TERMINALLY ILL ADULTS (END OF LIFE) BILL

A briefing on the private member's Bill introduced by Kim Leadbeater MP.

JULY 2025

Kim Leadbeater, the MP for Spen Valley, presented the Terminally Ill Adults (End of Life) Bill on 16 October 2024. On 20 June, the Bill received its Third Reading with 319 MPs voting in favour and 291 against. The Bill has now moved to the House of Lords. This briefing examines the features and safeguards of the Bill, drawing on the experience of other jurisdictions to assess the likely impact of this legislation.

What does the bill propose?

The Bill would amend the current law so that providing assistance to someone to end their life in accordance with the Act would not be an offence under the Suicide Act 1961. While using dishonesty, coercion or pressure to induce someone to request an assisted death, or falsifying or destroying documentation would be an offence (sections 34-36), the Bill contains nothing to prevent family members or doctors from encouraging someone with a terminal condition to request assisted suicide. This is true even if that person has learning disabilities. Vulnerable people are not protected; anyone who meets the broad eligibility criteria could receive lethal drugs. Amendments to protect people entirely motivated by depression or fear of becoming a burden were rejected.

What are the eligibility criteria?

Applicants must be terminally ill, mentally capable, 18 years or over, resident in England and Wales for at least 12 months and registered with a medical practice. The person must have a clear, settled and informed wish to end their own life, and have made a request voluntarily. They must then:

- Make a first declaration, which is signed and witnessed
- Be assessed by the coordinating doctor, who makes a statement
- Be assessed by a second, independent doctor, who also makes a statement
- Be referred to an Assisted Dying Review Panel, which verifies if eligibility criteria have been met
- Make a second declaration

If these requirements are met, the coordinating doctor may provide the person with lethal drugs with which they may end their life.

Terminal illness

The Bill states:

1. For the purposes of this Act, a person is terminally ill if —

- The person has an inevitably progressive illness or disease which cannot be reversed by treatment, and
- The person's death in consequence of that illness or disease can reasonably be expected within six months.

2. For the purposes of subsection (1), treatment which only relieves the symptoms of an inevitably progressive illness, disease or medical condition temporarily is not to be regarded as treatment which can reverse that illness or disease.

There are several causes for concern around this definition of terminal illness.

Forecasting life expectancy

The Bill assumes doctors can accurately predict a patient's future, but even experienced professionals often struggle to make an accurate forecast of life expectancy. In Oregon, 5% of patients who died under the Death with Dignity Act in 2023 outlived their six-month prognosis.[1] It is impossible to say how many more people who chose to die based on an inaccurate prognosis could have survived longer than six months. Errors in diagnosis for severe, life-threatening conditions can be as high as 20%.[2]

What is terminal?

Section 2 appears to discount medical treatment that would increase a person's prognosis beyond six months. For example, conditions such as diabetes "cannot be reversed by treatment", but treatment with insulin can prevent it from becoming fatal. A patient who stops taking insulin would, therefore, meet this definition. Other non-fatal conditions are increasingly being regarded as terminal. Colorado has seen a growing number of assisted deaths for "severe protein-calorie malnutrition". Twelve were reported between 2021 and 2023 — with nine recorded in 2023 alone — compared to zero cases in previous years. Although the Bill now ensures that someone who voluntarily refuses food and fluids would not qualify, the so-called "anorexia loophole" remains. People with eating disorders could still be eligible if their condition becomes life-threatening due to a lack of appropriate care.[3] This is one of the reasons the Royal College of Psychiatrists is opposed to the Bill.

Extending eligibility

There is already pressure to expand the criteria beyond a six-month terminal diagnosis. The campaign group My Death My Decision has expressed disappointment that it doesn't include conditions that "can make life intolerable for the sufferer well before they can be described as terminal".[4] Although Esther Rantzen says she regrets that the Bill does not apply to people with "chronic illnesses" she acknowledged that: "having these narrow criteria makes it possible politically to get this reform through".[5] When New Zealand's End of Life Choice Act was passed in 2019 it required a terminal prognosis of six months or less. Supporters of the law now want that condition removed. David Seymour MP, the Act's sponsor, admitted: "The six-month limit was a political compromise...I never supported it. I never wanted it. I didn't introduce it that way. I had to compromise because if I didn't get the votes, there'd be no law at all."[6]

Canada's Medical Assistance in Dying (maid) legislation, passed in 2016, was supposed to be limited only to people whose death was "reasonably foreseeable". A court challenge led to this requirement being dropped in 2021 as part of a five-year review of the law. Section 50 of the Leadbeater Bill requires the Secretary of State for Health to review the law after five years. This could provide an opportunity for a relaxation of eligibility criteria.

Proxies and independent advocates

Section 21 allows patients who are "unable to sign their own name (by reason of physical impairment, being unable to read or for any other reason)" to have the declaration forms signed by a proxy. This could be (a) a person who has known the person making the declaration personally for at least two years, or (b) a person of a description specified in regulations made by the Secretary of State. So, the proxy could either be well known to the patient or, depending on what is eventually specified in the regulations, potentially a stranger. There is also an inherent contradiction in expecting people who are physically incapable of signing their own name to administer the lethal substance to themselves.

Section 22 also requires regulations for the appointment of independent advocates to provide support for those who have substantial difficulty in understanding the assisted suicide process. The Bill specifically identifies people with learning disabilities, a mental disorder or autism. This section raises disturbing questions about the mental capacity of those who will be helped to end their lives. Can someone who experiences "substantial difficulty in understanding" the assisted suicide process really be said to have made a clear, settled and informed decision?

The role of doctors

The involvement of two doctors is proposed as a key safeguard in this Bill.

While it is welcome that doctors are not under a duty to raise the topic of assisted suicide with their patients, they would be free to do so even if a patient doesn't raise the issue first. This could result in some doctors routinely suggesting assisted suicide to anyone seen as eligible, potentially planting the idea into a patient's head.[7] Given the level of trust commonly afforded to the medical profession, such a suggestion could be highly influential for vulnerable patients. When addressing the Bill's committee Dr Rachel Clarke said: "I would suggest that stating it broadly like that is a form of pressure and that you are potentially unintentionally coercing that patient. The very act of raising assisted dying in that way will make that vulnerable patient think, 'God, is this doctor telling me that my life is not worth living any more?'".[8]

The law in New Zealand and in Victoria, Australia, prevents doctors from raising assisted suicide with patients who have not requested it, but this is permitted in Canada. This has led to some people being repeatedly offered MAiD even after insisting that they were not interested.[9]

Other reasons why the involvement of two doctors may not constitute a sufficient safeguard include:

Failure to recognise depression

Studies of the relationship between depression and the wish for a hastened death have repeatedly found that clinicians often fail to recognise depression in medically ill patients.[10] An amendment to specify that the second doctor be a specialist in psychiatry was voted down.[11] People with a history of depression are not explicitly protected.

Failure to recognise coercion

The "right to die" can quickly become a "duty to die". Evidence from other jurisdictions shows that many people request assisted suicide because they do not wish to be a burden on their family or caregivers. In 2023, 43.3% of people who died through assisted suicide in Oregon said they feared becoming a burden.[12] Although doctors are expected to check that a patient is not acting under coercion, they only need to be satisfied on the balance of probability that a request has been made voluntarily. Kim Leadbeater believes fear of becoming a burden is a perfectly valid reason for seeking assisted suicide.[13]

Conscience protections

The majority of doctors, especially those working closely with dying patients, do not support assisted suicide. When last polled, 82% of members of the Association for Palliative Medicine of Great Britain & Ireland rejected its legalisation [14] and the British Geriatrics Society remain opposed.[15] A 2020 poll commissioned by the British Medical Association found that 76% of palliative care physicians opposed legalisation.[16] While the Royal College of GPs recently changed to a stance of neutrality, their poll of members actually showed that support for changing the law had fallen from 41% in 2019 to 33.7% while 47.6% of respondents opposed a change in the law.[17] A 2019 survey from the Royal College of Physicians (RCP) put support at just 9%.[18] If it were legalised, most doctors caring for the terminally ill would be unlikely to participate in assisted suicide. The RCP survey showed that only 24% of doctors were willing to provide a lethal prescription. Only 18% of doctors in geriatric medicine, 24% in medical oncology and 5% in palliative care said they would participate.[19]

Assisted death specialists?

Although doctors would not be compelled to take part, section 5 (6) would require them to signpost patients to information on assisted suicide services. In jurisdictions where most medical practitioners do not wish to take part, it has given rise to a small contingent of doctors being involved in most of the deaths; of the 108 assisted deaths in Queensland in 2023, 23 doctors participated in some way with 11 to 20 patients, and 14 dealt with over 20 patients.[20] This means that the coordinating doctors are less likely to know the patient well. In Oregon between 1998 and 2021, the median duration of the doctor-patient relationship before death by assisted suicide was 11 weeks (range 0–2131 weeks). By 2023, this had fallen to just six weeks (range 0–1197).[21]

Hospices and care homes

Since hospices and care homes would have no right to opt out of assisted suicide procedures they could be obliged to facilitate them. All attempts to change this were voted down. One MP has even argued that they should lose public funding if they denied this “legal service”.[22] This lack of protection worries many in the hospice sector,[23] especially since hospices in other jurisdictions have been penalised for not providing medically assisted death. For example, the Delta Hospice Society in British Columbia lost $1.5 million in annual public funding over a decision to stop offering medical assistance in dying and was served with an eviction notice.[24]

High court replaced with panels

The key safeguard originally proposed in the Bill was approval by the High Court. Once the coordinating doctor and the independent doctor had concluded a patient had met the criteria, a judge was to declare that the terms of the Act had been fulfilled.

Sir James Munby was among those who voiced concerns about this provision in the run-up to the debate at Second Reading. Sir James, who retired from the High Court Family Division in 2018, argued that the role envisaged for a judge, conflicted with traditional judicial functions.[25] His chief concerns included procedural transparency, judicial discretion, conscientious objections and the potential for a judge to act as a rubber-stamp. He and others also questioned whether the Courts had the capacity to cope with the potential demand.

Despite criticism, this provision remained in the Bill at Second Reading. At least 61 MPs said the High Court safeguard was a key reason for their support and another 20 cited "judicial protections".[26]

On 10 February, Ms Leadbeater announced that the sign-off by a High Court Judge was to be scrapped in favour of an "expert panel".[27] This would be chaired by a senior lawyer — possibly a former or serving High Court judge, a part-time judge or a KC — and include a social worker and a psychiatrist.

The Prime Minister would also appoint a voluntary assisted dying commissioner who would:

- receive documents made under the legislation;
- appoint people to sit on assisted dying review panels;
- refer cases to these panels; and
- Decide applications for reconsideration of panel decisions

Despite this change, problems surrounding the lack of suitable personnel remain. Both the Royal College of Psychiatrists[28] and the British Association of Social Workers[29] have raised the issue of workforce shortages.

Sir James Munby, in his analyses of the proposed changes, raises significant concerns about the tribunal process, emphasising its lack of procedural safeguards and transparency.[30] He notes that the Bill does not specify who should be involved in proceedings beyond the patient, making it difficult to detect coercion or external pressures. Additionally, there are no clear guidelines for how the panel should evaluate key legal criteria such as terminal illness, capacity, and voluntariness. The Bill also lacks provisions for independent evidential investigations, funding for legal representation, and mechanisms for challenging evidence. Sir James warns that without rigorous procedures, the involvement of a judge would be improper, "little more than a rubber stamp providing a veneer of judicial approbation — and that is fundamentally unacceptable." He further questions the secrecy of the process, including decisions on private hearings and publication of reasons. Finally, he highlights a critical flaw: the commissioner can only review refusals, flawed approvals cannot be reconsidered. This means patients could be helped to die based on erroneous decisions.

He concludes that, "All in all, in relation to the involvement of the panel in the process, the Bill still falls lamentably short of providing adequate safeguards."[31]

Can safeguards be maintained?

It is worth briefly considering the experience of other jurisdictions regarding safeguards. Once assisted suicide is introduced, safeguards come to be seen as barriers, and the eligibility criteria are invariably expanded. Oregon and Vermont have recently removed residency requirements.[32] Hawaii reduced its statutory waiting period from 20 days to five.[33] In California, this was reduced from 15 days to 48 hours.[34] Since arguments for assisted suicide and voluntary euthanasia are so similar, its legalisation in some places has led to vulnerable groups like disabled infants or dementia patients, who have not requested death, being euthanised. Belgium and the Netherlands now permit the non-voluntary euthanasia of children. Reports from Belgium and Holland up until 2010 show that between 7% and 9% of all infant deaths involved active euthanasia by lethal injection.[35] In the Netherlands, the number of dementia patients killed by euthanasia rose from 12 in 2009 to 162 in 2019.[36] Between 2012 and 2021, the lives of 39 people with either learning disabilities and/or autism spectrum disorder were legally ended through assisted dying.[37]

Legal experts warn that the law could be dramatically widened by challenges on grounds of discrimination. Alex Ruck Keene KC, who represented Noel Conway, a motor neurone disease patient who brought a landmark case to the Supreme Court in 2017 said that, once the ban on assisted suicide is lifted, it is "entirely realistic" that a UK court or the European Court of Human Rights "would find that any legislation which placed restrictions upon who could access assistance with dying breached the non-discrimination provisions of the ECHR".[38]

Approved substance

Section 25 (2) of the Bill provides that once all the process has been completed, the coordinating doctor may provide the person with an approved substance with which he or she may end their life.

Section 27 states: Meaning of "approved substance"

- The Secretary of State must, by regulations, specify one or more drugs or other substances for the purposes of this Act.
- In this Act, "approved substance" means a drug or other substance specified in regulations under subsection (1).

The Bill, therefore, leaves it to future regulations to decide what lethal substances are to be used. Despite the popular misconception that an easily prescribed drug can consistently bring about death quickly and painlessly, the evidence reveals that hastening patient death is not so simple.

As the *British Medical Bulletin* has pointed out, no single drug or combination of drugs is agreed to be most effective for ending a human life.[39] Drugs used for medical purposes are required to undergo a stringent approval process in order to assess efficacy and safety. But the drugs being used for "assisted dying" have not undergone such a process; the safety and effectiveness of previous and current combinations of lethal drugs are largely unknown. Canada's MAiD protocol confirms this.

> *The pharmacokinetics and pharmacodynamics listed for the medications below are at typical therapeutic dosing, not MAiD dosing. There has been little to no research into their parameters at such high doses as seen with MAiD...*[40]

There is no peer-reviewed literature to guide best practice in compounding these medications. There are also concerns that an assisted death is not the peaceful and painless process of popular imagination. In 2021, Dr Joel Zivot, a practising anaesthesiologist and intensive care specialist with more than 26 years of experience, appeared before the Canadian Senate on the effects of the lethal drugs used in the MAiD scheme. He said:

> *"...when a person dies by lethal injection, they basically drown. Their lungs fill with fluid, and I would describe that the experience of dying under that circumstance is more akin to death by waterboarding, which we recognise to be cruel... it should be clear to the Canadian public that the kind of death that they will experience as a consequence of MAiD will be something other than the way it is represented. It could be exceedingly painful and more akin to drowning."*[41]

The lack of any commonly agreed protocol for ending life with drugs, and the possibility of assisted deaths actually being painful and distressing, is something that should be considered by parliamentarians, and not left to regulations. Attempts to address this problem were consistently voted down in committee.

Conclusion

There are many factors for Peers to consider before voting on this Bill — the impact on palliative care, the potential change in social attitudes towards suicide and the preservation of life and the concerns of the disabled community. These vitally important issues could not be covered in this briefing.

Kim Leadbeater claims that her Bill is "the strongest, most robust piece of legislation on this issue in the world". However, her most vaunted safeguard, sign-off by a High Court judge, was controversially dropped after Second Reading. Doubts remain as to whether the Bill's safeguards can protect vulnerable people from coercion and abuse. Its eligibility criteria are open to broad interpretation and risk expansion. Many essential matters will only be decided in future regulations, including the training offered to doctors on assessing capacity and spotting coercive control, as well as the substances to be used to end life. Section 8.8 (c) proposes "reasonable adjustments and safeguards" for people with a learning disability, but what this entails has yet to be decided.

Given the controversy around the make-up and conduct of the Committee, Peers will have to consider whether the process of a Private Member's Bill will prove sufficient to rectify these concerns. More fundamentally, individual parliamentarians will have to weigh up whether it is possible for the state to involve itself in the ending of human life without adverse consequences.

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