TERMINALLY ILL ADULTS (END OF LIFE) BILL

THIS BILL IS NOT SAFE, AND CANNOT BE FIXED

In November 2024, More in Common polling found that public support was "firmly conditional on strong safeguards being put into place". Only 3 in 10 people trusted MPs to get it right.

REPORT DAY 1 RECAP:

CRITICAL ISSUES

On Day 2, MPs will vote on issues which were barely discussed on Day 1.

PARLIAMENT AT ITS BEST?

"I think the government has been quite irresponsible - if it really wants this change to pass - by trying to do it through the private members' legislation... Commons scrutiny is being left to solve a whole range of problems it isn't equipped to deal with..."

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

REPORT DAY ONE:

- 90 MPs wanted to speak, only 26 were allowed.
- Many MPs tabling critical amendments did not even have a chance to explain the issue.
- Debate was stopped after just 4.5hrs. No further debate is possible on these issues.

SEVEN KEY ISSUES THAT REMAIN UNRESOLVED

1. **Doctors must not suggest assisted dying (NC1)**
The Bill permits any doctor to raise the option of ending the patient's life, no matter how young or vulnerable the patient. NC1 ensures assisted dying is something freely chosen and patient-initiated, protecting vulnerable individuals from implicit pressure in clinical settings. Even neutral mentions by doctors can feel like recommendations due to power imbalances, risking trust, especially among disabled or vulnerable patients.

2. **Eligibility for assisted dying must be for terminal illness, not societal failure (NC16)**
Public opinion opposes assisted dying eligibility based on "quality of life" issues like poverty or depression. Yet this Bill allows assisted dying even if the wish stems from depression, lack of care, or feeling like a burden - not from the illness itself. If someone wants to die because society has failed them, our duty is to fix the failure, not to offer lethal substances. NC16 clarifies that a "settled wish to die" must stem from terminal illness, not societal failures.

3. **Palliative care must be an option (amendments 80, 30, 31)**
The Bill leaves the door open for assisted death for someone who might be helped had they received proper, timely care. One in four people die without needed palliative support. Access is patchy, and worse for disadvantaged groups. Without addressing this, "choice" is simply illusory. Amendments 80, 30 and 31 aim to tie eligibility to cases where every effort has been made to explore effective palliative care, ensuring assisted dying is not a default due to systemic failings.

4. **A higher standard of proof is needed (NC9)**
72% of the public want proof that those seeking assisted dying are not being pressured. This Bill's "balance of probabilities" (51%) test isn't enough for this irreversible act. NC9 requires certainty at the end from both the approval panel and the doctor administering the lethal substance, using a tiered approach to prevent coercion or error while keeping initial checks less stringent.

5. **The Mental Capacity Act falls short (amendments 81, 24, 17, 102, 32)**
The Bill leans too heavily on the Mental Capacity Act (MCA) - simply whether an individual can understand, retain, use and weigh information - a legal test that was never designed for decisions about ending life. MCA capacity doesn't exclude severe mental illness or suicidal thoughts, which experts - including the Royal College of Psychiatrists - deem unsafe. Amendments 81, 24, 17, 102 and 32 strengthen safeguards to ensure decisions are free from impaired judgment or treatable suffering.

6. **Protecting our hospices (NC17, NC18, amendment 16)**
Hospices must have a clear legal right to opt out of assisted dying. Other countries protect this; this Bill would make England and Wales outliers. As the Bill stands, hospices risk legal action, workforce loss, and damage to community trust. Most hospices rely on charitable funding and already face staff shortages. Effectively forcing involvement could spark an exodus of palliative care professionals and deter patients who are worried about being pushed towards assisted dying.

7. **This Bill's default position is to exclude family (amendments 33, 10, 47, 8, 23)**
Family and loved ones are explicitly excluded from this process. The only reference is that doctors may, if they consider it appropriate, suggest patients discuss their request with next of kin or those they are close to. If they have not, or do not intend to, there is no requirement to explore why. This applies no matter how young or vulnerable the patient. The default of family exclusion risks patient isolation, and missed opportunities where the family might help to identify coercion, pressure or some remedial factor that is driving the decision, as well as ignoring the emotional impact on families or dependents blindsided by a loved one's death.

TO SECURE ASSISTED DYING FOR THOSE WHO WANT IT, THIS BILL RESULTS IN:

EVERY terminally ill person's choices being changed;
EVERY doctor being empowered to raise it;
ALL losing the default of help to the end;
ALL being expected to make a decision;
ALL being vulnerable to internal and external pressure.

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TURN OVER

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REPORT DAY 2

"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

"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, journalist and assisted dying supporter Prospect Magazine, 6 May 2025

FIVE KEY ISSUES TO LOOK OUT FOR

1. **Ministers will be able to fundamentally change the NHS through secondary legislation (amendment 12)**
Only 26% of the public believe that the NHS is currently in a fit state to provide people with the option of assisted dying. Yet, by 2029 the NHS will be radically reconfigured to include the state ending lives with lethal drugs, with MPs having very little say. We are still in the dark about what this will look like, how the NHS will change, and what people will experience at the point of access. Many safeguards governing integration into the NHS and the behaviours of doctors will rely entirely on non-binding codes of practice. Fundamental reconfiguration of the NHS and its principles shouldn't be done by regulation.

2. **The Bill signs off a cost-cutting, for-profit service, with no requirements for transparency by private contractors (amendment 15)**
The NHS will save £13k for every person who ends their life four months early. It creates perverse incentives within the NHS to encourage greater and earlier use of 'the service'. The risks are intensified as the Bill permits any doctor to propose ending the patient's life. Outsourcing 'the service' to "independent contractors" and for-profit private firms is openly being explored by Ministers. Promises of an amendment to cap profits haven't been kept, and transparency requirements for future providers are nowhere to be seen.

3. **The system has extraordinarily feeble oversight, with Parliament sidelined (NC19, NS2, amendments 88, 103, 104)**
Ministers are given sweeping powers under the Bill, with MPs sidelined. At best, MPs will have 90 minutes to debate and rubber-stamp decisions on statutory instruments on how to change the NHS or how to end patients' lives. Many decisions won't even be debated, giving Ministers carte blanche. Independent oversight of the system by the Chief Medical Officer has been removed. Instead, the 'Voluntary Assisted Dying Commissioner' assesses the system and marks their appointees' homework. How will policy or system failures ever be caught? Amendments 103 and 104 (Paul Kohler), and NC19, NS2 and 88 (Sarah Olney) strengthen procedure on regulations, and address monitoring, consultation and reviews.

4. **The Bill requires MPs to be relaxed about unregulated drugs and bad deaths (amendment 99)**
'Dignified death' is promised, but this is in no way secured by the Bill as drafted. As a bare minimum, it would be reasonable to expect strict regulation of lethal drugs, but the Bill bypasses the UK's established drug approval process. There is no minimum standard threshold, nor emphasis on avoiding unintended suffering or inflicting pain. Patients have no right to be informed of the risk of complications. There is no requirement to report when they do happen. Amendment 99 (Caroline Johnson) requires a report on drug effects (time to death, complications, side effects) before Parliament approves regulations.

5. **This Bill has no "off switch" and no guarantee of future choice (amendment 42)**
The four-year rollout plan is reckless and locks the country into the launch of 'the service' in 2029 - irrespective of what has been left undone, the state of the NHS, palliative care shortages or unforeseen crises. The Bill focuses on only one end-of-life option and gives no guarantee terminally ill people will be given a meaningful choice. It is a pathway leading in one direction. Amendment 42 (Adam Jogee) replaces auto commencement in England with a Secretary of State commencement order.

THESE ISSUES BARELY SCRATCH THE SURFACE OF WHAT IS NEEDED TO ADDRESS THE FLAWS WITH THE BILL.

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