Association for Palliative Medicine

26/8/26

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21 Questions for MPs to consider

The issue of Assisted Dying (AD) and its implementation in the context of the current healthcare system is complex. There are many areas within the currently proposed bill that may require some amendments to ensure clarity and safety. The questions below aim to highlight some of these issues and to stimulate an effective debate. Please read it along our 'myth buster' document, which has more information and references regarding specific topics.

Topic 1: Patient Safety – does the Bill adequately protect against harm?

1. **Unreliable prognoses**: doctors' predictions of death within 6 months are correct less than 50% of the time. (see point 2.1 in Myth Buster)
   How many untimely deaths of people who could have lived longer are you willing to accept should this Bill be implemented?
2. **Undetected coercion**: across professions and settings, coercion is exceedingly difficult to identify in each case. A rapid review of the Controlling or Coercive Behaviour (CCB) offence published by the Home Office has recognised that despite an increase in reporting of CCB, it remains difficult to identify, investigate and evidence despite 1 in 6 over 60 year olds experience abuse each year.
   How many cases of undetected coercion that led to AD are you willing to accept should this Bill be implemented?
3. **Feeling like a burden**: By accepting 'feeling like a burden' as a legitimate reason to pursue AD, the Bill risks shifting societal concepts regarding the value of life by normalising a belief that some lives are worth less than others. (see point 2.2 in Myth Buster)
   How will the Bill protect vulnerable patients who internalise such societal or familial pressures to end their lives prematurely?
4. **Multidisciplinary team assessments**: Multiple professional bodies (including RCP and CLADD) have stated that decisions within any AD legislation must be informed by clinicians with appropriate expertise, including those who know the patient. According to the Bill, the panel will use the coordinating doctor's assessment and will not need to see the patient. (see points 1.7, 2.3, 2.4, 3.3 and 3.5 in Myth Buster)
   What safeguards does the proposed Bill offer to ensure that an appropriate multi-disciplinary assessment has informed the decision, for example in the context of depression or other vulnerability?
5. **Painful deaths from lethal medications**: The side effect profile, including pain and failure rates, of any combination of medications used in AD, has not been tested or systematically reported. (see point 4.2 in Myth Buster)
   Why does the Bill omit MHRA (Medicines and Healthcare products Regulatory Agency) approval or mandatory disclosure of risks?
6. **Family exclusion:** For a major decision which can be driven by the patient feeling a burden, for example by financial pressures or by social pressure, there is no requirement to include family or even let them know AD has happened. (6% have AD in Oregon due to financial pressure – here p16)
   Should family have a role and be involved in an AD decision?

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7. **Treatment delays as a driver**: Treatment delays occur across the NHS, and may result in diagnoses being made when the disease is too advanced to be treated.
   Will such cases be eligible for AD, and if so does this represent true choice?

Topic 2: True Choice (between palliative care and AD)

8. **Patient choice**: The bill requires that patients are just informed of palliative care options—but does not require them to receive such care, nor does it account for regional disparities if access is minimal or no service is available. Prime Minister Andy Burnham has said that before assisted dying is considered in England and Wales, the funding of palliative and social care should be "fixed". (see points 1.1 and 1.2 in Myth Buster)
   How will this Parliament ensure that patients have true choice, offering high-quality, equitable and accessible palliative care, as well as AD?
9. **Funding guarantees**: 1 in 4 dying people lack access to specialist palliative care. (see points 1.1, 1.2 and 1.3 in Myth Buster)
   How will this Parliament ensure assisted dying funding does not worsen this postcode lottery?
10. **Hospice pressures**: Previous parliamentary debates suggested hospices could lose funding if they refuse to provide assisted dying. (see points 1.1, 1.2 and 1.3 in Myth Buster)
    How would the Bill protect the right of organisations, such as hospices, to opt-out of participating in AD, without facing consequences such as reduced funding or regulatory support?
11. **Workforce crisis:** NHS workforce data shows 1 in 8 palliative medicine posts are unfilled. 81% of Scotland APM members say AD will negatively impact recruitment. (see points 1.1, 1.2 and 1.3 in Myth Buster)
    Why has no assessment been made of how assisted dying services will impact health care and palliative care workforce and services?

Topic 3: Professional Conscience and system integrity

12. **Protection for Healthcare Professionals:** The GMC's Good Medical Practice acknowledges the right of medical professionals to act in accordance with their beliefs.
    Why does the bill not explicitly protect doctors, nurses and the wider multidisciplinary team from any discrimination if they conscientiously object to be involved with assisted dying at any level?
13. **The importance of data collection on the use of assisted dying:** There is no comprehensive gathering of applicant demographics and patient rationale within the current bill, thereby precluding any timely, evidence-based assessment of the legislation's real-world application and outcomes.
    Why were amendments rejected that mandated collection of demographic data and patient rationale data on applicants and the timely assessment of this data?

14. **Treatment:** A treatment is an intervention that improves a patient's health or quality of life. Assisted dying is an intervention with death as the outcome. Medical treatments in the UK

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are subject to scrutiny by NICE for effectiveness, safety and cost-effectiveness. (see point 1.6 in Myth Buster) The BMA state Assisted dying it is not a medical treatment.
Is assisted dying by lethal medications a 'medical treatment' in your view? If it is, why is it not subject to these usual processes?

15. **The need for a pause in the process if new patient information arises:** Amendments were rejected to account for new information or significant changes in a patient's condition or situation.
Why does the bill not include an emergency pause mechanism for cases where a patient's prognosis unexpectedly improves or new evidence of coercion emerges after approval but before administration of the lethal medication?

Topic 4: Vulnerable groups and wider impact

16. **Ignoring expert warnings**: Eating Disorder charities, multiple disability rights organisations, and several professional medical bodies have unanimously and repeatedly warned about risks to vulnerable patients. (see points 1.5 and section 3 in Myth Buster)
How will this Parliament ensure that these warnings will lead to meaningful amendments that will protect all potentially vulnerable members of our society?
17. **Preventing mission creep:** In Canada, assisted dying (MAID) has expanded to include poverty and homelessness as contributing factors. Similar examples of mission creep are available from other jurisdictions.
What specific legislative wording in this bill will prevent similar expansion in England & Wales?
18. **Socioeconomic safeguards**: Access to palliative care is inequitable in the UK, and least available in deprived areas. In these areas the hidden costs of dying (e.g. heating, electricity, financial impact on carers, loss of earnings etc.) are also felt the most.
What concrete measures will ensure that AD will present a true choice in these difficult circumstances?
19. **Ethnic Disparities in End-of-Life Care:** There is evidence from minority ethnic groups in England that the TIA bill may deepen mistrust and deter some individuals from accessing palliative care and healthcare in general, which is already less available to them. (see point 3.4 in Myth Buster)
What specific measures will you take to ensure that AD does not disproportionately impact these communities?
20. **Under-18s**: Children and young people are particularly prone to accept societal norms. Talking to or around children about AD normalises it, therefore effectively reducing choice in adulthood. (see point 3.2 in Myth Buster)
How could discussing 'future eligibility' with children be justified as a safeguard within the Bill?
21. **Doctor-Initiated Discussions:** A recent report by the Parliamentary and Health Services Ombudsman has highlighted severe flaws in communication between doctors and patients about end-of-life. Untimely or insensitive communication about sensitive topics can potentially damage the doctor-patient trust.
What specific safeguards exist in the Bill to prevent vulnerable patients being unduly influenced by doctors who may initiate discussion about AD insensitively?