill makes no provision for staff to opt out of such involvement, and the staff expected to provide care will find it very difficult to refuse. Many may find they need to provide such care simply because there is no-one else willing or available. This is particularly likely in community settings where staff numbers can be low and services thinly spread.

2. **Well-recognised workforce challenges[3] will be exacerbated**

   Surveys show that doctors who spend the most time caring for terminally ill patients are the most opposed to assisted suicide (e.g. geriatricians, palliative care physicians, oncologists).[4] A recent UK Association for Palliative Medicine (APM) survey showed that 75% of palliative medicine doctors would not be willing to be involved in any aspect of assisted suicide and 43% would resign if their institution were to provide assisted suicide.[5]

3. **Funding may be withdrawn**

   In Canada hospices do not have an institutional opt out. Some have had their funding withdrawn because they refuse to provide 'medical aid in dying' known as MAiD.[6]

4. **The risk of moral injury and burnout to staff.**

   Physicians in the Netherlands report high levels of stress participating in assisted suicide/ euthanasia.[7]

   The Association for Palliative Medicine has recommended the Bill makes provision for institutions such as hospices to opt out of providing assisted suicide services at an organisational level.[8] This would create protected spaces for patients and staff and avoid a return to hospices being seen by frightened patients as 'death houses'. It must be recognised however, that the provision of assisted suicide will not be limited to hospices. Large numbers of staff across the whole NHS working in community services, hospital wards and in care homes, will also be affected by this Bill.[9]

Specific duties in the Bill remain problematic for staff who object

Should the Bill be passed, the following actions will become legal professional requirements. These actions are not included in the Bill's definition of 'participation' and the Bill makes no provision for opting out of them:

- The duty to ensure that the person is '*directed to where they can obtain information and have the preliminary discussion'* about assisted suicide (clause 5.6).
- The duty to respond to enquiries made by the assessing doctor under clause 12.2(b) '*relating to health or social care the person is providing or has recently provided, to a person seeking assistance under the Act*' (clause 31.7(c)).

The Bill proposes a caveat to Section 2 of the Suicide Act 1961, but the requirements in the Bill undermine current clinical responsibility for suicide prevention. General Medical Council (GMC) guidance currently warns doctors that encouraging suicide is a 'serious departure'[10] from the principles set out in Good Medical Practice and that 'respect for a patient's autonomy cannot justify illegal action'.[11]

Should the Bill pass, the current GMC guidance will require a complete *volte face*, as support for assisted suicide will no longer be illegal. Doctors who for conscience reasons cannot fulfil the new duties required by the Bill in respect of assisted suicide, will find that they can no longer call on the GMC guidance for protection. This leaves the 'no-detriment' statement in the Bill (Clause 31.8) open to challenge.

CLAUSE 32:

Criminal liability for providing assistance – impact on suicide

The World Health Organisation defines suicide as the act of deliberately taking one's own life. In England and Wales, a coroner's verdict of suicide depends upon a finding that the deceased committed an act that resulted in their death and that they intended that act to result in their death. No formal definition of suicide, including that used by ONS or the National Confidential Inquiry into Suicide, includes a statement about motives or circumstances surrounding the death. The Suicide Act 1961 defines assisting the suicide of another person as illegal, including for example by provision of lethal drugs for self-administration. The Terminally Ill Adults (End of Life) Bill does not seek formally to redefine suicide or assisted suicide, but to introduce a set of circumstances in which assisting suicide becomes legal.

The term 'assisted dying' is a blanket term that covers the provision of lethal drugs for self-administration (assisted suicide) or administration by a health care professional (euthanasia).[1]

Terminal illness is a risk factor for suicide[2]

- Clinicians typically make a distinction between "actively dying" when the expectation is of hours or days of survival and "life-limiting disease" with expected survival in terms of months.[3] The risk of suicide is greatest at the time of diagnosis or disease recurrence, particularly when imparting the bad news has not been gentle. People with life-limiting illnesses who die by suicide share features with suicides in other situations and are likely to have many of the same risk factors such as hopelessness and fears for the future, mental health conditions, unmet needs, abusive coercive or unsupportive relationships and feelings of being a burden.[4]

The Bill creates inherent contradiction for psychiatrists in managing suicide[2,5]

- Clause 32(3) of the Bill amends the Suicide Act 1961 so that a person encouraging or assisting suicide will not be liable under that Act provided they 'reasonably believe' they are acting in accordance with the Bill, rather than have to demonstrate they have acted in accordance with the Bill's requirements.
- Doctors will have two contradictory roles – on the one hand, helping people with suicidal thoughts or plans with the aim of alleviating mental and physical suffering and reducing suicide risk; on the other hand, validating the wish for assisted suicide in others as a rational, autonomous choice.

Suicide rates do not decline when assisted suicide is legal

- Assisted suicide is not a form of suicide prevention, as has been claimed.[6]
- In 10 US states with assisted suicide laws, total suicide rates increased by 18% overall and non-assisted suicides by 6%.[7] From CDC data, suicides in Oregon have risen 34% in the last 20 years.[8]
- Studies in other jurisdictions have also failed to demonstrate lower rates of suicide.[9]
- Fears that legalisation of assisted suicide will undermine our National Suicide Prevention Strategy appear to be well-founded.

Suicide prevention principles should not be withheld in those wanting assisted suicide in the belief they are irrelevant because the person is terminally ill. Many people use terms suggesting a wish to die as a way to signal distress or unmet needs which can be resolved by careful assessment of social and psychological risk factors and appropriate care. When people can access the care and support they need, the vast majority of patients no longer wish to die and are glad to still be living.

CLAUSE 38:

Investigation of deaths – role of the Coroner

Under the current law, any death caused by ingestion of lethal drugs is classified as an unnatural death and must be referred to the coroner for further investigation before a Medical Certificate of Cause of Death can be issued. An inquest is not mandatory for every case notified to the coroner.

Clause 38 of this Bill will amend the Coroner's and Justice Act 2009 to:

- **Reclassify the legal status of assisted suicide from 'unnatural' to 'natural' death** (clause 38(1)). This change would remove coroners' statutory duty to investigate the circumstances and cause of an assisted death (Clause 38(1).
- Clause 38(2) Specifies how assisted suicide (within the meaning of the Bill) should be written on the Medical Certificate of Cause of Death (MCCD). It should state the route ingestion (oral or intravenous) to improve monitoring accuracy.

Making assisted suicide lawful does not make it natural

> Natural death has been defined as '*related to an internal bodily event not influenced by external occurrences; Death caused by disease, completely independent of any legally significant factors; and as unnatural, if caused by an external event. There is a consistency here in regarding causative matters external to the body as unnatural, thus embracing treatment interventions.'*
>
> Andrew Harris, Senior Coroner, solicitor and barrister Emeritus consultant in public health [1]

After a person dies in England or Wales, doctors have a duty either to issue an MCCD following scrutiny by a medical examiner, or to refer to a coroner if the cause of death may be unnatural, traumatic or potentially unknown. Unnatural deaths include those caused by treatment complications or errors, even if the person was terminally ill. Coronial scrutiny is required because life has been shortened, and death was not due to natural disease progression.

Loss of Coronial Scrutiny removes an important safeguard

The Royal College of Pathologists is the lead college for medical examiners. In their opinion *'deaths following assisted dying should be notified to the coroner, just as other deaths following the administration of drugs, prescribed or not, must be.'*[2] They go on to state:

'Notification to the coroner following an assisted death would ensure independent judicial review, which is particularly important given the concerns raised by many individuals, organisations and medical Royal Colleges about the lack of adequate safeguards in the Bill for vulnerable people. Lawyers, not doctors, are the most appropriate professionals to review these deaths. The medical examiner system was implemented to detect problems with medical care, not to identify discrepancies or malintent in the legal process required for assisted deaths. The training and resourcing for medical examiners to take on this new role would be significant, potentially taking medical examiners away from their current important role. Coronial referral for assisted deaths would be in line with current regulations, with all deaths due to a medical intervention or medicinal product being notified.' [2]

In addition, the Bill provides no independent medicolegal scrutiny of the interval between a certificate of eligibility being provided and the assisted suicide taking place and continues to exclude family from judicial review.

Considering the importance of robust safeguards Thomas Teague KC has observed that the inclusion of coronial scrutiny would provide a '*robust deterrent against wrongdoing, for example, the neglect of vulnerable persons by those caring for them, or the ill-treatment of prisoners by those responsible for their confinement.'*[3]

Cause of death data impacts national statistics and public health

- Accurate completion of MCCDs is essential for public health monitoring, planning and research.
- Future calculation of national mortality statistics will need to take into account assisted suicide as a cause of death. For example, the statistics for survivorship following new medical treatments will be impacted and distorted if natural lifespan is reduced prematurely by assisted suicide.
- Clause 38(2) requires the cause of death to be written as 'assisted death' alongside a record of the illness or disease which caused the person to meet the Bill's definition of terminal illness. 'Assisted death' does not allow differentiation between orally ingested or device-administered lethal drugs assisted suicide or euthanasia. This is an important distinction to make in a Bill that does not legalise euthanasia.

CLAUSES 47-50:

Monitoring and review

Monitoring of the operation of the Act rests with the Voluntary Assisted Dying (VAD) Commissioner, who will report to the Secretary of State or Welsh Ministers.

The Secretary of State will be required to make a total of 17 different reports to Parliament in the first five years after implementation of the Act, followed by a full review after five years.

Provision is made for reporting on access to health care for people with palliative care needs, impacts on disabled people and persons with protected characteristics.

There is no provision for independent review of the individual or public health impacts of the Bill.

Lack of provision for clinical reporting

Monitoring of participating doctors. Doctors' overarching aim must be to 'first do no harm'. The Bill places controversial new duties on medical professionals and health services but it requires no monitoring of individual doctors participating in the provision of assisted suicide. This forfeits the opportunity both for clinician learning and the detection and challenge of poor practice.

Monitoring of clinical outcomes. There is no requirement for the monitoring of individual clinical outcomes of persons accessing assisted suicide and no mechanism for transparent reporting of adverse events such as prolonged time to death, seizures or vomiting. These outcomes are included in the annual reports on Oregon's Death with Dignity Act, although they are limited by missing data in 72% of deaths (2023)[1].

Lost opportunities for research. The Bill mentions no role for the UK's National Institute for Health and Care Research (NIHR). Failure to collect data related to performance and outcomes seriously limits research opportunities. The lack of peer reviewed evidence about the pharmacology of substances used for 'assisted dying' suggests that any implementation of assisting suicide should be through well-designed clinical trials.

Role of the VAD Commissioner

The Voluntary Assisted Dying Commissioner has a judicial, rather than clinical, background and is required only to report on compliance with the Bill's stipulated processes. There is no provision in the Bill for external, independent scrutiny of the service that the VAD Commissioner provides. In some countries, transparent independent scrutiny after death (equivalent to the role of VAD Commissioner) is performed by multi-disciplinary panels e.g. by a physician, ethicist and lawyer in the Netherlands.[2] Panels have powers to contact the doctors involved and a duty to report within six weeks. The availability of these reports has enabled research, for example, into assisted death for people with autism.[3] Conversely, Queensland state's annual reports provide no information on patient outcomes.[4] Clinical complications that were 'very stressful for each family' were reported only coincidentally during coroners' investigation.[5]

Role of the Chief Medical Officers (CMOs)

The CMOs of England and Wales are senior scientific advisors with the '*unique authority to independently report to the public*'.[6] They are ideally placed to monitor the impacts of legislation on health care services and on public health. The Bill places no direct responsibility on them. It merely requires that they be consulted during the preparation of annual reports.

The CMOs are the most senior public health doctors in England and Wales. The government's equality impact assessment recognises that '*evidence on the impacts of assisted dying policies is limited*'.[7] The CMOs are best placed to ensure that meaningful public health outcomes are monitored and that 'no harm' occurs on a population basis. The need for thorough ongoing research following the introduction of new interventions into the NHS has been illustrated by the harms caused by poor implementation of the Liverpool Care Pathway[8] or misapplied DNACPR ('do not resuscitate') decisions.[9,10] The Bill will also have impact in other areas of public health such as suicide prevention[11,12] and staff/organisational attitudes to persons with terminal illness.[13]

The current focus on palliative and end of life care services presents an opportunity for an overdue economic analysis of their costs. Statutory reports should also contain information about the impacts of the legislation on the health and care workforce.

Risks to the vulnerable & potential for social injustice

Evidence from other jurisdictions indicates that vulnerable people such as those who have mental illness, physical or learning disabilities, those in poverty and those suffering from elder or domestic abuse, are at increased risk of feeling pressured by legislation for 'assisted dying', whether assisted suicide or euthanasia.

Since 'medical aid in dying (MAiD)' was introduced in Canada less than 10 years ago, significant concerns have been raised about the impact on vulnerable groups.[1] Data suggest that many seeking 'assisted death' (almost all are euthanasia) in Canada have unmet needs including loneliness, poverty, lack of access to effective and affordable services, and concurrent mental illness.[2] The case below illustrates the dilemma they may face.

> *Dr Ramona Coelho, a Canadian Family Physician describes a patient who*
>
> "… saw a national TV program showing a patient going through the assisted dying (MAiD) process. It was portrayed as an amazing experience. My patient found it very convincing. She had recently suffered a spinal cord injury, causing disability. She had symptoms of depression but had not had psychiatric care. She was experiencing long delays in receiving proper treatment for her symptoms. The government was not offering sufficient financial and social support to accommodate her new circumstances. She was contemplating choosing death because she feared a future of living in poverty with disability. She had already been told she would qualify for MAiD." [3]
>
> *The patient has given permission for her story to be shared*

For this patient, and many more like her, ending her life can appear to be a more attractive choice than facing inadequate access to medical, financial and social support. Their increased vulnerability can drive the decision to request 'assisted death' rather than a truly autonomous choice.

Why the increased risk to the vulnerable?

Eligibility criteria typically broaden with time to include vulnerable groups who do not have a terminal illness. In Canada people with chronic illness and disability now qualify, with extension to those with mental illness imminent. In the Netherlands, people with intellectual disabilities and autism have successfully applied for and received euthanasia.[4]

People living in poverty are more likely to experience social, psychological, physical and mental issues that can lead to the consideration of assisted suicide.

- 'The Time to Care 2024' report found that those with poorer financial circumstances use specialist palliative care services less than wealthier groups because of inferior access.[5]
- Data from Oregon demonstrates that 9.3% of those who chose assisted suicide did so in part for financial reasons. The proportion of people requesting assisted suicide who had private health insurance has fallen from 65% to 20% over 25 years. By 2022 most (80%) had government (Medicare or Medicaid) health insurance, suggesting they are from poorer sections of society.[6]

'Feeling a burden' and the risk of coercion are common to all vulnerable groups:

- In 2021, UN human rights experts raised concerns that, even when restricted to those with a terminal illness, "people with disabilities, older persons, and especially older persons with disabilities may feel subtly pressurised to end their lives" due to social attitudes and lack of appropriate services and support.[7]
- In Canada, over 50% of patients who undergo MAiD (usually euthanasia) for a non-terminal illness required disability support services.[8]
- In Oregon, 42% of people seeking assisted suicide cited 'feeling a burden' as a reason.[7]
- Not all families are loving and caring. The 2020/2021 Crime Survey for England and Wales estimated that around 750,000 incidents of elder abuse occurred in the year, including psychological, financial, physical abuse, and neglect.[9] The authors of this briefing paper also cite instances of family reluctance to pay for nursing home fees.
- Coercion of the vulnerable can be very subtle and difficult to detect, particularly where the victim is in a dependency relationship with the coercer. It requires skill and often needs several encounters with a person and their family or carers over time. The Bill contains no requirement for doctors to speak with relatives and the impact assessment's projected training is grossly inadequate to detect coercion.

Numerous amendments that would have reduced the risks to vulnerable groups were rejected at the House of Commons Committee stage of the Bill. These included:

- mandatory training for medical and legal professionals in identifying victims of coercive behaviours,
- psychological assessments to identify patients experiencing coercion, which may be subtle or covert, or the feeling of being a burden though internal or external pressures.

The Bill's sponsor agreed in the House of Commons debate that concerns about costs of future care would be an acceptable reason for someone to access assisted suicide under this Bill.

Patients do not have a real choice if they cannot access care or support, encounter ableist attitudes, feel they are a burden, or are subject to coercive influence. This Bill risks widening social injustices. It does not do enough to protect vulnerable groups from feeling they have no options open to them other than fully-funded assisted suicide.

The Impact of Assisted Dying on Palliative Care

Claims are often made that palliative care is unaffected or improves when assisted dying is legalised. The reality is very different and evidence from assisted dying (AD) jurisdictions around the world does not support this claim.

No 'assisted dying' jurisdiction defines palliative care

Some official reports state that the majority (up to 85%) of people undergoing an assisted death have received palliative care, although this can be as low as 26% in patients having rapid access to an assisted death as in Canada.[1] However, the nature of this 'palliative care' is never defined. General end-of-life care (EoLC) and specialist palliative care are often painted as the same, but care by an individual healthcare professional is not the same as care by a specialist, multidisciplinary palliative care team. In the same way, the care of a complex heart failure patient by a single practitioner, no matter how compassionate, is not the same as care by a specialist cardiology team. Specialist teams are experienced in complex situations that demand knowledgeable and skilled care and compassion. As a consequence, such teams are more likely to succeed in resolving problems that may otherwise appear intractable.

Neither end-of-life nor palliative care are available to all

The rankings of quality of dying have reduced in many assisted dying jurisdictions between 2015 and 2021; Belgium (5th to 26th), Australia (2nd to 4th), Canada (11th to 22nd), and Spain (23rd to 28th).

Almost half of Canadians who were described as palliative receive no palliative care before their death (48% in 2016-17; 42% in 2021-22).[2] Less than half of Canadian assisted death patients have seen a specialist palliative care team.[3]

In Australia, over half (59%) of dying hospital patients are never referred for specialist palliative care.[4]

In 2017, Hospice UK estimated that 118,000 patients (320 every day) who needed specialist palliative care could not access that care. That figure is likely to be much higher in 2025 as hospices have closed beds and funding for specialist teams fails to keep up with demand.

The relationship between palliative care and assisted dying varies considerably.[5,6,7]

While some services have incorporated assisted dying, these are a minority if they have the choice. In Oregon in 2012, two-thirds of hospices did not allow staff to take part in assisted deaths.[8] In New Zealand all but one hospice have refused to participate in assisted deaths, and the one hospice does so in a separate part of their premises. However, choice does not always extend to health practitioners and organisations. In Canada, assisted dying is viewed as a process to be provided by all and this is having a profound effect on healthcare, including palliative care.[9]

Specialist palliative care does not improve when assisted dying is legalised

In both Belgium and the Netherlands between 2012 and 2019, growth stalled in specialist palliative care services (community, hospital and hospice), while growth increased in European non-assisted dying jurisdictions.[10] Specialist palliative care services in Switzerland are estimated to be half of what is needed and are not growing.[11] In Oregon, growth in hospice services has been slower than elsewhere in the US.[12] In Victoria, Australia, palliative care funding has been reduced, while funding for assisted deaths has increased.[13]

Conclusions

Specialist palliative care does not improve when assisted dying is legalised and often suffers through funding freezes or cuts. When added to existing shortfalls in provision and increasing demand, this means more patients will fail to get the specialist care they desperately need.

Authors

This paper has been produced by the following lead authors:

Dr Kathryn Myers MA FRCP

Dr Elizabeth Lamb FRCGP

Dr Rosemarie Anthony-Pillai FRCP

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Turn over to see references

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‘First do no harm’

Concerns from senior doctors regarding the Terminally Ill Adults (End of Life) Bill

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