Association for
Palliative Medicine
Of Great Britian and Ireland

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Terminally Ill (Adult) Bill Committee Stage

APM supplementary evidence

1. Introduction

The Association for Palliative Medicine of Great Britain and Ireland (APM) is one of the world's largest representative bodies of medical/healthcare professionals practicing or interested in Palliative Medicine, with a membership of over 1,400. APM members have considerable and broad experience in caring for people with life-limiting illnesses, including at the end of their lives, in all care settings.

The APM is concerned about the limited time available to consider and create a robust and safe law about such a complex and serious topic.

Multiple surveys of APM members over the past 10 years show the vast majority (around 80% do not support legalising Assisted Dying (AD). (Here)

This evidence is supplementary to our main written evidence and Dr Sarah Cox's oral evidence session. This supplement is to demonstrate the evidence base for the oral session statements.

2. Impact of Assisted Dying on Palliative Care

Evidence from the last ten years in the US and Europe shows that, while there have been improvements in palliative care in jurisdictions with AD, **comparable jurisdictions without AD have made better progress.**[1]

Specifically;

- Between 2012 and 2019 the four European countries with AD (Belgium, the Netherlands, Luxembourg and Switzerland) **increased palliative care provision by 7.9%**, while the twenty non-AD countries in Western Europe **increased provision by 25%**.
- Between 2015 and 2019 palliative care teams in hospitals **increased by 3.2%** in U.S. States with AD while non-AD States saw an **increase of 9.4%**.

3. Death by suicide and Assisted Dying

People with severe physical illness have a higher risk of death by suicide (over twice the rate).[2] Research from the Office for National Statistics shows that the increase in risk of death by suicide in patients with severe physical illness is overwhelmingly in the **first six months after diagnosis**. The research, published in The Lancet, concludes that providing better psychological and mental health support to people with recently diagnosed physical illness is critical.[2] **Of note, this data includes no information about which of these patients might have been in their last six months of life**, however it has been used by campaigning groups to call for the legalisation of AD.

4. When would palliative care be adequate?

The adequacy of palliative care as a prerequisite for facilitating genuine choice in AD should be based on objective markers to ensure that no one opts for an assisted death due to inadequate care or support. Siloing consideration of AD/AS legislation away from the responsibility of providing palliative care to all who need it undermines the fundamental argument of providing real choice.

Universal access to high-quality palliative care is essential. Effective pain and symptom management must be available to all, with equitable access to expert symptom control. Beyond relief of physical symptoms, comprehensive psychosocial and spiritual support should be integrated into care to address emotional distress and existential concerns.

A well-trained palliative care workforce is equally critical. The UK must ensure a robust network of palliative care specialists, general practitioners, and hospice services, capable of delivering high-quality end-of-life care. Medical, nursing and allied healthcare education should include comprehensive training in palliative care to equip every healthcare professional with the skills needed to manage complex symptoms and provide compassionate support.

A national conversation is also necessary to address the broader societal and cultural implications of AD. The espoused bad deaths need to be contextualised and investigated appropriately to evidence the care not provided and why this happened. Public engagement, alongside ethical, religious, and cultural perspectives, should inform policy development. Additionally, discussions must extend beyond healthcare, including medicine, to include social care, ensuring that patients are not driven towards AD /AS because of inadequate support, loneliness, or lack of appropriate community services.

Ultimately, AD should only be considered within a society and healthcare system where high quality palliative care is universally accessible in all settings of care, is fully funded and sufficiently resourced.

5. How many people would die in pain even if they had the best palliative care?

An Office for Health Economics report published in November 2024 concluded that 20 people in the UK would die in pain every day[3], even if they had access to the best palliative care. In our view, this study – which was not peer-reviewed - has major flaws. Most importantly, the study assumes that people who access hospice care are the same with respect to pain as those who do not. This is a flawed assumption as severe pain is a common reason to be admitted to a hospice. Failure to account for this difference in “case-mix” is likely to greatly overinflate the headline figure. Of note, this study was built on a 2019 study that was commissioned by Dignity in Dying also with significant flaws.

References

1. Jones DA. Evidence of Harm: Assessing the impact of Assisted Dying/Assisted Suicide on Palliative Care. The Anscombe Bioethics Centre 2024. Evidence of Harm: Assessing the Impact of Assisted Dying / Assisted Suicide on Palliative Care - Google Search

2. Nafilyan, Vahé et al. (2023) Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people The Lancet Regional Health – Europe, 25: 100562

3. https://www.ohe.org/insight/20-people-a-day-die-in-unrelieved-pain-across-the-uk-at-the-end-of-their-lives/