BMA briefing – Terminally Ill Adults (End of Life) Bill

Bill Committee, w/c 24 February

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The Terminally Ill Adults (End of Life) Bill: BMA views on the Bill

The BMA is neutral on whether or not the Bill should pass, but our views on what we would want to see in the Bill, should it pass, are outlined in our written evidence and our recent oral evidence to the Committee.

This briefing highlights our views, thus far, on the clauses and amendments published by 24 February 2025. Updates to our briefing will be circulated, as-and-when necessary, regarding any further amendments on which we have taken a view. If you would like any input from the BMA with regards to new, or tabled, amendments, please do get in touch.

N.B. We have only commented on those clauses and/or amendments that are directly related to one of the issues on which the BMA has an agreed position. It should not be inferred that we would/would not support amendments on which we have not commented in this briefing.

Clause 4 and linked/grouped amendments – initial discussions with medical practitioners

Tabled amendments:

- **We oppose Amendment 8, Amendment 124, Amendment 342 & Amendment 276 to clause 4** – we strongly advise against amending the current provisions in the Bill concerning the communication between the doctor and their patient. We support the Bill's balanced position such that there is no prohibition on raising assisted dying with eligible patients where, in their professional judgement, the doctor considers this to be appropriate – but there is also no duty to raise it; doctors may, but are not required to, have the formal 'preliminary discussion' with a patient. Amendments 8, 124, 342 and 276 are illustrative of a number of attempts to amend the Bill's current provisions regarding this communication between the doctor and patient.
- **We oppose New Clause 7** – NC7(3) states that '*Initial discussions under section 4 may only take place with a registered medical practitioner if they are listed on the Register of Assisted Dying Medical Practitioners*'. Restricting these initial discussions only to those who are listed on the register could significantly reduce the number of doctors available to carry out this supporting role, which would be detrimental to patients. **Amendment 359** similarly appears to say that it must be the coordinating doctor who has the preliminary discussion with the patient. This could either exclude others from taking on that role or require the patient to have the discussion twice. Therefore, we are concerned that NC7(3) and Amendment 359 could be detrimental to patients.
- Furthermore, NC7(4) appears to state that the register of assisted dying medical practitioners must include all registered practitioners other than those who have completed the necessary training

and have opted in to be listed on the register. This is confusing and appears to undermine the intention of the register.

- **We oppose Amendment 126** – it risks causing significant confusion about who needs to opt in, and undermining the protection currently provided to health professionals under the Bill.
- **We oppose Amendment 288** – this amendment '*would require the coordinating doctor to record efforts to dissuade the person from taking their own life and subsequently make this available to the medical examiner*'. In such situations, it is not the role of a doctor to dissuade a patient from their intended course of action, but to explore with them the reasons for their request and to provide them with all the necessary information to enable them to make an informed choice as the nature of their death.
- **We strongly urge MPs to support Amendment 338 to clause 4** – this amendment, as well as Amendment 341, would remove the 'referral' requirement in relation to the preliminary discussion (clause 4(5)). **Linked to this, we strongly urge MPs to support New Clause 13,** which would establish an official body to provide factual information to patients about the range of options available to them – doctors could direct (rather than refer) patients to this body, ensuring that the doctor's views are respected, whilst also – crucially – ensuring that patients can easily access the information and support they need.

BMA policy – the rationale for our position on these amendments

Re. opposition to Amendments 8, 124, 342 and New Clause 7:

There should be no duty to raise the issue of assisted dying with patients

We welcome the Bill's provision that a doctor is not under a duty to raise assisted dying. This is necessary to avoid any suggestion that doctors have a legal duty to raise it. We are concerned that these amendments would remove that provision, leaving doctors in a position of legal uncertainty.

If doctors are concerned that they may be legally obliged to raise assisted dying with all potentially eligible patients, this will impact on how, when, and by whom the issue is raised. There is a risk, for example, that patients could be asked repeatedly about assisted dying by different members of their healthcare team and/or very soon after a terminal diagnosis has been given and before they have had time to reflect on that information. It is essential that decisions about when and how to discuss assisted dying are made on the basis of what is best for the patient – rather than to avoid legal challenge.

All patients deserve to have this important and sensitive conversation with a doctor who is confident, competent and happy to have the discussion. Doctors who are unable or unwilling to do this, for any reason, should be able to decline such requests and direct the patient elsewhere (i.e. to the official information body proposed in NC13).

There should be no prohibition on doctors initiating discussion with patients about assisted dying

We welcome clause 4(2). Doctors should be able to talk to patients about all reasonable and legally available options; a provision that limits or hinders open discussion about any aspect of death and dying is likely to be detrimental to patient care. Doctors should be trusted to use their professional judgement to decide when and if a discussion about assisted dying would be appropriate, taking their cue from the patient as they do on all other issues.

Adding a prohibition or limiting factors in the Bill would also create uncertainty and legal risks for doctors, which may inhibit effective doctor/patient communication and understanding. Some patients find it difficult to bring up sensitive subjects in their consultations, and doctors are skilled at reading between the lines of what patients say and working out what has been left unsaid. It may be clear to the doctor that the patient wishes to explore the topic without them actually mentioning assisted dying. In this situation, a doctor who responded by gently exploring whether this was an issue the patient wished to discuss, could subsequently be open to legal challenge (for example, if a family member argued that the doctor, rather than the patient, had initiated the discussion).

It is worth noting that official bodies in New Zealand (pages 7 and 10) and Victoria (page 34) have raised concerns about the impact of this provision in their legislation, and have recommended that it is amended.

Read about the importance of this issue in an interview with the BMA's Medical Ethics Committee Chair, and the consensus from the medical profession in the RCGP's oral evidence: *'We very much follow the opinion I heard from Dr Green from the British Medical Association earlier in the week…We are very protective of our relationship as GPs, and want to give patients the options that they might want to choose for themselves…We would want to protect that in whatever way...'*

Re. opposition to Amendment 126:

There are certain activities specified in the Bill that are a part of the assisted dying process itself. As the Bill is currently drafted, health professionals are able to choose whether to opt in to provide these roles. Concurrently, there are other roles, such as the preliminary discussion, and providing professional opinions on capacity or life-expectancy to assist those who are making the formal assessment of eligibility. These 'supporting' activities, (which are referred to in clauses 23(1) and 23 (2) as 'the provision of assistance'), are directly linked to, but not a part of, the formal assisted dying process and do not require doctors to opt in, as the Bill is currently drafted.

We support this distinction in the Bill, which this amendment appears to seek to remove. In our view, depending on how 'the provision of assistance' is interpreted, this amendment would either significantly reduce the number of doctors available to carry out these supporting roles (which would be detrimental to patients), or significantly reduce the protection to doctors currently afforded in the Bill.

Re. support for New Clause 13 and Amendment 338:

We strongly urge MPs to support these amendments which would remove the 'referral' requirement in relation to the preliminary discussion (clause 4(5)), and establish an official body to provide factual information to patients about the range of options available to them

As acknowledged during our oral evidence, the Bill should be amended to clarify that a doctor who is unwilling or unable to conduct the preliminary discussion, should direct a patient who is requesting an assisted death to where they can obtain information and have that discussion. There should be no requirement to refer them directly to another doctor willing to have the discussion or the assisted dying service (noting the significance of the word 'refer').

This is analogous to doctors' professional and legal obligations regarding abortion, and is consistent with the Bill's inclusion, at clause 23, of a right to refuse to carry out activities directly related to assisted dying for any reason.

In tandem, we believe creating an official body to provide individual information and advice to patients, to which doctors could direct (rather than refer) patients, would ensure that the doctor's views are respected, whilst also – crucially – ensuring that patients can easily access the information and support they need. Currently, whilst the Bill acknowledges the need for accurate, impartial information and advice for patients, it gives no indication of how this might be delivered – generic published information would not be sufficient. Patients would need individual advice, guidance, and support so that they can make informed decisions, and an independent information service could meet this need.

Consensus for this amendment from medical profession – RCGP's oral evidence: *'The BMA referred to the word "refer"—referring to a colleague, for those who did not want to do it. We agree that signposting is a better process…'*

The Royal College also said in its evidence: '*Similar to other services, such as termination of pregnancy, we think that the best option would probably be that the GP could signpost to an information service, such as something like what the BMA suggested the other day. They would not have to do anything more than that, and they would not withhold any option from the patient…*'

Furthermore, there was acknowledgement of the significance of 'referral' from the Chief Medical Officer: '*..I suspect that if they [doctors] themselves did not feel able to do it—because of conscience or choice, or because they did not feel that they had the necessary skills—the great majority would have no problem referring on, but it might be an issue for some people. Personally, my view is that we should be able to have the range, provided that people are aware in general that, if one person cannot provide it and then does not wish to discuss it, there are alternative routes…'*; and from the GMC: '*The word "referral"—this is part of the BMA's position—has a particular meaning in the world of medicine…*'

New Clause 4 – 'Assisted Dying Agency'

Tabled New Clause/Amendments:

- **NC4 and consequential amendments** – NC4's creation of a separate 'Assisted Dying Agency' is in line with our view that assisted dying, if legalised, should be delivered as a separate service (and not integrated into everyday medical practice).
- **However, we do not agree with Amendment 71, consequential to NC4,** which would require a doctor to refer a patient to this 'Agency'.

BMA policy – the rationale for our position on NC4 and consequential Amendment 71

Assisted dying as a separate service (but not necessarily separate from the NHS)

There is currently nothing in the Bill about how an assisted dying service might be delivered, although the possibility of a separate service is mentioned in the explanatory notes. Whilst it is not for the BMA to determine how any assisted dying service should be delivered, our view is that assisted dying should not be part of the standard role of doctors or integrated into existing care pathways – it is not something that a doctor can just add to their usual role. It is likely that most doctors would rarely receive such requests, making it difficult for them to build up the knowledge, experience, and confidence to provide the service to a high standard, which is what all patients would deserve.

Having an assisted dying agency, as proposed in NC4, is one way of providing this separation. It could take the form of a professional network of specially trained doctors from across the country who have chosen to participate, who come together to receive specialised training, guidance, and both practical and emotional support. They would then provide the service within their own locality – for example, in the patient's usual hospital, or their home. Or it could be a combination of some specialist centres and an outreach facility.

However, as discussed in relation to clause 4 (see above), we do not agree with a requirement for doctors, who may be unwilling or unable to have the preliminary discussion, to 'refer' the patient onwards.

The model proposed in Jersey[1], whereby the Jersey Assisted Dying Service would 'coordinate and deploy the professionals' who would provide the service, provides an example of how this separate service could work.

Clauses 5, 8 & 19 and linked/grouped amendments – training criteria for the opt-in

Tabled amendments:

- **We strongly urge MPs to support New Clause 12 and linked Amendments 335, 336, 337** – taken together, these would clarify and safeguard the Bill's design based on an opt-in model for doctors, and ensure that only those who have received specialised training are able to provide assisted dying (providing reassurance for all involved).
- **We oppose Amendment 290** – whilst we agree that Physician Associates (PAs) should not be coordinating doctors, under the Act, this amendment incorrectly asserts that PAs are, or will be, registered medical practitioners. They are not, and even following registration by the GMC, they will not be on the medical register or have a licence to practise medicine as a doctor does. To accept this amendment would also exclude many skilled doctors, such as experienced resident doctors and those currently working in a locum tenens post, from any future process.

BMA policy – the rationale for our view on these amendments

Re support for NC12 and Amendments 335-37:

We strongly urge MPs to support these amendments which would define the 'training' explicitly in the Bill as specialised training to provide assisted dying, undertaken by those who opt in (clauses 5(3), 8(6), 19(2))

We have been vocal that the Bill should be based on an opt-in model, and we were pleased that Ms Leadbeater confirmed the Bill's opt-in model during the Committee's oral evidence sessions. Reinforcing this, we believe NC12 and Amendments 335-337 would make two important aspects of this provision in the Bill clearer:

1. **That providing assisted dying is not, and would not in the future, be expected of all doctors** – the Bill's current all-encompassing reference simply to 'training' does not preclude this training being prescribed as standard general medical training via the regulations, in which case it would apply to all doctors and make the opt-in redundant. Specifying that it is 'specialised' training on the face of the Bill, and making clear that there is no obligation on doctors to undergo the training, would safeguard the opt-in model in the Bill's first principles.
2. **That only those who undergo specialised, tailored training on assisted dying could provide the service** – during the oral evidence sessions, there has been much discussion about the importance of specialised training for those who opt in to carry out the service. Specialised training for those providing the service is essential for doctors and provides additional protection and safeguards for patients – it should be explicitly referenced in the Bill. (This would not prevent general guidance/training also being made available to other health professionals).

Clause 33 and linked/grouped amendments– notifications to Chief Medical Officers (CMOs)

Tabled amendments:

- **We support Amendments 172 & 173** – currently, the Bill only states that the Secretary of State *may*, by Regulations, specify the information that registered medical practitioners must provide to the relevant CMO. We have urged the Committee to ensure that the Bill requires (rather than permits) the Secretary of State to make such Regulations – these amendments would achieve that.

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[1] A separate assisted dying service – 'the Jersey model' – can be viewed on the BMA's website here: www.bma.org.uk/media/c4qhenaf/bma-flow-chart-jersey-model.pdf

BMA policy – the rationale for our position on these amendments

Data collection and publication is essential for transparency and developing trust in the system – therefore, a requirement for data about all assisted deaths to be collected centrally, and for aggregated data to be published on a regular basis, should not be optional.

Key outstanding issues on remaining clauses – the BMA urges the Committee to table the following amendments for consideration at the Bill's Committee Stage:

- **Establish increased oversight and regulation (clauses 33-35) by requiring a process for the routine review of all individual assisted deaths** – including ensuring the process was followed correctly, identifying the time from taking the drugs to death, and any complications or unforeseen circumstances that arose and how they were managed. Common in other jurisdictions, this process can provide additional scrutiny and lead to improved service delivery and governance.

- **Add a provision for safe access zones, as is now available throughout the UK outside abortion clinics** – such a provision could be invoked should the need arise, to protect staff and patients from harassment and/or abuse.