Royal College of General Practitioners

Royal College of General Practitioners Briefing

Second Reading of The Terminally Ill Adults (End of Life) Bill

House of Commons, Friday 11 September 2026

RCGP Position on Assisted Dying

- The RCGP neither supports nor opposes assisted dying being legal.
- The College moved to this position in March 2025 following a debate and vote of UK Council. This decision was informed by an all-member survey that ran between January and February 2025.
- As a College we have and will continue to engage with the legislative debate to ensure that any changes to the law that may be approved by the UK Parliament protect the interests of all patients and healthcare professionals in line with the College principles for legislation agreed in September 2024.
- Further information, including copies of all our previous briefings and submissions on the issue of assisted dying can be found at: www.rcgp.org.uk/representing-you/policy-areas/assisted-dying

Our principle	What the Bill says	What the RCGP wants
Any assisted dying service should be seen as a standalone specialised service that GPs and other healthcare professionals may opt to provide, with additional training and should not be deemed core GP work.	At present, there is nothing in the Bill itself setting out 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 Bill states that people will be directed to information but currently gives no indication of what that information would be, or how this might be delivered.	The College believes that any assisted dying provision must be separately funded and delivered through a distinct pathway and service and that this would best be set out on the face of the Bill. Whilst it is not the role of the RCGP to design exactly how this standalone service and pathway would operate in practice, we do not believe it is appropriate or practical for this to sit within the core responsibilities of general practice. However, this does not necessarily mean separate from the NHS. The establishment of a separate service which covered every stage of the process, including

		the provision of impartial information, would ensure healthcare professionals of multiple disciplines (including GPs) can provide assisted dying services, arranged through a different pathway. This separate service would also be able to provide the wrap-around services patients and their families need.
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 them for doing so.	Clause 31 of the Bill has a general and comprehensive right to refuse. This ensures that there is no duty on any person to take part in the Bill's provisions (either in the provision of assisted dying or in a supporting role) if they choose not to, for whatever reason. This is welcome. While it is implied that the Bill includes an opt-in model for doctors, the wording of the proposed legislation as it stands does not use this language. The Bill's supporting impact assessment (IA) also uses "opt out" language throughout.	We are asking Parliamentarians to consider supporting explicit clarification on the face of the Bill that participation is not presumed and that it will be truly **opt-in**. It should be clear that there is no expectation on any doctor (including GPs) to participate and it is only those who positively choose to do so (via an Opt-in) who would have the specialist training and participate. 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. We would therefore like to see a Ministerial commitment to amend the Suicide Act 1961 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.

An independent and transparent system of oversight, monitoring and regulation should be established.	The current wording of the Bill says that any assisted dying service should be reviewed by the Secretary of State 5 years after the legislation has received Royal Assent. A Voluntary Assisted Dying Commissioner is set up as part of the Bill. The Commissioner must monitor the operation of the Act, including compliance with its provisions and any regulations or code of practice made under it, investigate, and report to an appropriate national authority on, any matter connected with the operation of the Act.	There should be a routine review of all individual assisted deaths – including ensuring the process was followed correctly and ruling out hidden coercion. There should also be 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 any assisted dying service. Data about all assisted deaths needs to be collected centrally, and for aggregated data to be published on a regular basis to help identify any trends, particularly related to deprivation, gender and ethnicity. Given the significance of the proposed legislation, it is only right that Parliament and the wider public are given an early opportunity to assess if the Act (if passed) has successfully met its intended aims and not created any unintended consequences.
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. Work to define standards and training for those involved in delivering assisted dying services would need to be conducted on a cross College, multi-professional basis.	A legal 'duty to consult provision' requires the Secretary of State to identify and consult such persons they consider appropriate, prior to making regulations related to the Bill. There is a legal duty on the Secretary of State to set training, qualifications, and experience requirements for co-ordinating and independent doctors. A requirement for the registered medical practitioner acting as the coordinating and independent doctor to have undertaken	We would support more clarity, either on the face of the bill or verbal commitment from a Minister, that the duty to consult will be extensive, meaningful and include all relevant medical bodies and patient representative groups with a particular focus on marginalised groups. We would welcome further commitments that all regulations brought before Parliament related to this legislation will be given full and considered scrutiny.

	training on domestic abuse, including coercive control and financial abuse. The Bill in its current form leaves a lot of decisions up to the Secretary of State via regulations and secondary legislation. This includes how a declaration is made, proof of identity, relevant forms/reports, appointment of independent advocates, drugs used, codes of practice and other guidance around operation of Act.	Royal College's involvement would be essential in shaping clear, safe, and workable guidance for clinicians, and ensuring that regulations are informed by real-world clinical insight from practitioners across multiple specialties who often look after their dying patients at home. The time commitment and emotional toll on professionals involved in assisted dying must be acknowledged. All medical professionals opting to provide the service should be able to access funded mental health support.
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 a registered medical practitioner conducts a preliminary discussion with a person, the practitioner must explain to and discuss with that person all appropriate palliative, hospice or other care, including symptom management and psychological support, and offer to refer them to a registered medical practitioner who specialises in such care for the purpose of further discussion. The Secretary of State is required to publish an assessment of the availability, quality and distribution of palliative and end of life care services as part of the first report on implementation of the Act (to be undertaken within 1 year of the Act being passed).	It is essential to ensure that every patient approaching the end of life has access to high-quality palliative care—regardless of where they live, or their background. The Bill's Equality Impact Assessment noted that regional disparities in access to palliative care risk leading some individuals to consider assisted dying when they might not have done so if appropriate care had been available. While we recognise that allocating specific funding for services is not something that is normally covered in primary legislation, with general practice and palliative care stretched, the Bill or its implementation should not de-prioritise these services, indirectly influencing patient choices. We therefore continue to urge Parliamentarians to see what further steps and or commitments can be made around the expansion of palliative and end of life care provision and to ensure access is truly equitable.