TERMINALLY ILL ADULTS (END OF LIFE) BILL

A briefing on the private member's Bill introduced by Lauren Edwards MP

JULY 2026

On 17 June 2026, Lauren Edwards, the MP for Rochester and Strood, reintroduced the Terminally Ill Adults (End of Life) (TIA) Bill into the House of Commons. This followed the failure of the same Bill to complete its passage through Parliament in the previous session. By reintroducing the legislation as it was when it received its Third Reading on 20 June 2025, it appears Ms Edwards is hoping to take advantage of the Parliament Act, which would allow the Bill to become law without the approval of the House of Lords. Enacting a private member's Bill in this way is unprecedented, and throws up many questions.

Use of the Parliament Act would necessitate introducing an identical Bill, with very little scope for MPs to amend it. As Ms Edwards Bill has not been printed at the time of the publication of this briefing, this analysis examines the text from the Leadbeater Bill as of its Third Reading.

WHAT DOES THE Bill PROPOSE?

The TIA Bill sets out the circumstances in which health professionals could assist someone to end his or her life without committing 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 unlawful (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 groups are not protected; anyone who meets the broad eligibility criteria could receive lethal drugs. Amendments to provide additional protection for 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. Evidence provided to the House of Lords highlighted the fact that "There are no valid tools, tests, or clinical examinations that can reliably and safely identify that a person is expected to die within six months."[1] On 29 October 2025, Professor Martin Vernon of the British Geriatrics Society told the Lords Select Committee that there is at least a 20% to 30% unreliability in such predictions.[2]

In Oregon, 6% of patients who died under the Death with Dignity Act in 2025 outlived their six-month prognosis.[3] 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.

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. Although the Bill was amended to prevent someone who voluntarily refuses food and fluids from qualifying, 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.[4] This is one of the reasons the Royal College of Psychiatrists is opposed to the Bill.

A study undertaken by Chelsea Roff (founder of Eat Breathe Thrive) and Dr Catherine Cook-Cottone found that at least 60 people worldwide have been "helped" to die because of eating disorders.[5] This figure includes deaths in Colorado, California and Oregon where the law requires an applicant to have a terminal condition. Ms Roff told the Lord Select Committee: "We saw anorexia nervosa listed by name as a terminal condition."[6] Each of these cases involved women with no comorbid conditions or organ failure.

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 the Bill. While doctors are not under a duty to raise the topic of assisted suicide with patients, they would be free to do so even if a patient hasn't raised 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 select committee in January 2025, 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 anymore?'"[8]

The law in New Zealand prevents doctors from raising assisted suicide with patients who have not requested it, but it is permitted in Canada. This has led to some people being repeatedly offered Medical Assistance in Dying (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 2025, 39.8% 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. Many advocates of assisted suicide (including Kim Leadbeater, the Bill's previous sponsor) believe fear of becoming a burden is a perfectly valid reason for hastening death.[13]

In evidence submitted to the Lords select committee on 30 October 2025, Dr Jane Monckton-Smith, Professor of Public Protection at the University of Gloucestershire, pointed to a clear link between domestic abuse, coercive control and suicide. She told the committee that every week in the UK an estimated 34 suicides were linked to domestic abuse.[14] She also argued that perpetrators often staged a murder to appear as a suicide and warned that the legislation might inadvertently worsen this situation.

During the same hearing, Cherryl Henry-Leach, Chief Executive of Standing Together Against Domestic Abuse, cited research published by the Mayor of London's Office in 2019 that indicated that in 10 per cent of domestic abuse cases, the perpetrator was the victim's carer. A 2024 review of domestic abuse deaths showed that healthcare professionals had failed to identify an abusive situation in over 50 per cent of cases.[15] The Bill makes no requirement for robust, face-to-face evaluation to protect vulnerable individuals from coercion.

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[16] and the British Geriatrics Society remain opposed.[17] A 2020 poll commissioned by the British Medical Association found that 76% of palliative care physicians opposed legalisation.[18] 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.[19] A 2019 survey from the Royal College of Physicians (RCP) put support at just 9%.[20] 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.[21]

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 professionals do not wish to take part, it has given rise to a small contingent of practitioners being involved in most of the deaths; of the 1,072 assisted deaths in Queensland in 2024-25 period,[22] 16 doctors (7%) participated in some way in the deaths of 11 to 20 patients, and 50 dealt (22%) with more than 20 patients.[23] This means that the coordinating doctors are less likely to know the patient well. In Oregon between 1998 and 2023, the median duration of the doctor-patient relationship before death by assisted suicide was nine weeks (range 0–2,138 weeks). By 2025, this had fallen to just four weeks (range 0–789).[24]

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".[25] This lack of protection worries many in the hospice sector,[26] especially since hospices in other jurisdictions have been penalised for not providing medically assisted death. For example, the Delta Hospice Society in British Columbia, Canada, lost $1.5 million in annual public funding over a decision to stop offering MAiD and was served with an eviction notice.[27]

During scrutiny of the Bill in the House of Lords, Peers highlighted a distinct lack of consultation with the wider care industry, referencing data showing that the vast majority of care providers had not been consulted on the Bill's operational implications.[28] They also warned that entire hospices or faith-based care institutions could face funding threats or structural pressures if they attempted to institutionalise a conscientious objection to providing the assisted suicide on their premises.[29]

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. This proposal was heavily criticised by the late Sir James Munby, who retired from the High

Court Family Division in 2018. He argued that the role envisaged for a judge, conflicted with traditional judicial functions.[30] His chief concerns included procedural transparency, judicial discretion and conscience protection for judges. He also questioned whether the courts could cope with the potential demand.
Regardless of 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".[31]

On 10 February 2025, Kim Leadbeater, announced that the sign-off by a High Court Judge was to be scrapped in favour of an "expert panel". [32] 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[33] and the British Association of Social Workers[34] have raised the issue of workforce shortages.

Before his death on 1 January 2026, Sir James Munby also raised significant concerns about the tribunal process, emphasising a lack of procedural safeguards and transparency that could make it difficult to detect coercion.[35] He noted that the Bill does not specify who should be involved in proceedings beyond the patient. There were no clear guidelines for how the panel should evaluate key legal criteria such as terminal illness, capacity, and voluntariness. The Bill made no provision for independent evidential investigations, funding for legal representation, and mechanisms for challenging evidence. Sir James warned 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 questioned the secrecy of the process, including decisions on private hearings and publication of reasons. Finally, he highlighted a critical flaw: the commissioner can only review refusals, faulty approvals cannot be reconsidered. This means patients could be helped to die based on erroneous decisions. He concluded 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."

CAN SAFEGUARDS BE MAINTAINED?

The experience of other jurisdictions shows that 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.[36] Hawaii reduced its statutory waiting period from 20 days to five.[37] In California, this was reduced from 15 days to 48 hours.[38] 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.[39] In the Netherlands, the number of dementia patients killed by euthanasia rose from 12 in 2009 to 162 in 2019.[40] Between 2012 and 2021, the lives of 39 people with either learning disabilities and/or autism spectrum disorder were legally ended through assisted dying.[41]

In Canada, a legal challenge to the country's MAiD law resulted in assisted dying being provided to people who are not terminally ill and whose death is not "reasonably foreseeable".[42] Legal experts in the UK 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".[43]

In the Australian state of Victoria, a statutory review five years after the implementation of the law resulted in the removal of legal restrictions on health professionals raising the option of assisted suicide with patients. Section 50 of the TIA Bill mandates a five-year review similar to the one in Victoria. This could provide an opportunity to expand eligibility criteria and remove safeguards.

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 they 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.[44] Drugs used for medical purposes are required to undergo a stringent approval process to assess their 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…"[45]

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 water-boarding, 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."[46]

The lack of any commonly agreed protocol for ending life with drugs, and the possibility of assisted deaths 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 MPs 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.

Supporters of the TIA Bill have claimed it is "the strongest, most robust piece of legislation on this issue in the world".[47] However, its most vaunted safeguard, sign-off by a High Court judge, was controversially dropped after its Second Reading in 2024. Scrutiny by the House of Lords has highlighted the inadequacies of the Bill's safeguards for 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 seismic social change legalisation of assisted suicide represents, MPs will have to consider whether a Bill with so many serious flaws can be given a Second Reading. This is especially true as it appears that the passage of the Bill will be entirely dependent on the Parliament Act. 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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