The Terminally Ill Adults (End of Life) Bill:

Why this Bill can't be fixed

"I think the government has been quite irresponsible—if it really wants this change to pass—by trying to do it through private members' legislation…Commons scrutiny is being left to solve a whole range of problems it isn't equipped to deal with—like how to produce legislation that most people would see as fair to those who want the option …[and] others who may feel under pressure—whether to preserve their inheritance, or because carers are, you know, pushing them to the edge."

Jill Rutter, Senior Fellow, Institute for Government, March 2025

"We still don't know a whole host of important things about what assisted dying would really be like—from details such as which cocktail of drugs will be used to end a life to the huge question of how the service will be provided within the NHS…one feels for the poor civil servants who had not only to attempt to nail jelly to a wall, but were forced first to grade the possible consistency of the wobbling mess"

Mark Mardell, Prospect Magazine, 6 May 2025

"What is proposed will not command – does not deserve to command – public confidence. Without very significant changes and improvements [to the panel] we face the all too real prospect of the system provided for by the Amended Bill falling into disrepute and worse – a prospect which society surely cannot tolerate where the issues are so grave and the consequences of error simply too appalling to contemplate."

Sir James Munby, former President of the Family Division of the High Court of England and Wales, May 2025

"A bill that is just 55 clauses long…but it's got 38 powers in it…five of these powers are Henry VIII powers which enable Ministers to amend primary legislation…there's also nine new criminal offences"

Ruth Fox, Hansard Society, May 2025

WHO IS ELIGIBLE

- Aged 18 or over at first declaration
- Terminally ill and 'reasonably expected' to die within six months
- Mental capacity assumed unless proven otherwise
- If only 51% certain that criteria are met, doctors and panel must approve
- Depressed and suicidal
- Those who feel they are 'a burden'
- Those driven to it for financial reasons
- Those with no access to palliative care or other support
- Those who voluntarily stop eating and drinking to worsen their condition
- Those who refuse treatment to qualify

TURN OVER AND SEE THE MANY PROBLEMS WITH THE BILL AND WHY IT IS NOT FIT FOR PURPOSE

THE ASSISTED DYING PROCESS

Step	Summary	What problems still haven't been dealt with?
1	**Preliminary discussion with registered medical practitioner.**	Any doctor can raise, multiple times. Including with 16 and 17 year olds. No training required to raise option. Patients cannot stop doctors raising it. Risk of pressure, coercion and abuse. Can raise with those with Down's syndrome and learning disabilities.
2	**Initial request for assistance: first declaration.**	Can apply immediately after diagnosis and prognosis, irrespective of state of mind. No explicit ban on encouraging someone to seek assistance to end their life. Applicant can "shop around" if blocked by first doctor. A proxy who doesn't know the person can sign their application for them.
3	**First doctor's assessment: coordinating doctor.**	If 51% satisfied the criteria are met, the doctor must approve. No multi-disciplinary assessment. No minimum floor of qualifications or experience required in the Bill. No need to consult specialist in patient's condition. No assessment from mental health professional. No guaranteed meeting with palliative care specialist. No need to ask why. Doctor must make further enquiries only if they think it 'appropriate'. No requirement to specify uncertainties of diagnosis & prognosis. No requirement to spell out risk of a 'bad death' from complications from lethal drugs. £87m cost-saving service can be outsourced to for-profit companies.
	First period of reflection: 7 days.	
4	**Second doctor's assessment: independent doctor.**	Applicant can "shop around" for a second opinion if blocked by the independent doctor. If blocked again, they can restart the process. If the doctor is unable or unwilling to continue to act for a patient - for whatever reason - another doctor can be approached. No explanation needs to be given or recorded.

Process continues:

		The problems continue...
5	**Panel review of eligibility (legal representative, a psychiatrist, and a social worker). Must hear from assessing doctor(s).**	Panel does not have to ask questions or make further enquiries. Hearing from applicant can be waived or pre-recorded. Panel can sit in private. No requirement for other interested parties to be notified. No investigatory powers. Evidence is not heard on oath. Panel cannot summon witnesses. Commissioner (the judge or retired judge) only considers refused applications. Families have no route to raise concerns (e.g. of coercion or abuse).
	Second period of reflection: 14 days (or 48 hours if less than 1 month to live).	
6	**Confirmation of request for assistance: second declaration.**	Can be signed by a proxy with no knowledge of the individual.
7	**Approved substance is dispensed to the coordinating doctor.**	Sharp departure from how all other medicines are regulated in the UK. Allows lethal combinations and doses of drugs that have not undergone any trials or MHRA approval process. No requirement to establish the safety or efficacy of the drugs, or make public risk of complications, including pain, once ingested. Common events include vomiting, seizures, prolonged death and even re-awakening. US studies found complications and prolonged death much more likely in younger patients.
8	**Provision of assistance (coordinating doctor remains with the person).**	Can be done by a private provider for profit and 'reasonable remuneration'. Hospices and care homes have no legal right to opt out from having Assisted Dying carried out on their premises. The Bill does not protect hospices from the Government financially penalising hospices for not participating.
9	**Final statement made by coordinating doctor.**	No requirement to record what happened once the drugs were taken, nor record complications.
10	**Death certification.**	Families will not be notified at any stage in the process and may not find out until after the death. Deaths would not be referred to the coroner, despite long-standing requirement to investigate any death involving drugs or medical intervention. Diagnostic errors and cover-up of medical errors could go undetected.

THE BILL IS NOT SAFE AND CANNOT BE FIXED. TURN OVER AND SEE ADDITIONAL MAJOR CONCERNS ›

The Terminally Ill Adults (End of Life) Bill:

Major concerns

Too much left off the Bill

- Detail is simply not present in the Bill: instead we have huge power given to ministers of any stripe to do as they please.
- Over-reliance on non-binding codes of practice to protect the vulnerable.
- Protecting the vulnerable is not a secondary policy detail.

Few limits on power

- The Bill does not spell out who will deliver Assisted Dying. We know nothing about how the service will work in practice. Nor how it will be regulated.
- Ministers will decide nearly every aspect and can make changes, with parliament largely excluded, including changing the NHS founding principles.
- These powers will be available to any future government to use as they see fit.

If MPs pass the Bill, there is no 'off switch'

- The Bill automatically commences in four years, no matter what.
- Will have to start no matter what the circumstances at the time, or how many problems there are with the system, or how underfunded palliative care is, or whatever occurs between now and 2029. This is not an approach other legislation takes.

Independent oversight removed

- This Bill will introduce an unprecedented new regime in England and Wales – one that literally has life-or-death consequences, but with little accountability or oversight.
- Oversight by the Chief Medical Officers has been removed.

This Bill is not safe, and cannot be fixed.

It is weaker than before Committee began. Whatever your view on the principle, this Bill is not the way forward.