Briefing on Report Stage of the Westminster Terminally Ill Adults (End of Life) Bill

Health professionals' concerns after Committee Stage

May 2025

The Terminally Ill Adults (End of Life) Bill introduced by Kim Leadbeater MP in October 2024 seeks to permit doctors to supply terminally ill adults with lethal drugs to end their own lives (assisted suicide).

Summary

Our Duty of Care (ODOC) is a campaign group of over 5,300 health care professionals across the UK who oppose assisted suicide. Instead, we advocate for equitable access to excellent palliative and end of life care.[1] We are funded and administered by Care Not Killing.[2] We are from all faiths and none. We bring the experience of doctors, nurses, pharmacists, and allied health professionals from the front line of hospitals, hospices and primary care together with clinical academics across a wide range of disciplines.

Doctors who spend the most time caring for the dying overwhelmingly reject changes in the law to decriminalise assisted suicide,[3,4] as reflected by the position statements of the Association for Palliative Medicine[5] and the British Geriatrics Society.[6]

The safeguards and protections in the Terminally Ill Adults (TIA) Bill have been weakened after an intensely debated Committee Stage February-March 2025. More than 80 amendments intended to strengthen the Bill's safeguards were rejected and new risks identified. The late extension of the proposed implementation period from 2 to 4 years demonstrates concerns about the feasibility and workability of the Bill and its provisions.

We summarise some of the evidence that the Bill's safety has been further eroded through a rushed Committee Stage and the wide-ranging harms and risks that would result from implementation within routine NHS healthcare systems, at a time of unprecedented NHS crisis.

1. Removing the key High Court safeguard undermines the safety and credibility of the Bill

Case-by-case approval of requests by a High Court judge was promoted as the Bill's key safeguard against coercion. It was emphasised as one of the Bill's most important safeguards during the Second Reading debate. The replacement by a three-person panel – social worker, psychiatrist, and a lawyer – removes the promised judicial scrutiny. These panels can be held in private and will not have the power to summon witnesses or take evidence under oath. The skills of panel professionals would be better placed earlier in the assessment process. If multi-disciplinary team members were able to meet the applicant, they would provide more effective safeguards by exploring their reasons for requesting assisted suicide, providing effective capacity and mental health assessment and more thorough exploration of pressure and coercion.

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[1] https://ourdutyofcare.org.uk/

[2] https://www.carenotkilling.org.uk

[3] https://apmonline.org/wp-content/uploads/APM-survey-on-Assisted-Suicide-website.pdf

[4] https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/physician-assisted-dying-survey

[5] https://apmonline.org/wp-content/uploads/APM-Position-Statement-on-Assisted-Dying-October-2024-v2.pdf

[6] https://www.bgs.org.uk/resources/bgs-position-statement-on-assisted-dying

Further safeguarding amendments rejected by the Committee include:

- Patients should be referred to a multi-disciplinary team at the start of process
- The doctor should ask why the applicant wants assisted suicide
- The Panel should be able to question the patient and doctor

2. Removing Chief Medical Officer oversight prevents independent scrutiny

Previously under the Bill the Chief Medical Officers for England and Wales were required to produce an annual report analysing the operation of the Act. This safeguard has been replaced by a 'Voluntary Assisted Dying (VAD) Commissioner' who has also been given the remit to run the assisted dying processes – appointing panel members, referring cases to them and overseeing the appeals process, leading to understandable concerns that the assisted dying system will be 'marking its own homework' [7] by removing independent scrutiny and reducing transparency.

The Bill requires amendment of the Coroners and Justice Act 2009 to remove a Coroner's duty to investigate a suicide if it has been assisted under this legislation, further reducing the scrutiny of assisted suicide processes and increasing risks of undetected coercion.

3. The Committee's reframing of assisted suicide as medical treatment conflicts with NHS founding principles

The TIA Bill Committee debates revealed the intention to introduce assisted suicide as a medical 'treatment', fully funded through routine end of life and palliative care services. This was not made clear at the Bill's second reading and has seismic implications for health services, including a requirement to amend the NHS Act 2006 because medical assistance in suicide conflicts with the NHS's founding principles 'to secure improvement' in health through 'the prevention, diagnosis and treatment of physical and mental issues'[8].

British Medical Association Consultants recently concluded that 'assisted suicide is not a health activity and it must not take place in NHS or other health facilities'.[9] To say that the NHS is to provide 'assistance to end life' risks breeding mistrust in doctors and health services. It is unclear whether NHS doctors would ordinarily be the providers of assisted suicide. As a former President of the Association for Palliative Medicine stated: 'It has taken many years for the public to believe that palliative medicine consultants, using powerful and dangerous drugs have the skills and motivation to kill the pain and not the patient.'[10]

Further safeguarding amendments rejected by committee include:

- Businesses and individuals should not be able to profit from assisted suicide
- Prohibiting doctors from being able to promote or advertise assisted suicide services
- Doctors must have completed medical training

4. Assisted suicide is not risk-free and does not guarantee a 'good death'

4.1 Assisted suicide lacks the evidence mandated for a medical treatment

Doctors have a professional responsibility to offer treatments they believe will provide benefit and minimise harm to patients. This requires understanding of the evidence base for treatments at both an individual and population level. Any new NHS-funded treatment must undergo rigorous assessments

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[7] https://hansard.parliament.uk/commons/2025-03-11/debates/65c2789a-d838-4fcb-acb4-889fa5486d08/TerminallyIllAdults(EndOfLife)Bill(TwentyFirstSitting)#contribution-2EE864B9-67E7-4689-A4E0-446AF34EB29C

[8] https://www.legislation.gov.uk/ukpga/2006/41/part/1/crossheading/the-secretary-of-state-and-the-health-service-in-england

[9] https://www.bma.org.uk/media/0vznagee/uk-consultants-conference-agenda-2025-final.pdf

[10] https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB149.

including intended benefits, efficacy, safety, risks, potential adverse outcomes.[11] In the UK use of prescription medicines is based on published, peer-reviewed clinical trials providing evidence of their benefits, effectiveness and unwanted harms. Despite their use in other countries, remarkably, this evidence base does not exist for substances used for assisted suicide. These have not been subject to any of the clinical trial processes that would be required to license them as medicines or approve them as treatments. Substances used for assisted suicide tend to be medicines used off-license in overdose, often in combinations which risk unpredictable drug interactions. They have not been trialled for effectiveness in causing peaceful death, nor for rates of complications that could distress the patient or family.

The use of unlicensed drugs for assisted suicide is essentially experimental and any substance used for this purpose will be based on limited reported experience from other countries.

It remains unclear how the lethal substances for assisted suicide will be chosen and approved in the UK.

4.2 Evidence of harm caused by oral drugs used in assisted suicide

The state of Oregon has used many different drug combinations since assisted suicide was introduced in 1997.[12] In recent years combinations of 4-5 drugs in overdose have been used (often >100 tablets), and there are significant gaps in side effect reporting (no data reported for 72% deaths in 2023). [13]

Ingestion of a lethal substance does not ensure that death occurs quickly, peacefully and uneventfully. Oregon 'Death with Dignity' Annual reports show unpredictable time to death and unwanted effects including seizures, vomiting, regurgitation, and regained consciousness.[14] Death may not occur in all cases. In 2023 half of the 67% of people with data available took more than 53 minutes to die, with the longest time to death being 137 hours (5.7 days).

Data are promised from Australia, which uses different substances to bring about death,[15] but no peer-reviewed outcomes are currently available, as would be mandatory for any other treatment. The 2022-23 Victoria Voluntary Assisted Dying (VAD) report mentions prolonged deaths after oral assisted suicide in neurological patients and suggests 'practitioner administered VAD' (euthanasia) would be preferable in these cases.[16] Medical evidence to a Queensland Coroner's investigation in February 2024 reported evidence of two delayed deaths that were 'very stressful for each family' since the VAD services started in January 2023.[17] The Coroner's report states that 'various people have required the intervention of a health practitioner administering 'iv VAD dosage' to ensure the patient's death', thereby converting oral assisted suicide to euthanasia. These complications are not mentioned in the Queensland State's VAD annual reports.[18]

4.3 Evidence of harm caused by intravenous drug protocols used in assisted dying

Intravenous (iv) approaches to assisted dying also lack evidence base, but autopsy review of prisoners executed by lethal injection have shown a high frequency of acute fluid retention in the lungs leading

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[11] https://www.nice.org.uk/about

[12] A Worthington, I Finlay, C Regnard. Efficacy and safety of drugs used for assisted dying. Br Med Bull. 2022 142 (1) 15-

[22] https://doi.org/10.1093/bmb/ldac009

[13]https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year26.pdf

[14]https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx

[15] https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB376.htm

[16] https://www.safercare.vic.gov.au/sites/default/files/202308/VADRB%20Annual%20Report%202022-23.pdf

[17] Coroners Court of Queensland. Reasons for decision. Inquest into the death of ABC (a pseudonym), clause 34: https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0003/808545/reasons-for-decision-inquest-into-the-death-of-abc-a-pseudonym.pdf

[18] https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1362124/vad-annual-report-2023-24.pdf

some to question whether intravenous drugs commonly used in state executions – often the same as those used in euthanasia – may be inhumane.[19] No clinical studies have been conducted to provide reassurance that patients are not distressed as they die.

Prescribing with this level of uncertainty and lack of safety and efficacy data would be unthinkable in other areas of UK medical and pharmaceutical practice.

4.4 Risks to patients and doctors when assisted suicide fails

The Bill requires that a doctor remain in the vicinity of the patient until they die. Despite multiple attempts to gain clarity the Committee failed to give any advice or guidance for doctors on what action they should take should a patient wake up or develop distressing complications such as seizures during an assisted suicide. When questioned the Minister for Care Stephen Kinnock stated that doctors could be trusted to act according to their professional judgement in line with the Hippocratic Oath, in the best interests of the patient.[20] The ensuing debate challenging his fundamental reinterpretation of the meaning of the Hippocratic Oath to include assisted suicide ended with the Minister stating that it was not his 'job to get into the whys and wherefores of the philosophy that underpins the Bill'.

5. Risks due to over-reliance on the Mental Capacity Act

The reliance of the TIA Bill on the Mental Capacity Act (MCA) to confirm assisted suicide eligibility is fundamentally flawed. The MCA is designed to support a patient's decision to discontinue life-sustaining treatments such as ventilation. However, the MCA is not designed to support decisions that actively bring about death *(S4.5*) such as assisted suicide.[21] S62 of the MCA states *'for the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961 (c. 60) (assisting suicide)'.*[20]

The principles of the MCA are clear and simple but their application in the real world of complex health and social care needs is anything but straightforward. The Chief Medical Officer has demonstrated how easily the MCA can be misunderstood and its application oversimplified.[22] Whilst the Committee has supported the provision of training in the Bill, it is only when theory is applied in practice that the real challenges of assessing the capacity of frail, distressed and potentially depressed people become apparent.

Using the MCA to safely assess patients' eligibility for assisted suicide was extensively discussed by the Committee, but safeguarding amendments were rejected.

6. Risks to vulnerable people have increased after committee

Multiple opportunities to improve safeguards for vulnerable people were rejected by committee.

6.1 If assisted suicide is a treatment, doctors will have a duty to discuss it

The Committee rejected a safeguarding amendment preventing doctors from raising the option of assisted suicide with eligible patients unsolicited. Raising assisted suicide risks placing undue influence on vulnerable patients. The TIA Bill states that doctors are under no obligation to suggest the option of assisted suicide to a patient. However, UK doctors are legally required to discuss all available treatment

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[19] JB Zivot, MA Edgar, DA Lubarsky. Execution by lethal injection: Autopsy findings of pulmonary edema. medRxiv 2022. https://doi.org/10.1101/2022.08.24.22279183

[20] https://hansard.parliament.uk/commons/2025-03-11/debates/65c2789a-d838-4fcb-acb4-889fa5486d08/TerminallyIllAdults(EndOfLife)Bill(TwentyFirstSitting)#contribution-69CD8F2E-020B-4FA4-B8AA-ACD326D57B7E

[21] The Mental Capacity Act 2005 s 4.5, s62 https://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

[22] Telegraph, February 14th 2025: https://www.telegraph.co.uk/news/2025/02/14/chris-whitty-got-assisted-dying-evidence-wrong/

options with patients (Mongomery vs Lanarkshire 2015).[23] This ambiguity was not resolved by the Committee, showing a lack of understanding of the vulnerability of many who would meet the Bill's eligibility criteria, and the resulting complex ethical dilemma created for doctors.

6.2 Domestic abuse victims

The Centre for Women's Justice (CWJ) and Standing Together Against Domestic Abuse both gave evidence to the Committee and stated that the TIA Bill failed to consider domestic abuse or the risk that perpetrators could coerce or pressure victims into assisted dying. This predominantly relates to women and disabled people. Amendments that would have provided greater safeguards were rejected. These included: mandatory training for medical professionals and judges identifying coercive behaviour, the inclusion of 'manipulation' when doctors assess for coercion, and informing family members of an individual's decision to elect for an assisted death.

6.3 Down Syndrome, Autism, and Learning Difficulties

The Committee rejected Amendment 368 by 13 votes to 8, which would have provided specific protection for those with Down Syndrome. The amendment was supported by 50 groups, including Down's Syndrome UK. The TIA Bill fails to consider how a person with Down's processes information, and this is crucial at the point of a doctor's suggestion of assisted suicide as an option. CEO of Down's Syndrome UK, Nicola Enoch, said: "The lives of those with Down Syndrome are too often misunderstood and devalued. This makes people with Down Syndrome especially vulnerable to coercion and pressure under assisted suicide laws." The Committee also rejected (13-8) an amendment requiring that if a person is autistic or has a learning disability, they must be given accessible information and sufficient time to consider it.

6.4 Risks to those who already feel they are a burden

An amendment was rejected that sought to explicitly exclude those feeling they are a burden from being eligible for an assisted death. An amendment that sought to require psychological assessments to identify patients who may be seeking assisted suicide due to pressure, or the feeling of being a burden, was rejected despite it being a safeguard for vulnerable people. In Washington, data from 2022 shows 59% of people pursuing an assisted death did so as they felt like a burden. The Bill sponsor was content to agree that concerns about costs of future care would be an acceptable reason for someone to access assisted suicide under this Bill.

6.5 Anorexia and eating disorders

The Committee rejected an amendment protecting those with eating disorders such as anorexia from qualifying for assisted suicide. As many as 34 eating disorder charities had called for the amendment saying: "The bill does not contain any provisions to prevent individuals with eating disorders from being classified as 'terminally ill' based on the physical consequences of their condition, should they decline or be unable to access treatment." Worldwide, legalisation has enabled at least 60 patients to access assisted dying because of anorexia. The majority are young women. Examples include cases in Oregon, California, and Colorado.

[23] https://www.supremecourt.uk/cases/uksc-2013-0136

6.6 Risks that existing social injustices will be widened

Access to palliative care and other services is worse in areas of social deprivation, and ethnic minorities often face barriers to accessing palliative care.[24] With systemic deficiencies in health, social and mental health care, this Bill risks widening injustices by creating a system that leaves vulnerable groups feeling they have little option open to them apart from opting for fully-funded assisted suicide. Suicide is not a truly free choice when there are inequities in access to high quality care.

7 Risks to suicide prevention

Assisted suicide and suicide prevention are contradictory. Rather than preventing suicides, there is emerging evidence that legalising assisted suicide increases un-assisted suicides.[25] The assertion by the Minister for Health and the Premier of Victoria, Australia, that legalising assisted dying would prevent 50 suicides of terminally ill people every year ('one a week') was not borne out. Rather than decreasing un-assisted suicides among older people in Victoria by 25%, they actually increased by 50%.[26] Introducing euthanasia or assisted suicide is associated with a significant increase in total suicide rates, most strongly amongst women.[10] An amendment requiring doctors to ensure someone with remediable suicide risk factors cannot be approved for assisted suicide was rejected.

8 Risks to children

The Committee discussions revealed a risk that was not discussed at second reading, namely that the Bill would allow doctors to raise assisted dying as an option for people under the age of 18. An amendment designed to prevent this was rejected by the Committee.

9 Risks to palliative care provision

An amendment that would require patients to consult with a palliative care specialist to ensure they were fully informed of all available palliative care options before opting for an assisted death was rejected (15-8). The Committee has voted against opt-outs for hospices that do not want to facilitate assisted dying, and against the protection of funding for hospices and care homes choosing not to offer assisted suicide. The British Medical Association (BMA) recently voted in favour of a motion that if assisted suicide becomes law, it must include an 'opt-in' model to ensure no consultant is expected to be a part of this process. The Association for Palliative Medicine (APM)'s survey showed that more than two in five respondents would leave their organisation if assisted dying was implemented. Palliative care expert, Professor Katherine Sleeman, has voiced concerns that those who cannot access good palliative care may opt for an assisted death and stated research shows palliative care can alleviate one's wish for an assisted death.

The APM has expressed concern that vital funding for palliative care, such as hospices, will be diverted away in favour of implementing and facilitating assisted suicide. Hospices receive an average of only one third of their funding from the Government and rely on charitable fundraising to meet the shortfall, with many closing beds or reducing staffing in the face of current financial pressures.[27] A recent critical review has confirmed the adverse impact of assisted dying legislation on palliative care service provision.[28]

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[24] N Aker, S Griffiths, N Kupeli *et al.* Experiences and access of palliative and end of life care for older people from minority ethnic groups: a scoping review. *BMC Palliat Care* **23**, 228 (2024). https://doi.org/10.1186/s12904-024-01555-8

[25] https://publications.parliament.uk/pa/cm5901/cmpublic/TerminallyIllAdults/memo/TIAB125.htm

[26] https://gript.ie/elder-suicides-have-risen-50-in-victoria-after-legalising-voluntary-assisted-dying/ accessed 5/5/25.

[27] https://www.nursingtimes.net/workforce/hospice-to-lay-off-dozens-of-staff-amid-palliative-care-funding-crisis-28-06-2024/

[28] https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albertjones.pdf