



Briefing on the “Terminally Ill Adults (End of Life) Bill”

Summary of the Bill:

It proposes to legalise assisted suicide for adult residents of England & Wales with a terminal illness which is likely to cause death within six months. Approval; is required by two doctors (who need not be Consultants or specialists) and a High Court judge. This process could be completed in 21 days (or nine days where death is anticipated within a month).

The Bill runs to 38 pages¹ and was **published on 11 November, allowing just 18 days for consideration before second reading**. In contrast, Rob Marris’s 12-page Assisted Dying (No 2) Bill² was published seven weeks before its second reading, giving MPs the whole of the summer recess to study and consult on the Bill. They rejected it by 330 votes to 118.

Specific Concerns

1. Eligible patients would have to be resident in England or Wales. However, but Oregon and Vermont had such a requirement, and the same activists who established it as a safeguard have since overturned it in the courts. Eligible patients would be 18 or over, as was the case in Belgium before their law was extended to children of all ages in 2014, and as is the case in Canada, where Parliament has been considering extension to “mature minors” (comparable with Gillick Competence in the UK.) Eligible patients would have a terminal illness “reasonably... expected” to cause death within six months. Leaving aside the well-documented unreliability of such prognoses, the rule reflects Oregon’s – where health authorities have reinterpreted it (without amendment) to include otherwise ineligible people who forego treatment, including some with anorexia.³ Through court challenges, Canada’s law has expanded from those whose deaths are “reasonably foreseeable” to those with chronic illnesses and disabilities and from March 2027 will include those with solely mental health conditions; Assistant Professor in Law Philip Murray has outlined why such a challenge would likely arise here under the ECHR in the UK.⁴

Section 23(a) says “no registered medical practitioner or other health professional is under any duty (whether arising from any contract, statute or otherwise) to participate in the provision of assistance in accordance with this Act.” **This conscience clause is undermined in various ways:** 4(5) says an “unwilling” doctor “must” identify and refer an enquiring patient to a doctor they believe is willing and able to proceed (and predisposed to assent.)

¹ publications.parliament.uk/pa/bills/cbill/59-01/0012/240012.pdf

² publications.parliament.uk/pa/bills/cbill/2015-2016/0007/16007.pdf

³ carenotkilling.org.uk/articles/six-months-redefined/

⁴ ukconstitutionallaw.org/2024/10/30/philip-murray-looking-down-the-slippery-slope-can-assisted-suicide-be-restricted-to-the-terminally-ill/

GPs are required to act as information managers for the process, and no provision is made for the conscience rights of pharmacists or indeed judges

The Bill relies heavily on what participants “may” do, rather than “must.” They *may* advise patients of treatment and palliative care options before formally commencing the process, but aren’t required to. They *may* advise the patient to consult their GP and loved ones, but aren’t required to. If they doubt the patient’s capacity, they *may* refer them for further evaluation, but are not required to, and even if they do, they are only required to “take account” of that specialist opinion. The Bill states in Section 4 (2) that “nothing... prevents” a doctor from choosing to raise the possibility of assisted dying themselves, if they deem it appropriate. Most significantly, doctors **may be under a duty to raise the subject of assisted suicide with eligible patients** (putting subtle pressure on them) under existing GMC guidelines and English and Welsh law if it is to be considered medical treatment or a healthcare option.

Both the coordinating doctor and the independent doctor – neither of whom need be previously known to the patient – are required to assess the patient, but the Bill does not require that either be a specialist in the underlying illness (their training, qualifications and experience are deferred to later regulations) and **does not specify a physical examination**. Given that the Bill later specifies two “in person” requirements, but does not do so here, there seems to be nothing in the Bill to preclude video consultations as happens in the USA. How coercion is likely to be detected in such situations remains unclear, especially as an abuse partner may be sitting out of camera shot.

The Bill (like its sponsors⁵) does not address the fact that doctors are not trained in **detecting coercion**, which would be even more difficult where doctors did not previously know the patient. The Bill says the assessing doctor must discuss available treatment and palliative care/support; in the midst of the current funding crisis, this could involve **pointing to hospices which are cutting beds and jobs**, and palliative care services that aren’t available out of hours. They are required to discuss what the patient would want to happen if there are complications, but not to inform them of known complications (such as vomiting, prolongation of death and reawakening from coma.)⁶ Ultimately, if the second doctor feels they cannot approve the application, the coordinating doctor may refer the patient on again – **doctor-shopping**. Section 14 says that if at any point an applicant wishes to cancel their request, they can do so verbally to “any registered medical practitioner from the person’s GP practice”; bearing in mind how variable data management can be within the NHS, and the fact that neither of the assessing doctors need belong to the practice, a recording failure here could see an unsettled wish to die carried forward.

⁵ [spectator.co.uk/article/watch-lib-dem-mp-flounders-on-assisted-dying/](https://www.spectator.co.uk/article/watch-lib-dem-mp-flounders-on-assisted-dying/)

⁶ onlinelibrary.wiley.com/doi/full/10.1111/anae.14532

The Bill mandates that the High Court issue declarations “that the requirements of this Act have been met” following “such procedures as it deemed necessary” – more details left to later regulations. While the Court “may” hear from the patient (and anyone else they wish to), the Bill only *requires* that one doctor be heard from, and the Bill specifies that they can appear by video or even audio link. While an applicant could appeal a refusal, approval could not be appealed. Former High Court Family Division President Sir James Munby calculates (using Ms Leadbeater’s estimates) that AD would demand 34,000 sitting hours a year, when the Division currently only sits for 19,000 with a full caseload. The Court of Appeal in *Conway* doubted **judges’ ability to detect coercion**, and Sir James Munby has written: “*only those who believe implicitly in judicial omniscience and infallibility – and I do not – can possibly have any confidence in the efficacy of what is proposed.*”⁷

“At the time the approved substance is provided”, the coordinating doctor must be “satisfied” that the patient’s wish to die is settled, and that they have “not been coerced or pressured by any other person.” Their feeling “satisfied” remains the only guidance, and the reference to a “person” ignores **structural coercion** like relative poverty, inappropriate housing, isolation or lack of support. The Bill would permit the doctor to “prepare a medical device”, perhaps like intravenous devices used in Switzerland,⁸ and to “assist that person to ingest or otherwise self-administer the substance.” Does this level of involvement – **arguably very close to euthanasia** – chime with public perceptions of AD? The doctor is required to remain until the patient has died but this could prove unworkable: Oregon, the model for this bill, has seen AD participants take more than five-and-a-half days to die.

Section 32 would grant the Secretary of State “powers to ensure assistance [to die] is available.” Given the well-documented financial crisis among hospices, and international precedents (e.g. defunded hospices in Canada), it is conceivable that palliative care providers which opt not to provide AD could lose out on scarce Government funding in future. Section 25 mandates a review of the Act’s operation, including “an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs,” after five years. 100,000 die in the UK each year without needed palliative care, prompting the Health Secretary to question whether AD would represent a “real choice”; no wonder November 2024 polling found **70% want a Royal Commission to assess the state of palliative care before any further debate on AD.**⁹

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⁷ transparencyproject.org.uk/assisted-dying-what-role-for-the-judge-some-further-thoughts/

⁸ telegraph.co.uk/news/2024/05/16/teacher-no-illness-suicide-clinic-alastair-hamilton/

⁹ carenotkilling.org.uk/articles/70-say-royal-commission-on-care-then-debate-pas/