Royal College of General Practitioners Briefing: Report Stage/Third Reading of The Terminally Ill Adults (End of Life) Bill 2024-25

House of Commons, Friday 16 May 2025.

RCGP Position on Assisted Dying

On 14 March 2025, the RCGP UK Council voted to move to a position of neither supporting nor opposing assisted dying being legal. The UK Council debate and subsequent decision was informed by an all-member survey that ran between January and February 2025. More information can be found at: RCGP shifts to position of neither supporting nor opposing assisted dying

Should Parliament vote to legalise assisted dying, the College recommends:

- Any assisted dying service should be seen as a standalone specialised service that healthcare professionals may opt to provide and should not be deemed core GP work. The establishment of a separate service would ensure healthcare professionals of multiple disciplines (including GPs) who wanted to do so could still opt in to provide assisted dying, but this would be arranged through a different pathway.

- Any assisted dying service would need to be separately and adequately resourced and should not, in any way, result in a de-prioritisation of core general practice or palliative care services.

- If assisted dying was legalised, an independent and transparent system of oversight, monitoring and regulation should be established.

- If assisted dying was legalised, there should be a right for GPs to refuse to participate in the assisted dying process on any ground, and statutory protection making it unlawful to discriminate against, or cause detriment to, any doctor on the basis of their decision to, or not to, participate in the process. There should also be the provision for safe access zones such as those for abortion providers. It is vital that participating staff and patients must always be protected from harassment and abuse.

- If the Bill was passed there should be a full and extensive consultation on defining the regulatory framework, standards and training for all those involved in delivering assisted dying services would need to be conducted on a multi-professional basis. This training and regulation would need to prepare healthcare professionals for and cover all elements of the provision of assisted dying, including but not limited to capacity assessment, coercion identification, mental health support, medication and prescribing decision making, and death and certification.

If you have any questions, please contact Jonathan.blay@rcgp.org.uk

Standalone specialised service

The best way to ensure that no medical professional is forced to participate in assisted dying is to run it as a completely standalone specialised service. It should not be part of the core GP contract so no GP who wants to be involved would need to. If someone asks their GP to support them through the process that would be a matter for the individual GP to decide but it would not be considered part of their core GP work.

Having a standalone service would clarify what happens when a patient talks to a GP about assisted dying and the GP does not want to be involved. The GP would then be able to simply say that this is not a process that they have chosen to be involved in and can point them towards a website or phone number.

At present, there is nothing in the Bill itself about how an assisted dying service might be delivered, only that the Secretary of State must ensure arrangements are in place for assistance to be provided in accordance with the Bill, including arrangements for the funding of any provision made.

The RCGP calls for details of the separate service to be on the face of the Bill. If this is not possible it is important to get a Ministerial commitment that any assisted dying service would be a standalone separate service and not core GP work.

Clarifying wording to ensure that no doctor is forced to participate in the assisted dying process

In the current clause 28 of the Bill there are provisions to ensure that health professionals are able, without detriment, to decline requests to provide professional opinions to assist those determining eligibility, or to carry out tasks directly related to the assisted dying process (such as to help set up a medical device to enable the person to self-administer the substance).

The clause uses the term 'provision of assistance', however this term is also used in earlier clauses to refer to that part of the assisted dying process where the substance is provided to the patient for self-administration. There is a risk, therefore, that the protection provided by clause 28 may be inadvertently limited to the activities covered in earlier clauses, contrary to the original intention.

We support amendment NC10 to ensure that this clause delivers the protection for health professionals it was intended to provide. This means extending meaning to cover all activities associated with assisted dying and not be limited to a narrower interpretation of the 'provision of assistance'.

Protection for doctors working with patients across borders

As different legislation is developing separately across different jurisdictions it is important that Parliament considers how to protect doctors in one jurisdiction who

might be supporting people in another jurisdiction where the law on assisted dying might be different.

The Assisted Dying Bill in the Isle of Man has completed its passage and has been sent for Royal Assent. This has significant implications for doctors working in England. Many patients from the Isle of Man receive specialist care in England (often in shared care arrangements paid for by the Isle of Man Government). Those specialist doctors, who are treating patients (in England) who are eligible for – and may wish to choose – assisted dying in the Isle of Man, would still be bound by the terms of the Suicide Act 1961. This means that if they do, or say, anything (whilst in England) that might be perceived as 'encouraging or assisting' their patients to have an assisted death in the Isle of Man, they would be committing a criminal offence. The same would apply with doctors who, whilst in England, treat patients who live in Jersey (which has already agreed in principle to change the law to permit assisted dying).

If legislation on assisted dying is past anywhere in the UK we would like to see a Ministerial commitment, to amend the Suicide Act 1961 (in Clause 29) to ensure no medical professional is criminalised for the provision of assistance in accordance with current (or future) assisted dying legislation in the rest of the UK and/or Crown Dependencies.

Funding

The debates around assisted dying have highlighted the lack of support available for people with palliative care needs. While funding for services is not something that is normally covered in primary legislation, the debate is a good opportunity for the Government to make a clear commitment that funding for any service would be additional to that already outlined for the NHS and that the next spending review includes a clear plan to expand palliative care.

Preventing GPs not involved in assisted dying being criminalised for record keeping

Clause 32 (4) makes it a criminal offence for a GP to intentionally or 'recklessly' fail to notify the co-ordinating doctor about a cancellation or fail to record a cancellation on the patient's medical record.

A GP who is not the coordinating doctor and not involved in the provision of assisted dying may well be told by a patient that they are having second thoughts. In those circumstances the doctor would update their patient's medical records about the conversation. Doctors are already under a professional obligation to keep good medical records and can face regulatory sanctions if they fail to do so.

Even if the GP did not update the patient's record there would be no risk that the assisted dying would proceed against the patient's wishes. The patient is required to confirm their continued wish to proceed at various stages up to and including when the substance is provided.

It is however possible to imagine a situation where a grieving family member who objected to assisted dying blaming the GP for not updating the records and push for legal action against them.

We believe that the criminal sanction proposed is excessive, and heavy-handed, when balanced against the possible harms.

Other areas needing consideration:

- **A commitment to provide mental health support** to those professionals opting in to provide the service.
- **Provision for safe access zones.** Safe access zones are 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.
- **An earlier review of the implementation.** The current wording of the Bill says that it should be reviewed by the Secretary of State 5 years after Bill is implemented. The RCGP believe that this review should take place after 2 years instead, to allow for earlier learning to be implemented.
- **Increased oversight and regulation ('Monitoring and review' clauses) by requiring a process for the routine review of all individual assisted deaths** – including ensuring the process was followed correctly and ruling out hidden coercion.
- **Data collection and publication** Data about all assisted deaths needs to be collected centrally, and for aggregated data to be published on a regular basis. We would also wish to see a formal mechanism set up to analyse this information (from all assisted deaths), with a view to making recommendations about how the system could be improved to ensure the compassionate, safe, and practical operation of the Act.