Association for
Palliative Medicine
Of Great Britian and Ireland

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Assisted Dying (AD) myth buster on the Terminally Ill Adults (End of Life) bill for Parliamentarians (January 2026)

Claim	Evidence
Eligibility	
Doctors can reliably identify those who have only 6 months to live.	Research across thousands of prognosis assessments show that doctors' assessments of which patients are likely to die within 6 or 12 months are correct less than 50% of the time. (Here)
People won't be able to have an assisted death because they feel they are a burden.	The Bill does not require that patients are asked why they want to die. Thus any reason for wanting assisted dying, including feeling a burden, would be OK. Around half of people in other jurisdictions choose AD because of feeling a burden on family and friends. Oregon is 42% (Here) Canada is 50.3% (Here)
The Mental Capacity Act is agreed to be the appropriate framework for testing capacity for the decision to have an assisted death.	The Royal College of Psychiatrists have stated "The Mental Capacity Act does not provide a framework for assessing decisions about ending one's own life", see point 4: (Here)
Application of the Mental Capacity Act in the context of assisted dying would be straightforward.	Leading psychiatrists disagree. Dr Annabel Price has said "I'm a liaison psychiatrist with a PhD looking at capacity in assisted suicide. I know my way around the MCA and assess capacity regularly. Am I confident I would get the capacity assessment right for people requesting AD? No."
Vulnerable groups	
The TIA Bill adequately protects vulnerable people.	Support for the Bill by professional organisations, associations or regulatory body does not exist. The Royal College of Physicians, Royal College of Psychiatrists, Association for Palliative Medicine, Disability Rights UK, British Geriatric Society, MIND, BEAT, Liberty, Standing together against Domestic Abuse, KCL complex End of life and Death Decisions group, Gold Standards Framework Centre, and British Association of Social Workers all have explicitly stated that the Bill fails to protect the vulnerable.
Assisted dying won't affect children.	This law will affect children in many ways. Professionals can bring AD up, and discuss it with children. For children with life-limiting conditions, this law may send societal messages that some lives are not worth living. See editorial here

People with anorexia would not be eligible for assisted dying under the TIA Bill.	The Royal College of Psychiatrists are clear that there is a risk that people with anorexia – whose mental illness causes physical frailty – would be eligible (Here -p6) as is BEAT Eating disorders (Here)
People from minoritised ethnic groups generally access assisted dying less than white people. Therefore there are no concerns around vulnerability of these groups.	It is true that rates of AD are lower in minoritised groups. To understand the risks to different groups we need to examine not just *whether* people access AD but *why* they access it. There is evidence from community groups in England that this law may deepen mistrust, and worsen health and care, for minoritised people. There is evidence from other jurisdictions of people accessing AD because of social and economic suffering (Here). Accessing AD in Oregon because of financial reasons has risen from 5% to 9.1% over the last 20 years. (Here)
Under this Bill, someone could not request an assisted death because they were depressed.	Having treatable depression will not exclude people from an assisted death within this Bill. Depression is common among people with terminal illness, is often treatable, and does not necessarily impair capacity. See evidence given by The Royal College of Psychiatrists to the House of Commons TIA Bill Committee. (Here)
Disabled people support assisted dying.	It's correct that in some public opinion polls around 70% people who are disabled support AD. But not a single disability rights organisation – which tend to represent people with the most severe, life-long disabilities - supports assisted dying.

Pain and morphine

Pain is inevitable at the end of life.	Most dying people never experience pain. It is always sad, but dying is not in itself painful.
Assisted dying legalisation means people won't die in excruciating pain.	**First**, assisted dying doesn't relieve pain, and it is not possible to predict who might experience severe pain at the end of life. **Second**, many different drugs and non-medical approaches (*such as nerve blocks*) can effectively relieve pain in dying people. But many dying people (*over 150,000 every year*) do not receive the palliative care they need. **Third**, pain is low down the list of reasons why people request AD in jurisdictions where it is legal – not in the top 5. (Here) **Finally**, it is worth noting that the TIA Bill is silent on pain and on suffering.
20 people per day (or around 7,000 people per year) would die with unrelieved pain even if they received high quality palliative care.	This data comes from a report that has not been peer-reviewed, and it was based on a flawed assumption. See explainer blog here. Marie Curie outline over 150,000 people last year who should have palliative care couldn't access it – this is one every 5 minutes. (Here)
There is an upper limit to the amount of morphine dying patients are 'allowed'.	There is no upper limit to morphine dose. The dose of drugs used at the end of life should be titrated according to patients' symptoms, and given regularly as the medication is metabolised. If

	people have side effects from one drug, alternatives can be used to ensure pain relief. Adequate pain relief means that people can die in peace. Palliative Care is an evidence based specialty.
People with morphine allergy cannot receive pain relief.	True morphine allergy is very rare. What is more common is experiencing side effects such as nausea – which can be managed with medication and does not mean the morphine must be stopped. People who *are* allergic to morphine can receive other opioids safely. There are also non-opioids, and non-drug approaches, that are used to manage pain.
Use of morphine when people are in their last phase of life hastens their death.	There is no evidence that in appropriate doses, and titrated carefully to someone's pain, that giving morphine at the end of life hastens death (Here). The misunderstanding comes about because two things are true: (1) dying people often receive drugs such as morphine for pain relief, (2) dying people die. These facts are correlated, rather than *causatively* related.

Experiences at the end of life

Vomiting faeces is something that commonly happens when people are dying.	Vomiting faeces is incredibly rare. What is more common is vomiting old, semi-digested food, which may have a brownish colour and therefore be mistaken for faeces. Explainer blog here
The rate of suicide in terminally ill people is twice the rate in non-terminally ill people.	It is correct that suicide risk is around twice as high among people diagnosed with severe physical illness. However, suicide risk is highest immediately after diagnosis and falls quickly within 3-6 months. There is no good evidence that suicide risk is higher in people who are in their last 6 months of life. This evidence supports better mental health support at the time of diagnosis of severe physical illness. (Here)
People approaching the end of life often resort to starving themselves to death.	Eating and drinking less is a natural part of dying. The body just doesn't need as much nutrition when someone is dying as it did when they were well. Voluntarily stopping eating and drinking is very unusual.

Rhetoric

Assisted dying is a medical treatment.	The Bill itself is silent on the question of whether assisted dying is a treatment or not. This is a critical question because it has implications for healthcare, clinical practice and law. This opinion piece makes the case that assisted dying should not be considered a treatment and that it should be out-with medicine. There are alternate models available also (Here)
Assisted dying need not detract from palliative care.	There are many ways in which assisted dying can impair palliative care. Through competition for resources (*funding, staff capacity*), through moral distress and burnout (*85% of palliative medicine doctors are anti-AD*), and through patients and families having fear of hospices and palliative care services.

The Terminally Ill Adults Bill incorporates an 'MDT approach'.	A 3-person panel, at the end of the assessment process, will not allow for multi-disciplinary decision making in its true sense. To be meaningful multi-disciplinary assessment needs to happen at the beginning of the process, not the end, and each multi-disciplinary team member should independently assess the patient in person.
This debate is simply about people facing terminal illness who want control over their deaths.	There are four groups of people who must be considered in this debate: 1- those who might want (*and might benefit from*) AD. This group receives the majority of media attention. 2- those who might be pushed towards it. For example, vulnerable groups pressured or coerced (*by individuals or by their situation*) to 'choose' an assisted death. 3- People for whom there has been mis-diagnosis, mis-prognosis, or mis-management that leads them to seek it. 4- those approaching the end of life for whom the very existence of this legislation changes the care landscape, potentially influencing choices, for example because they are reluctant to accept palliative care or because palliative care is less readily available.
We are not protecting vulnerable people now, this Bill is safer than the status quo.	There is a small group of people (*those with terminal illness who die by suicide*) for whom this Bill adds safety. But there is another - much larger - group of people (*those at risk of being pressured into AD, and those for whom the introduction of AD means worse care*) for whom this Bill adds risk.
The public overwhelmingly support assisted dying.	Opinion polls show general public support. But they also show that support is fragile. For example, half of supporters say they would switch to oppose if people had assisted deaths because they couldn't access the health and care they need. (Here)
We do not check for coercion now when people go to Dignitas. Therefore, this Bill just puts a legislative framework around this decision.	This Bill doesn't stop people being coerced into going to Dignitas even if enacted. In addition, coercion cannot be reliably detected by professionals. Recent BBC article where Safeguarding minister Jess Philips has admitted professionals can't detect domestic abuse. (Here) Of the 114 UK nationals deaths from euthanasia by Dignitas in 2024, at least 21% were not terminally ill (Here) and would not fulfil the criteria of the TIA Bill, therefore the Bill would not stop these people going to Dignitas.
Palliative care professionals are generally against assisted dying because they are very religious.	There is no evidence for this. It is notable that those doctors who are most anti-assisted dying are the ones who spend most of their time caring for dying people (*palliative medicine, geriatrics, oncology*).